Treating More than Symptoms: A Proposal to Address the Socio-Economic Needs of the Patient

Business Plan submission

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TABLE OF CONTENTS

PROJECT SUMMARY

The intent of this document is to provide a framework for meeting the physical and social needs of the patient through the integration of non-profit agencies and benevolent organizations into the primary care setting.

The transition to value-based health care in the United States is no longer something for the future. It is here now. To succeed in this model, while treating any given patient for an acute illness, chronic illness, or even minor trauma, clinicians and staff must also focus time, attention and effort on preventative care. This is especially true with over a dozen value-based payment structures and alternative payment models (APMs) now offered by the Centers for Medicare and Medicaid (CMS) as well as with most major insurance companies. (Centers for Medicare and Medicaid 2019).

Many physicians and providers try to look at the whole person, their circumstances, living conditions, etc., and recently those day-to-day needs of patients have become a strategically targeted focus. CMS has written requirements within the Comprehensive Primary Care Plus (CPC+) program that participating clinics must assess each empaneled patients' social determinants of health (SDOH). While this is well and good, what help is it to the patient to assess a need for behavioral health counseling, a need for more adequate nutrition, or even a need for a place to live if there are no resources to offer that patient?

The solution to having those resources available is to establish and/or strengthen relationships between the primary care clinic and various non-profit agencies and other benevolent organizations. The ability to truly treat the whole person relies on much more than just having a list of resources. There needs to be an introduction of the patient to a point of contact within whatever resource the patient needs. There may be multiple introductions for any one patient. Yet the plan would be to enable the patient to build relationships with the contact or someone within the non-profit or benevolent organization, ultimately empowering the patient to care for his or her own needs.

EXECUTIVE SUMMARY

Company

Northland Family Care (NFC) is a private primary care clinic just outside the Kansas City suburb of Liberty, Missouri; with two physicians, four full-time-equivalent nurse practitioners and approximately 22 staff. NFC is owned by the two physicians who have spent their entire career with the same practice – one 26+ years and one 17+ years. Both physicians live in and are active in the community where the clinic is located. It is because of this longevity and locality that each physician knows many of their patients very well, both in and out of the clinic.

Mission Statement

With a mission statement proclaiming, "Commitment to Health; Compassion to Heal," and with providers (both physicians and nurse-practitioners) that know so much about their patients, those providers have a deep-seated desire to help heal the whole person. To that end NFC has established multiple programs for their patients. They have quarterly group diabetic education classes; monthly group meetings for seniors; quarterly educational meetings on topics ranging from understanding Medicare and Medicare replacement plans to understanding the difference between assisted living and a nursing home. They have embedded both a dietician and a family counselor into the weekly operations.

Market Opportunity

Moving forward and being halfway through year three of a five-year commitment to CPC+, NFC is focusing on the required screening for the social determinants of health but is also trying to be forward-thinking. They are not just asking "What will CPC+ require next?" They are also looking at the physical, mental and spiritual health of patients. Providers most of the time know who has behavioral health needs, who has nutritional counseling and accountability needs, who needs help obtaining medications, who is struggling financially and even who is homeless. These are the patients who might be described as 'underserved.'

Treating the 'underserved' is the focus of this proposal. This model would, in phases, begin with identifying a variety of established benevolent organizations, including, but not limited to, clothes closets, food pantries, county health resources and organizations serving senior citizens. Once the key contact person of each organization is identified, a referral process and other logistical issues can be established. The market opportunity of this business plan is truly the 'underserved' current patient population of Northland Family Care.

Management and Key Personnel

It will be up to the physician/owners, practice manager and care coordinator to build the needed relationships for this piece of business. One physician brings a strong aptitude for business, forever questioning if there is a better way or more economical way to do things. The other is a spiritual leader in his religious organization, and truly understands the need to and has the desire to treat the whole patient. The practice manager has served in benevolent roles in the past and worked in and has connections to the non-profit world. The care coordinator has already built a small library of local and national resources to which she refers patients. Success of this extended model will be dependent on those individuals building strong working relationships

with the leaders and contacts from identified outside organizations, be they non-profit organizations, churches, societies, etc.

Competition

The practice manager sent an inquiry to the Greater Kansas City Community Foundation (GKCCF) in an effort to identify similar business models. As of the time of this proposal no non-profit agency in the greater Kansas City area has been identified as having partnered with a primary care clinic in this formal of a fashion. There are multiple agencies that have informal agreements with clinics, mostly in the inner-city.

Further research revealed there is a non-profit clinic in the Kansas City area that has forged a similar business model. KC CARE Health Center has formed strong alliances with non-profit agencies by utilizing social workers. They, too, are located in the inner-city, over twenty miles from Northland Family Care. Consequently, there should be little if any cross-over of patient population being served. It is even possible Northland Family Care leadership could learn from KC CARE Health Center leadership.

It should be stated that this proposed initiative is not intended to compete with any other business in the community, nor is it intended to be an independent line of business within NFC. Rather the scope is to offer the most comprehensive treatment and healing possible to patients.

Financial Information

Financial impact is expected to be minimal the first year of the program. Currently one of the nurse-practitioners works half time as Care Coordinator and half time as a clinician. Her duties would shift to 75% or more as Care Coordinator, utilizing the CPC+ care coordination fees to cover her salary. In year two and three a second care coordinator or possibly a part-time licensed independent clinical social worker (LICSW) will be hired to administer this initiative.

Capital requirements would consist of a computer at the end of the first full year of the initiative. Ongoing expenses would primarily be computer maintenance such as virus protection and licensing fees.

Recently the leadership of NFC met with a major payer concerning their quality initiatives. In that meeting the payer informed NFC that the care management fees paid would increase by $4,500 per month in the fiscal year beginning July 1, 2019. This would be the primary funding source for the entire initiative.

Projected cashflow statements and projected income statements can be found in the “Financial Documents” section of this proposal. Each time a major value-based strategy has been added at the clinic quality-based payments have increased shortly afterwards. This has historically been due, at least in part, to closer attention to and better understanding of hierarchical condition category coding (HCC coding). That has driven risk scores assigned by payers higher, and consequently increased care management payments.

The clinic is prepared to absorb the cost for this initiative in the beginning, as previously mentioned. Leadership expects that by the middle to end of year two the care management payments will increase sufficiently to cover costs.

It should be mentioned that the biggest uncertainty is in year three. The CPC+ initiative is due to sunset on December 31, 2021, which coincides with the clinic's implementation of phase III, spiritual and social connections. Until CMS makes it known what, if anything, will replace CPC+, or if CPC+ might continue, planning for that year will be difficult at best. Contingent plans could include applying for grants or exploring a partnership with KC CARE Health Center.

ORGANIZATIONAL PLAN

EXISTING BUSINESS

Company

Just outside of Kansas City, Missouri is the quickly growing suburb of Liberty. Sitting inside the Kansas City city limits, but just across the I-35 freeway a privately owned, thriving primary care clinic, Northland Family Care (NFC), treats between 300 and 400 patients weekly. Two physician-owners still round on their own patients at the hospital each day and supervise six nurse practitioners (four full-time-equivalents). Each provider knows his or her own regular patients well enough to know who needs behavioral health counseling, nutritional counseling, group sessions, individual education, who is having financial struggles and who is homeless. Both board-certified family practice physicians live in and are active in the Liberty community and the surrounding Kansas City community, allowing them to know many of their patients outside of the clinic walls. Both have spent their entire career with NFC – one 17+ years and one 26+ years. NFC's providers believe in the mission statement: "Commitment to Health; Compassion to Heal." The healing within the clinic has grown to include quarterly group diabetic education classes; an embedded family counselor; an embedded certified dietician; monthly senior support group sessions (65+ years old) with plans to expand to two groups, one 65-79 years old and one 80+ years old; and most recently evening care-giver classes on various topics.

SWOT Analysis

SWOT	POSITIVE	NEGATIVE
	Strength	**Weakness**
Internal	Established quality assurance processes & staff	No office space for growth
	Well-established practice / location	Nursing turnover
	Engaged providers	
	Skeleton resource list established	
	Patient longevity & practice involvement	
External	**Opportunities**	**Threats**
	Strengthen community ties	Potential alienation of entities not selected to participate
	Exceed CPC+ expectations	CPC+ sunsets in 2021

Northland Family Care became one of the Centers for Medicare and Medicaid (CMS) Comprehensive Primary Care Plus (CPC+) Track II practices in 2017 and does very well at meeting or exceeding the minimum quality metric requirements for incentive payments. As commercial payers began offering similarly structured value-based contracts NFC saw the value and signed those contracts. As of May 2019, revenue from the combined CPC+ and commercial value-based contracts are nearly 30% of the practice's total revenues. Both physicians are in full support of these contracts and do everything they can to keep quality metrics as high as possible.

Location is another positive attribute for NFC. Located just 3 blocks off two major highways, patients from rural communities to the North have as fast and easy access as those from the suburban or urban areas to the South. There are three well-known hospitals within 12 miles of the practice, with the physicians rounding at one of those daily.

Patient longevity should be considered one of the strengths of NFC. One of the physicians commented in an interview that he has now treated at least three generations of the same family. One of the easiest overlooked strengths of NFC is its Patient and Family Advocacy Council (PFAC). This committee of engaged patients provides feedback in person on a quarterly basis; and by telephone and/or email continuously. One initiative the current PFAC has proposed is for NFC to help find ways for patients to be involved in the community and possibly even in clinic operations.

Currently the biggest challenge facing NFC for existing or new business is space. With as many as six providers in office on some days and only twelve exam rooms they already struggle to keep appointments timely. The business office has three employees in what should be one and one-half cubes and three others answering phones in a single small office. Annual turn-over in the practice has been 26% in the last three years, primarily due to a former administrator who had to be prosecuted. Initially, continual training could make parts of this initiative very challenging.

CPC+ now requires screening for social determinants of health. NFC has already implemented this process and has already built a database of certain non-profit and/or benevolent organizations to help meet patients' needs. The time seems right for NFC to carry this to the next level; to be a leader in the industry of integrating the physical, mental and spiritual wellness of its patients.

Northland Family Care's physicians have expressed on multiple occasions their fear that at the end of the five-year pilot program, when CPC+ ends, CMS will go back to straight fee for service. This would end the funding currently being used to pay for many of the extras: behavioral health specialist, dietician, group sessions, etc. The other more realistic concern and potential threat is the changing landscape of the commercial value-based contracts. It has been said in company meetings that it seems the insurance companies hold all the cards, that the practice is at their (the insurance companies') mercy.

Strategy

Owners of NFC held a strategic planning meeting in the fall of 2018. One of the primary agenda items was what the owners saw as the future of NFC. The final decision was to not pursue growth, that is not to add another physician at this point and not to do any targeted advertising for new patients. Simultaneously, they decided not to shrink the business, either. New patients are still welcome, but the owners' decision was to focus efforts on the quality care of the current patient base.

Strategic Relationships

The most important established strategic relationships are those between the physicians and nurse-practitioners with the community of faith in the area. All four full-time clinicians are active in their churches, with one being a key leader in his. Additionally, one of the part-time providers is a professor at the local university.

Key Stake Holders / Key Decision Makers

Internally there are six primary key people who must be involved: the four full-time clinicians mentioned above, the care coordinator, and the practice manager. Secondarily the quality initiatives team will be key to the success of this part of the business. They will shoulder the responsibility of establishing the logistical processes.

NEW BUSINESS

SWOT

SWOT	POSITIVE	NEGATIVE
	Strength	**Weakness**
Internal	Strong referral process in place	Quality assurance team's contract focus
	Existing relationships between providers and community	Measuring success not fully defined
	Opportunities	**Threats**
External	Multitude of Agencies	Multicultural community
		Selection process
		CPC+ sunsets in 2021

Internally this initiative will capitalize on the strong referral process already in place, including follow-up on referrals. Additionally, it will utilize the existing relationships between providers and certain employees with community organizations. Externally there are multiple agencies and organizations available to consider for partnership.

The multiplicity of organizations could create a threat, though. The clinic needs to be careful to prioritize, first partnering with organizations whose values and efforts will benefit the patients best. There are very few reasons to exclude any organization that is willing to be involved. However, since this is to be an ongoing relationship the organizations' financial stability should be considered. Excessive liabilities and continual operating losses are signs of a non-profit that is in trouble, as is one that does not focus on its mission. Strategic communication to any interested organization not chosen will be of the utmost importance.

The internal challenges potentially lie within the quality assurance team and their traditional focus on meeting quality metrics for value-based contracts. Measurement tools for the success of this initiative will require careful construction and may have subjective components that will need interpretation. Additionally, the area is multicultural, which could become particularly challenging for Phase III, when the clinic institutes a spiritual guidance component.

Strategy

The clinics participating in CPC+ are required to maintain a directory of services and, when appropriate, direct patients to those services. Rather than hand a business card or contact information to a patient in need, an integrated collaboration between the clinic and a network of benevolent organizations within the community will be established. The ultimate goal is to

provide for at least the basic needs of any patient with whom providers come in contact, with a secondary goal of meeting the patient's social and/or spiritual needs.

This model would begin with identifying a variety of established non-profit agencies and/or benevolent organizations and reaching out to the leadership of each. Phase I, for year one would include food pantries, homeless shelters, and transitional housing entities. Year two (phase II) it would add clothes closets, organizations offering transportation and organizations offering utility-bill assistance. The county health department and any county senior services organizations would be included. While some of the aforementioned organizations would likely be churches, the final phase purposely includes churches and/or religious leaders to meet the spiritual needs of patients; and guiding patients who need it, to become involved in some organization to help meet any social needs.

Once players are identified, and leadership interest established multiple other decisions will need to be made. Benevolent organizations typically have some type of a vetting process to try to make sure those who receive assistance are truly in need. In this proposed model, the physician/provider and his or her staff would begin that vetting. Ideally, though, most of the decisions about tactical operations and the day-to-day policies and procedures would be delegated to the care coordinator in the clinic with input from the quality assurance team.

Implementation of this program must be well defined and specifically designated to the care coordinator. In Phase II this program would necessitate hiring at least one person to manage the program. This lead person must be empowered to make the decisions needed when they are needed without fear of repercussion. He or she must be able to communicate well with people of almost any socio-economic background, ethnicity or religion. Additionally, this person would coordinate scheduling for all parties involved. With the addition of this manager, the current care coordinator can focus on patient care.

Scheduling and staffing do become key issues at this point. Ideally representatives from two or three organizations would be at the clinic on a specific day. Since many benevolent organizations are volunteer, the clinic should consider making this late afternoon or early evening. A clinic employee would act as liaison between the organization's representative and the patient, making introductions and assisting where necessary. The most practical person for this role would be the newly hired care manager or LICSW. This could be done multiple days a week once schedules are established in this collaboration. Staffing models would need to be reviewed at both the clinic and the participating organizations to make this happen.

Following the warm hand off, ideally the patient would have a representative from the benevolent organization as an advocate. However, there may be times when the patient needs to meet with the organization at the clinic multiple times. Either way, this is where cultivation of a social connection can begin when needed. There are many various potential scenarios dependent on what organizations are involved in the collaboration.

Strategic Relationships / Key Stakeholders / Key Decision-Makers

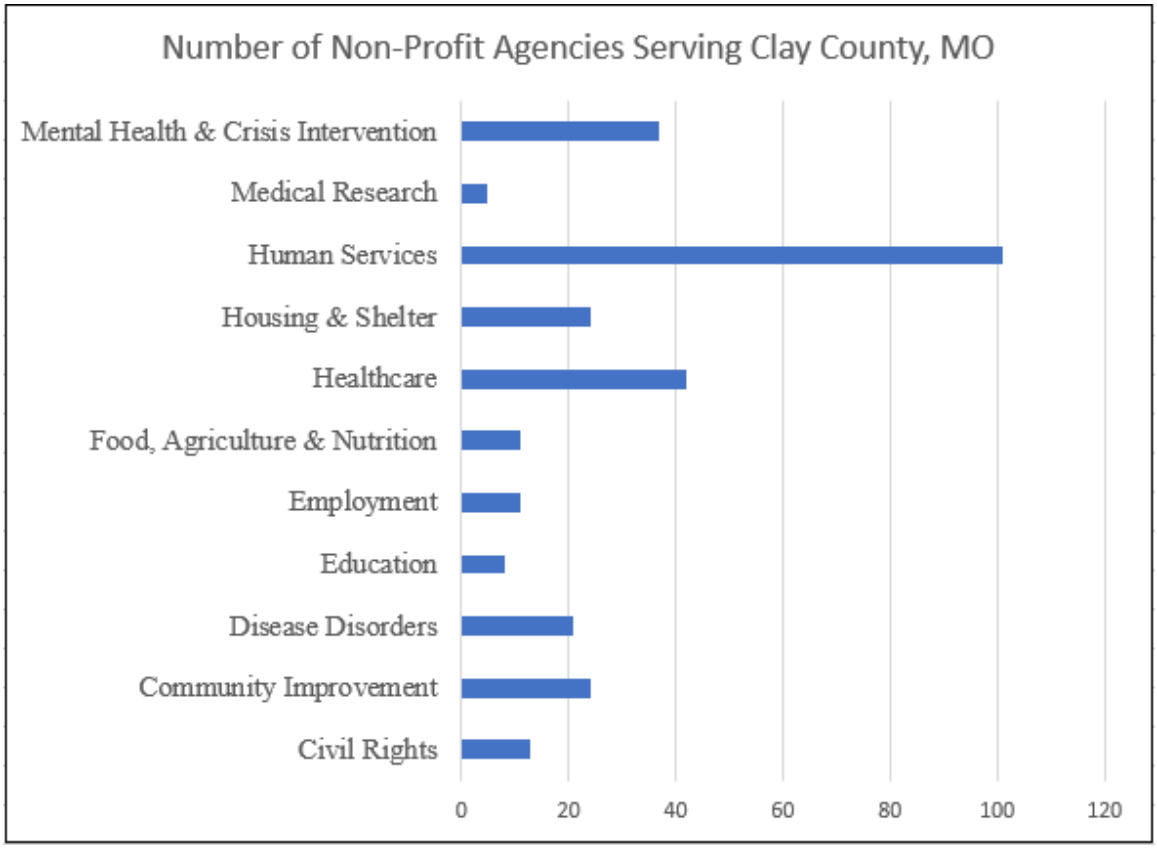
In addition to the strategic relationships already discussed above, one of the key people from the practice would form a strong working relationship with the Greater Kansas City Community Foundation (GKCCF). This foundation has a wealth of information on various non-profit organizations in the region, as well as national organizations with a strong local presence.

GKCCF staff could be instrumental in making appropriate introductions to the appropriate leaders in chosen entities.

Another potentially outstanding strategic relationship would be forged with KC CARE Health Center. Current quality assurance staff and the practice manager and certain key staff recently met with the center's executive director and discussed similar strategies. The executive director commented that they have no strategic plans to establish facilities and/or services anywhere near Northland Family Care.

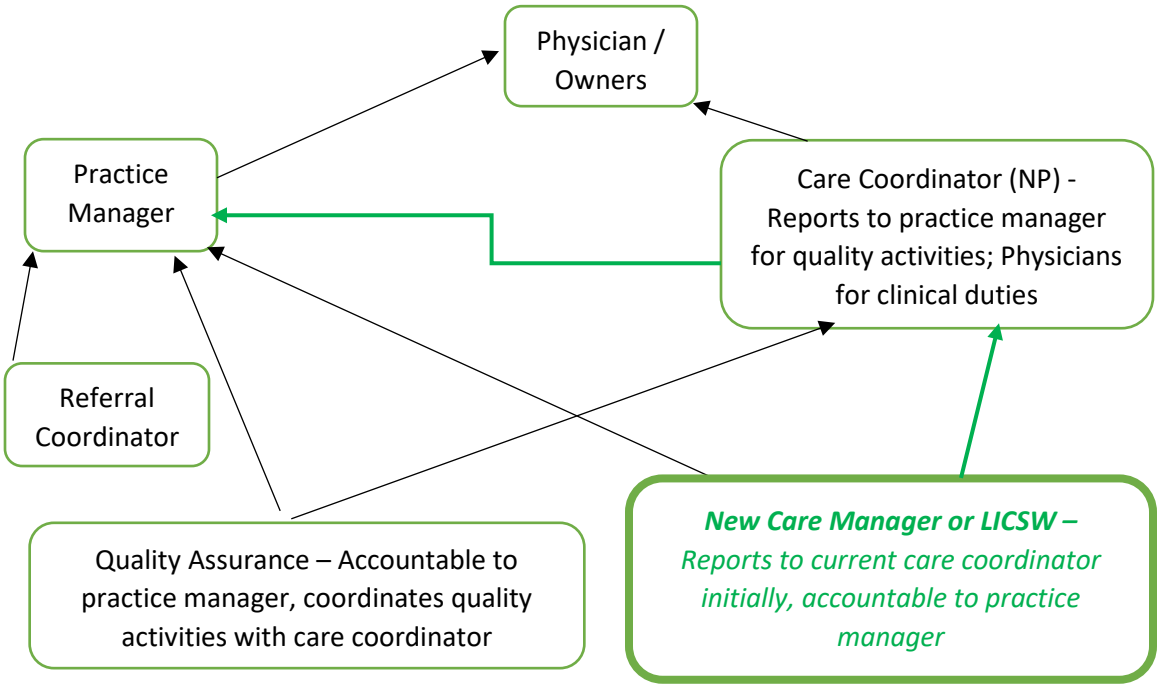
SERVICES

While the long-term goal is to meet the multiplicity of needs of the clinic's patients, focus in year one will be to establish the program and focus on housing and nutrition. The following chart shows the magnitude of resources available via Internal Revenue Service designated 501(c)3 organizations serving the local area. (Greater Kansas City Community Foundation - Guidestar 2019). This does not include the multitude of churches or county resources.



ADMINISTRATIVE PLAN

Ultimately the owners must approve the plan, but after the practice manager and care coordinator work out many of the tactical details. The organizational chart would remain in its current form as illustrated below during phase I. Upon implementation of phase II, when a care manager is hired, the reporting structure would change slightly, again illustrated below in darker green. At all times, cooperation and teamwork between each of these parties is crucial to success.



Planning and operational details will be assigned in the following manner:

Responsibility	Owners	Practice Manager	Care Coordinator	Providers	Referral Coordinator	Quality Assurance	Potential PFAC Involvement
Plan Approval	X						
Resource Identification		X	X				X
Introductory Meetings		X	X				X
Collaborative Agreements		X	X				
Staff Introductions			X				X
Patient Identification				X			
Referral					X		
Patient Introduction			X				
Follow-up						X	

The selection of agencies/organizations is the first critical step after plan approval. Realistically there are very few reasons to exclude any organization that is willing to be involved. However, since this is to be an ongoing relationship the organizations' financial stability will be considered. Any organization that does not focus on its mission, that has continual operating losses, or that has excessive liabilities should be carefully scrutinized.

In order to prioritize which organizations to target, the clinic will begin by identifying agencies/organizations that provide housing or nutritional assistance (year one objectives – see timeline that follows). The organizations that are deemed best should be contacted first. Those involved in the selection process should remember that there is no need for exclusivity for any one service. Different organizations that focus on homelessness may focus on different aspects: transitional housing; counseling; temporary shelter, etc. Additionally, there may be no additional capacity of a given resource when a patient is in need. The proposed agency's/organization's reputation in the community as well as the agency's/organization's stability should be considerations.

During this process a master collaborative agreement and necessary Health Insurance Portability and Accountability Act (HIPAA) release forms will be drafted and provided to legal counsel for review. While not intended to be a contract, the collaborative agreement will serve as a document outlining the expectations of both NFC and participating entities. Once agencies/organizations are identified, the practice manager and care coordinator will reach out to the key contact people to meet with them and gauge interest. Providing the entity is interested, the aforementioned documents will then be signed.

Simultaneously with the above, the care coordinator, quality assurance team, and referral coordinator will establish internal workflows for the actual referral process. The details need to include five elements. First there must be a method to communicate the referral to the entity. Then a 'warm handoff' to the representative from the entity. This would be best done by having the representative in the clinic at specified times in any given week. Optionally, providing the entity has the capacity, there may be an on-call contact person who could come to the clinic. Documentation of the referral and handoff within the current electronic medical record is critical for both CPC+ reporting and for measuring the success of this plan. Another part of measuring the success is a follow-up plan with the entity, to be sure communication is sufficient and expectations are met for both groups. Most importantly would be a follow-up and feed-back loop with the patient. Providers and quality assurance need to know that the efforts going into this are worth the resources invested.

Once infrastructure is in place and participating agencies/organizations are identified, a vetting process or processes will be discussed. While NFC wants to treat the patients truly in need, they should be cognizant of the capacities of participating agencies/organizations and work diligently to ensure the best use of resources. In some cases, the entity may already have a vetting process in place that NFC would adopt. In others, there may not be a need for anything more than a provider stating the patient needs the services.

OPERATIONAL PLAN

The above activities will be scheduled to be completed in the fourth quarter of 2019, with a plan to implement phase I, housing and nutrition, in 2020. Phase II will consist of transportation and utility assistance and be scheduled for implementation in 2021. Phase III, spiritual guidance and social connectivity will be scheduled for no later than 2022.

The biggest challenge with this plan is measuring its success. During the planning and implementation process providers and the current care coordinator will need to carefully review available social determinants of health screening tools. There are a number of tools available due to the CPC+ requirements. A great starting place would be the American Academy of Family Physicians, since the practice's physicians are already members and the organization has developed such tools. The assessment will be given to the patient by the provider at the patient's appointment. The assessment will let the care coordinator know what needs the patient has, and she can make the necessary referrals.

Once the patient has had contact with, and presumably benefit from an agency, the feedback loop begins. First the agency will be responsible for contacting the provider's office, providing information such as date of service,, what needs were addressed, and what follow-up, if any, the agency has planned with the patient. Following that contact, the provider and/or care coordinator will need to determine the need and timing for any follow-up appointment(s). During one of those appointments the patient will be given the same needs assessment as before, to be compared to the prior. The elimination of the patient's socio-economic needs would be the ultimate goal.

The quality assurance team currently looks at more than just quality metrics within value-based contracts. With this expanded line of business, they will be forced to look more closely at subjective data.

Phase III will likely be the most complex to implement. The local population and patient population in the area is certainly multi-cultural. All staff will need at least some basic understanding of various religions to avoid potential insult to patients. Then the coordination with temples, churches, synagogues and mosques for religious guidance for patients could be problematic based on the tolerance of any given religion towards any or all of the others.

INCORPORATION STRATEGY

Institution of this business model would necessarily start with formalized agreements with social agencies. The current care manager already has contacts with leadership within various organizations. She and the practice manager would meet with them at their place of business to introduce the concept and answer questions. The capacity of any given agency should be noted, so NFC can be cautious to not overwhelm any agency. Once all questions are answered, a formal agreement would be available for signature.

The next step would be detailing the logistics of patient referrals and communication. NFC currently has a well-defined referral process for medical tests and procedures, including 'closing the referral loop,' that is following up for test results, documentation, etc. That process can rather easily be adapted to meet the needs of the outside entities that ultimately partner with the clinic. Some social agencies require a formal application process while others have minimal information requirements. NFC would have the current care manager help the patient in need complete any required documentation and provide it to the agency in the agreed upon method.

Communication from the agency back to NFC will be critical to measuring the outcomes of this model. Quality assurance staff would want to know, for instance, if a patient needed help just once with food or if it is a recurring need. There may be times when the most apparent need is only a symptom to be treated rather than the disease that can be healed. Because of this, the patient feed-back loop will be well defined by the appropriate staff before determining the best method of documentation. The two options at this time are scanning in a paper document, possibly a questionnaire, completed by the patient; or building user-defined fields within the current EMR. Typically, for reporting purposes the latter is better.

One aspect that has not yet been mentioned is coding the encounter on the date of service when the referral is made. There are International Classification of Diseases, Tenth Edition, Clinical Modification (ICD-10cm) codes that relate to all the services being considered except the social involvement in phase III. These codes do not currently have any weight with the HCC coding mentioned in the financial section of the executive summary but will be needed for reporting purposes.

EXIT STRATEGY

While this plan is intended to be perpetual, the possibility of it not succeeding must be considered. Each collaborative agreement will have an exit strategy built into it for both the entity and the clinic, much like a cancellation clause in a contract. Evaluation of the business will be done on a quarterly basis using the plan-do-study-act method. With this being an internal initiative, at any point the practice leadership determines this is not a valuable resource for patients, or chooses to discontinue it for any other reason, there will be little if any action needed.

MARKETING PLAN

OVERVIEW AND GOALS

This proposed plan expands the types of services NFC has incorporated over the last three years. Any marketing campaign would be primarily to current or new patients, to make them aware of the added dimension of services available. Secondarily it would strengthen the already strong reputation the clinic and providers have within the community. This plan is not intended to grow the practice in number of patients, but in depth; in completeness of meeting the needs of those who already entrust their health and well-being to NFC.

MARKET ANALYSIS

Target Market and Audience

As indicated in other parts of this business plan, the new business segment is not intended to sell a product or service to a given market segment, but rather to offer a low or no-cost service to specifically identified patients. Realistically there are two target markets to this plan. The first is the non-profit and benevolent organizations needed to make it work. After executing the selection process NFC will need to gain the buy-in of the leadership within the chosen organizations.

Beyond the leadership buy-in, NFC will need to learn something about the penetration of each agency. They will need to understand what populations each already serves, for example an agency might only serve people in one county, or over a particular age. And in Phase III, religion becomes a consideration as well.

The second, and more important target markets are the NFC patients, that most likely fall near the poverty rate. Clay county, Missouri where NFC is located has an 8.89% poverty rate of its nearly quarter of a million residents. The neighboring counties, Clinton, Caldwell and Ray, have poverty rates of 11%, 13.3 % and 15.6%, respectively (DATA USA 2019). The cross section of NFC patients who fall into these poverty groups would be the most likely recipients of aid through this program.

County	Poverty Level	% of Patients in County	# of Patients in County	Yr 1 Potential Beneficiaries	Yr 2 Potential Beneficiaries	Yr 3 Potential Beneficiaries
Clay County	8.89%	47%	3995	355	555	755
Caldwell County	13.30%	11%	935	124	130	177
Clinton County	11.00%	13%	1105	122	153	209
Ray County	15.60%	18%	1530	239	213	289
Totals:			7565	840	1051	1430

The chart above shows the estimated number of potential beneficiaries of this initiative, broken out by county. Total potential beneficiaries in year one is based simply on the county poverty level and the number of patients within that county. Realistically there are many that need assistance who are above the poverty level. To calculate total potential beneficiaries for year two, an additional 10% of the county's population was included. For year three, 20%. These numbers are projections and will fluctuate based on any number of factors. A family moved to transitional

housing in year one may be self-sufficient by year two. Other patients or families may have events that force them to ask for help when they were not in the original estimates.

This business plan is geared toward aiding current patients who need more than medical attention. Physicians and nurse practitioners are already in a habit of screening patients for the social determinants of health while they treat the medical conditions. The most efficient marketing of this plan is a warm handoff from the provider to the care manager, who would offer specific resources to the patient. Since NFC still accepts new patients, the same standard of care would apply to them. Other marketing campaigns would include informational posters placed throughout the clinic, specifically including on the bulletin board in each exam room; email and text blasts to current patients, and a small supply of business cards would be printed for each of the entities that partner with NFC.

Competition

This plan is not intended to compete with any entity in the area, in part because no other primary care clinic in the immediate area has been identified as implementing such a plan. As described in the operational plan the intent is to compliment those organizations wanting to, trying to and designed to reach out to the people in need. NFC would help those organizations to identify people that do not know of available services. Via this partnership, NFC will also be positioned to help the organizations that do not already have a process in place to evaluate the effectiveness of their services through an established feed-back loop with the patient.

Market Trends

As previously mentioned, value-based payment models have begun to include assessment of social determinants of health in their reporting requirements. While a quick review of the numbers show that the poverty level has been decreasing in Missouri over the last five years, from 16.2% in 2013 to 13.4% in 2018 (Talk Poverty 2019) it's estimated that over 1,000 people are in emergency shelters any given night in the Kansas City area (Greater Kansas City Coalition to End Homelessness 2019).

Market Research

Demographic statistics gathered for this document came primarily through sources offered by GKCCF. Patient demographics were gathered from the clinic's electronic medical record.

IMPLEMENTATION OF MARKET STRATEGY

With a simple market strategy and minimal costs, just prior to the implementation of Phase I posters and business cards will be ordered from a professional printer. Also, as more complete demographic and socio-economic data is gathered and entered into the current EMR, well-crafted, targeted email and/or text messages can be sent to carefully selected patient population segments.

SUMMARY OF FINANCIAL NEEDS

FINANCING NEEDED

Financing in the planning stages and year one will be absorbed by the clinic utilizing current revenue streams. The current care manager and quality assurance team will administer the program during this time. Later in year two (2021) the clinic will plan to hire a person to focus on the coordination of this entire program. Phase one should help determine if this will be a full-time or part-time position. There will also be a nominal amount of funding needed for printed materials. Other costs to consider would include space within the clinic to operate, computer and possibly software, incremental utility costs, and any insurance costs.

Funding Sources

During the planning in the fourth quarter of 2019 and the implementation of Phase I in 2020 the current care management fee allocations from CPC+ and other value-based contracts will cover the salary and printing costs. Recently NFC learned their improved quality performance with a major payer has resulted in a $4,500 per month increase in care management fees. This will be earmarked for an additional employee's salary. According to Medical Group Management Association's Data Dive, the average annual salary of a Managed Care Coordinator is $38,480 (MGMA Data Dive 2019). Should the clinic choose to utilize a part time LICSW, according to Indeed.com the average full-time annual salary is $51,460. (indeed.com 2019) Thus, the care management fee increase will cover the salary and employer taxes.

Capital Requirements

The only capital investment that will be required for implementation is a new computer. This would be acquired through the current vendor at an estimated price of $1,300. The acquisition will be made while replacing all computers using Windows 7 operating system, helping keep the price down by purchasing in quantity. Though not capital expenditures, other hard costs associated with this initiative will include software licensing fees for Microsoft Office ($12.50 per month) and monthly fees for virus and spyware protection ($54 per month).

Resource Costs / Opportunity Costs

The potential opportunity costs should be carefully considered. Currently the goal is to have four providers in clinic on any given day. Each provider utilizes three exam rooms. Two of the twelve available exam rooms are occupied by behavioral health and dietary counseling on the days those services are available. The clinic will need to strategically schedule any meetings with agencies/organizations and/or patients, being cautious how many rooms are in use. This initiative cannot be allowed to impede or reduce current patient flow.

Costs Allocated from Original Business

In addition to the capital costs noted above, this proposal requires that a certain proportion of salary expense be allocated from the current business during the logistical planning and during Phase I. It also requires printing expense and office supplies at less than $500 during this same time period. There will be legal fees to have the formal agreement reviewed.

Expectations Around ROI

Each time the clinic has implemented a major quality strategy the value-based payments subsequently increased. That has been the case with one major payer this year, and the increase will cover the costs of this initiative.

In some cases, Current Procedural Terminology (CPT) codes have later been identified allowing billing for certain services. While there are no CPT codes currently available to bill for the types of social services being discussed, new codes need to be reviewed annually in case that changes.

Proper ICD-10 coding will ultimately affect the return on investment for this initiative. In the value-based care contracts funding is based on patient acuity. In most cases the insurance company follows CMS guidelines concerning risk scores. While the provider's goal is to keep the patient as healthy as possible, on paper any and all diagnoses need to be reported to maximize the income that is ultimately used to keep the patients healthy. Simply stated, the patient needs to look ill on paper. Going forward, whatever SDOH tool is chosen, it will lend itself to coding ICD-10 codes for situations such as housing, nutrition and/or safety issues. And in extreme cases learning about a person's socio-economic needs may uncover other disorders or disease processes, adding to the acuity of the patient.

FORECAST

PRO FORMA CASH FLOW STATEMENTS

The most important line to note in the projected cash flow statements below is the equipment. During the third and fourth quarters of 2019 the clinic will replace all computers that are on the Windows 7 operating system, causing a substantial investment in technology, estimated to be $50,000. Less impactful, yet important, is the end of a copier lease in late 2021. Unless needs change dramatically only a desktop copier will be required.

The physician-owners of this practice loathe paying taxes on income. To minimize tax payments, the last day of the year checks are issued for physician year-end bonuses and January expenses. The total dollar amount of checks issued is based in part on expected January income. Because of this, the December 31 checkbook balance is always a negative amount.

	Jan - Dec 19	Jan - Dec 20	Jan - Dec 21	Jan - Dec 22
OPERATING ACTIVITIES				
Net Income	-	-	-	-
Net cash provided by Operating Activities	-	-	-	-
INVESTING ACTIVITIES				
Equipment	(50,000.00)	-	-	(700.00)
Accumulated Depreciation	9,000.00	9,000.00	9,000.00	9,000.00
Net cash provided by Investing Activities	(41,000.00)	9,000.00	9,000.00	8,300.00
Net cash increase for period	(41,000.00)	9,000.00	9,000.00	8,300.00
Cash at beginning of period	(129,641.90)	(170,641.90)	(161,641.90)	(152,641.90)
Cash at end of period	**(170,641.90)**	**(161,641.90)**	**(152,641.90)**	**(144,341.90)**

Three Year Income Projection

The major direct expense of this initiative, the increase in CPC+ salaries and related taxes are reflected in 2021, the year an additional employee would be hired. A concurrent reduction in contract expenses will occur the same year with the expectation the person in the newly created position will absorb a portion of that contracted work.

There are several other items of note in the profit and loss projection below. The first major item is the end of CPC+ on December 31, 2021. Though clinic leadership fully expects CMS to have a replacement program for CPC+, the income projection reverts to estimated pre-CPC+ fee for service rates, approximately a 17.5% increase in overall fee-for-service income. The expenses directly attributed to CPC+ will be eliminated the same year. With no plan to eliminate any staff, salary expenses will be absorbed into normal operating expenses. Other incentive income will need to be carefully reviewed each year at contract renewal and appropriate adjustments made.

Other significant items include annual planned increases in health insurance costs, and medical supplies. A planned reduction in computer maintenance fees is reflected due to the replacement of two-thirds of the practice's computers in calendar year 2019. There is an expensive copier lease that expires late in 2021 and the current plan is to replace it with a desktop unit unless the business needs dictate differently by that time. And finally, provider compensation shows no increase in 2022 over 2021 due to the uncertainty of any CPC+ replacement program.

Most expense line items other than those mentioned above have been forecast at a 3% increase from year to year. Fee for service income has been forecast at an average of 4% per year. This is in anticipation of NFC reviewing major contracts and recent discussions of extending business hours utilizing current staff.

	Jan - Dec 19	Jan - Dec 20	Jan - Dec 21	Jan - Dec 22
Ordinary Income/Expense				
Income				
Cerner Incentives	100.00	100.00	150.00	175.00
Optum Incentives	5,000.00	5,000.00	5,000.00	5,000.00
UHC Incentive				
UHC Other Incentives	750.00	750.00	1,000.00	1,000.00
UHC PMPM	20,000.00	20,000.00	20,000.00	20,000.00
Total UHC Incentive	20,750.00	20,750.00	21,000.00	21,000.00
Coventry Incentive	4,000.00	5,000.00	5,000.00	5,000.00
Cigna Incentive	5,000.00	6,000.00	7,000.00	7,000.00
BCBS Incentives				
BCBS - PMPM Bonus	350,000.00	380,000.00	400,000.00	400,000.00
BCBS - Enhanced Encounters	6,000.00	7,500.00	9,000.00	9,000.00
BCBS Incentives - Other	10,000.00	10,000.00	10,000.00	10,000.00
Total BCBS Incentives	366,000.00	397,500.00	419,000.00	419,000.00
ACO K-1 Income	-	-	-	-
Humana -Transcend Incentive Pay	30,000.00	32,500.00	35,000.00	37,500.00
CPC+ Care Management Payment				
PBIP	25,000.00	25,000.00	30,000.00	-
CPCP	70,000.00	75,000.00	80,000.00	-
CMF	285,000.00	290,000.00	300,000.00	-
CPC+ Care Management Payment	380,000.00	390,000.00	410,000.00	-
Fee for Service Income	2,100,000.00	2,200,000.00	2,275,000.00	2,700,000.00
Refunds	(1,500.00)	-	-	-
Total Income	2,909,350.00	3,056,850.00	3,177,150.00	3,194,675.00

Gross Profit	2,909,350.00	3,056,850.00	3,177,150.00	3,194,675.00
Expense				
CPC+ Quality/Reports				
Payroll Taxes	5,150.00	5,300.00	5,500.00	-
Contracted Expenses	10,500.00	11,000.00	7,000.00	-
Salaries	72,000.00	74,200.00	76,400.00	-
Total CPC+ Quality/Reports	87,650.00	90,500.00	88,900.00	-
CPC+ Marketing				
Supplies	100.00	100.00	100.00	-
Total CPC+ Marketing	100.00	100.00	100.00	-
CPC+ PFAC				
Meals/Volunteer Appreciation	600.00	600.00	600.00	-
Total CPC+ PFAC	600.00	600.00	600.00	-
CPC+ Care Management				
CPC+ Care Mgmt Travel	300.00	300.00	600.00	-
Contracted Expenses	8,000.00	8,200.00	8,400.00	-
Payroll taxes	3,500.00	3,600.00	6,550.00	-
Salaries	46,000.00	47,400.00	86,000.00	-
Total CPC+ Care Management	57,800.00	59,500.00	101,550.00	-
Employee Compensation & Benefit				
AFLAC	4,500.00	4,600.00	4,700.00	4,800.00
Books & Journals	200.00	200.00	200.00	200.00
Continuing Education	1,000.00	1,000.00	1,000.00	1,000.00
Dues and Subscriptions	2,500.00	2,600.00	2,700.00	2,800.00
Insurance-Dental	2,000.00	2,100.00	2,200.00	2,300.00
Insurance-Health	110,000.00	125,000.00	135,000.00	145,000.00
Insurance-Life & Disability	1,400.00	1,500.00	1,600.00	1,700.00
Meals and Entertainment	4,000.00	4,000.00	2,400.00	-
Payroll Taxes	50,000.00	50,235.00	50,500.00	62,550.00
Retirement Plan Administration	1,000.00	1,000.00	1,000.00	1,000.00
Salaries-Staff	637,000.00	640,000.00	643,000.00	805,400.00
Section 125 reimbursement	2,500.00	2,600.00	2,700.00	2,800.00
Travel Expense	2,000.00	2,100.00	2,200.00	2,300.00
Total Employee Compensation & Benefit	818,100.00	836,935.00	849,200.00	1,031,850.00
Medical Supplies & Expenses				
Drugs/Vaccines	160,000.00	165,000.00	170,000.00	175,000.00
Laboratory Fees	16,000.00	16,500.00	17,000.00	17,500.00
Laundry	3,500.00	3,600.00	3,700.00	3,800.00
Medical Supplies	45,000.00	46,400.00	47,800.00	49,200.00
Waste Management	15,000.00	15,500.00	16,000.00	16,500.00
Total Medical Supplies & Expenses	239,500.00	247,000.00	254,500.00	262,000.00
Operating Expenses				
Credentialing	3,850.00	4,000.00	4,100.00	4,200.00
Accountant	7,000.00	7,200.00	7,400.00	7,600.00
Advertising and Promotion	1,600.00	1,600.00	1,600.00	1,600.00
Answering Service	4,000.00	4,100.00	4,200.00	4,300.00
Bank Service Charges	6,000.00	6,200.00	6,400.00	6,600.00
Computer and Internet Expenses	61,000.00	50,000.00	51,500.00	53,000.00
Computer Maintenance	40,000.00	41,200.00	42,400.00	43,700.00
Credit card fees	4,000.00	4,100.00	4,200.00	4,300.00
Depreciation Expense	9,000.00	9,000.00	9,000.00	9,000.00
Dues & Subscriptions	4,500.00	4,600.00	4,700.00	4,800.00
Equipment Rental	7,000.00	7,200.00	7,400.00	-
Gifts	500.00	500.00	500.00	500.00
Insurance-General	7,500.00	7,700.00	7,900.00	8,100.00
Insurance-Malpractice	21,000.00	21,600.00	22,200.00	22,900.00
Marketing Expenses	3,000.00	3,100.00	3,200.00	3,300.00
Miscellaneous	500.00	500.00	500.00	500.00
Office Supplies	30,000.00	30,900.00	31,800.00	32,800.00

Payroll Service	21,000.00	21,600.00	22,200.00	22,900.00
Postage/NexGen EDI	3,750.00	3,250.00	3,300.00	3,400.00
Professional Fees	4,200.00	4,500.00	4,600.00	4,700.00
Rent Expense	160,000.00	170,000.00	170,000.00	170,000.00
Repairs and Maintenance	1,000.00	1,000.00	1,000.00	1,000.00
Licenses	1,000.00	1,000.00	1,000.00	1,000.00
Taxes				
Property Taxes	500.00	500.00	500.00	500.00
Total Taxes	500.00	500.00	500.00	500.00
Taxes - Use Tax	1,500.00	1,500.00	1,500.00	1,500.00
Total Operating Expenses	403,400.00	406,850.00	413,100.00	412,200.00
Provider Comp & Benefits				
Licenses-Provider	1,200.00	1,200.00	1,500.00	1,500.00
Credentialing-Provider	5,000.00	5,200.00	5,400.00	5,600.00
Physician Compensation	1,150,000.00	1,300,000.00	1,350,000.00	1,350,000.00
Payroll Taxes-Physician	52,700.00	60,000.00	62,000.00	62,000.00
Physician health & dental ins	15,000.00	16,000.00	17,000.00	17,500.00
Physician Malpractice	1,000.00	1,000.00	1,000.00	1,000.00
CME	5,000.00	5,000.00	5,000.00	5,000.00
Computer expense	7,000.00	7,200.00	7,400.00	7,600.00
Dues & subscriptions	5,000.00	5,000.00	5,000.00	5,000.00
Telephone	8,000.00	8,000.00	8,000.00	8,000.00
Total Provider Comp & Benefits	1,249,900.00	1,408,600.00	1,462,300.00	1,463,200.00
Total Expense	2,857,050.00	3,050,085.00	3,170,250.00	3,169,250.00
Net Ordinary Income	52,300.00	6,765.00	6,900.00	25,425.00
Net Income	**52,300.00**	**6,765.00**	**6,900.00**	**25,425.00**

PROJECTED BALANCE SHEETS

It should be noted that the projected balance sheets, based on the projected income statements and cash flows, have no projected liabilities. The physician-owners of this practice do not believe in debt. There are two company credit cards that are paid off monthly. Any year end liabilities, for instance any required 401(k) contributions, are paid out as quickly as possible in the following year. Consequently, no liabilities are reflected in these statements.

	Dec 31, 19	Dec 31, 20	Dec 31, 21	Dec 31, 22
ASSETS				
Current Assets				
Checking/Savings				
Commerce Bank Savings	1,000.00	1,000.00	1,000.00	1,000.00
Commerce Bank Checking Acc	(121,433.37)	(105,668.37)	(89,768.37)	(56,043.37)
Cash	100.00	100.00	100.00	100.00
Petty Cash	150.00	150.00	150.00	150.00
Total Checking/Savings	(120,183.37)	(104,418.37)	(88,518.37)	(54,793.37)
Total Current Assets	(120,183.37)	(104,418.37)	(88,518.37)	(54,793.37)
Fixed Assets				
Computer Software	95,793.95	95,793.95	95,793.95	95,793.95
Equipment	309,311.83	309,311.83	309,311.83	310,011.83
Furniture and Equipment	93,419.52	93,419.52	93,419.52	93,419.52
Leasehold Improvements	224,923.00	224,923.00	224,923.00	224,923.00
Medical Equipment	180,192.64	180,192.64	180,192.64	180,192.64
Accumulated Depreciation	(727,926.36)	(736,926.36)	(745,926.36)	(754,926.36)
Total Fixed Assets	175,714.58	166,714.58	157,714.58	149,414.58
Other Assets				
Investment in KCMPA-ACO LLC	193,687.18	193,687.18	193,687.18	193,687.18
Investment in KCMPA, LLC	32,463.22	32,463.22	32,463.22	32,463.22
Security Deposit	24,515.75	24,515.75	24,515.75	24,515.75
Total Other Assets	250,666.15	250,666.15	250,666.15	250,666.15
TOTAL ASSETS	**306,197.36**	**312,962.36**	**319,862.36**	**345,287.36**
LIABILITIES & EQUITY				
Liabilities				
Current Liabilities				
Other Current Liabilities				
Retirement payable	-	-	-	-
Payroll Liabilities	-	-	-	-
Total Other Current Liabilities	-	-	-	-
Total Current Liabilities	-	-	-	-
Total Liabilities	-	-	-	-
Equity				
Common Stock	15,000.00	15,000.00	15,000.00	15,000.00
Paid in Capital	19,595.00	19,595.00	19,595.00	19,595.00
Retained Earnings	219,302.36	271,602.36	278,367.36	285,267.36
Net Income	52,300.00	6,765.00	6,900.00	25,425.00
Total Equity	306,197.36	312,962.36	319,862.36	345,287.36
TOTAL LIABILITIES & EQUITY	**306,197.36**	**312,962.36**	**319,862.36**	**345,287.36**

Historical Profit/(Loss) Statements

Value-based programs have been very beneficial to the clinic. In 2017, the first year, value-based payments made up 13.25% of operating revenue. The next year that percentage increased to 24% and for 2019 the projected value-based payments will be 27.75% of total operating revenue. The largest cost for any business is typically payroll and payroll taxes. The major fluctuation over the last three years have been a combination of adding a mid-level provider in 2017 and two maternity leaves by employees with higher compensation.

While it appears in the operating expenses that company insurance increased dramatically, this is due to a change in the treatment of professional liability insurance. There is an offsetting decrease in provider compensation section. There was also a substantial increase in computer maintenance expense in 2017, and a major unidentified "other operating expense."

At one time the clinic was part of an accountable care organization (ACO) and realized significant profits from this endeavor in 2017. While they are still a part of and active in an independent physicians' association, there are few if any profits on a regular basis from that organization.

	Jan - Dec 16	Jan - Dec	Jan - Dec	Jan - Jun
Ordinary Income/Expense				
Income				
CPC+ Income	-	355,536.79	375,647.08	221,747.74
Other Incentive Income	-	5,265.00	276,300.42	157,015.10
Fee for Service Income	2,339,540.53	2,363,854.3	2,037,512.0	965,844.92
Other Income	-	41.13	25,127.95	3,585.76
Refunds	(6,856.66)	(3,204.00)	(240.28)	(883.93)
Total Income	2,332,683.87	2,721,493.2	2,714,347.1	1,347,309.5
Expense				
CPC+				
Salaries	-	8,611.82	115,713.90	35,063.33
Payroll Taxes	-	48.21	8,598.22	4,252.46
CPC+ Care Mgmt Other Expenses	-	-	-	179.70
Contracted Expenses	-	1,424.42	18,811.05	32,474.73
Supplies	-	-	75.10	-
Meals/Volunteer Appreciation	-	109.38	284.79	271.29
Total CPC+ Expenses	-	10,193.83	143,483.06	72,241.51
Employee Compensation & Benefit				
Salaries-Staff	610,770.83	707,216.36	670,856.04	351,095.28
Payroll Taxes	50,265.23	53,512.72	51,487.38	24,995.20
Insurance / Insurance Related	55,691.92	80,581.09	112,200.01	66,007.44
Other Employee Related Benefits	9,836.07	59,447.60	10,690.24	5,011.15
Total Employee Comp & Benefit	726,564.05	900,757.77	845,233.67	447,109.07
Medical Supplies & Expenses				
Drugs/Vaccines	156,816.30	122,498.39	160,622.03	51,789.78
Laboratory Fees	-	-	16,659.36	6,646.61
Laundry	2,989.03	3,909.23	3,092.45	1,490.86
Medical Supplies	67,432.93	73,772.25	43,033.59	21,362.69
Waste Management	18,314.24	18,924.49	11,486.30	9,357.78
Total Medical Supplies & Expenses	245,552.50	219,104.36	234,893.73	90,647.72
Operating Expenses				
Lease Expense	164,054.37	174,416.65	161,287.58	80,629.71
Computer Related Expenses	107,447.47	118,954.77	105,995.01	48,001.23
Office Expenses	43,347.70	56,100.48	51,639.43	16,860.05

Professional Fees	38,180.15	35,053.15	32,274.59	17,878.36
Insurance / Insurance Related	7,965.00	40,022.00	28,073.26	2,160.00
Banking Expenses	14,896.63	15,179.66	14,037.25	4,537.54
Depreciation Expense	4,690.79	13,785.47	8,935.75	-
Equipment Rental	7,200.20	10,939.24	7,082.89	4,415.01
Promotion, Advertising &	465.33	752.00	4,639.79	2,046.07
Taxes	52.77	4,457.57	72,571.00	1,719.35
Other Operating Expenses	8,667.97	31,946.06	13,536.18	11,767.19
Total Operating Expenses	396,968.38	501,607.05	500,072.73	190,014.51
Provider Comp & Benefits				
Licensing & Credentialing	-	-	5,849.81	297.30
Compensation	814,256.04	1,128,004.2	973,103.00	303,318.89
Payroll Taxes	40,032.14	51,796.77	47,989.53	22,655.57
Health Related Insurance	15,561.49	21,142.20	14,984.81	6,191.60
Computer Expense	-	1,647.03	5,550.69	84.95
Other Provider Benefits	76,417.33	54,972.51	17,477.79	8,114.09
Total Provider Comp & Benefits	946,267.00	1,257,562.7	1,064,955.6	340,662.40
Total Expense	2,315,351.93	2,889,225.7	2,788,638.8	1,140,675.2
Net Ordinary Income	17,331.94	(167,732.49	(74,291.65)	206,634.38
Other Income/Expense				
Other Income				
KCMPA-ACO LLC K-1 ND expenses	(82.00)	(7.00)	(2.00)	-
KCMPA-ACO LLC K-1 Income	-	327,274.00	2,331.00	-
KCMPA LLC K-1 Income	(248.00)	66,922.00	21,352.00	-
Total Other Income	(330.00)	394,189.00	23,681.00	-
Other Expense				
Penalties	-	227.00	176.08	-
Total Other Expense	-	227.00	176.08	-
Net Other Income	(330.00)	393,962.00	23,504.92	-
Net Income	**17,001.94**	**226,229.51**	**(50,786.73)**	**206,634.38**

Historical Balance Sheets

As noted in the discussion about projected balance sheets, the physician-owners do not buy on credit, and have no outstanding liabilities except the year-end payroll and retirement account. Those are paid at the beginning of the following year. The checking balance at year end reflects a negative amount because checks are issued prior to December 31 each year in an effort to spend down any profits, and thus avoid taxes when possible.

	Dec 31, 16	Dec 31, 17	Dec 31, 18	Jun 19
ASSETS				
Current Assets				
Checking/Savings				
Commerce Bank Savings	1,008.08	933.11	892.11	840.11
Commerce Bank Checking Acc	(56,812.46)	(67,133.98)	(130,784.01)	73,205.40
Cash	100.00	100.00	100.00	100.00
Petty Cash	150.00	150.00	150.00	150.00
Total Checking/Savings	(55,554.38)	(65,950.87)	(129,641.90)	74,295.51
Other Current Assets				
Due from Employee			552.80	-
Total Other Current Assets			552.80	-
Total Current Assets	(55,554.38)	(65,950.87)	(129,089.10)	74,295.51
Fixed Assets				
Computer Software	95,793.95	95,793.95	95,793.95	95,793.95
Equipment	256,917.56	256,917.56	256,917.56	259,311.83
Furniture and Equipment	93,419.52	93,419.52	93,419.52	93,419.52
Leasehold Improvements	224,923.00	224,923.00	224,923.00	224,923.00
Medical Equipment	166,853.00	175,947.68	180,192.64	181,146.80
Accumulated Depreciation	(696,205.14)	(709,990.61)	(718,926.36)	(718,926.36)
Total Fixed Assets	141,701.89	137,011.10	132,320.31	135,668.74
Other Assets				
Investment in KCMPA-ACO LLC		281,142.18	193,687.18	193,687.18
Investment in KCMPA, LLC	5,078.00	23,379.00	32,463.22	32,463.22
Security Deposit	24,515.75	24,515.75	24,515.75	24,515.75
Total Other Assets	29,593.75	329,036.93	250,666.15	250,666.15
TOTAL ASSETS	**115,741.26**	**400,097.16**	**253,897.36**	**460,630.40**
LIABILITIES & EQUITY				
Liabilities				
Current Liabilities				
Other Current Liabilities				
Retirement payable	37,286.68	43,556.06	-	-
Payroll Liabilities		51,857.01	-	98.66
Total Other Current Liabilities	37,286.68	95,413.07	-	98.66
Total Current Liabilities	37,286.68	95,413.07	-	98.66
Total Liabilities	37,286.68	95,413.07	-	98.66
Equity				
Common Stock	15,000.00	15,000.00	15,000.00	15,000.00
Paid in Capital	19,595.00	19,595.00	19,595.00	19,595.00
Retained Earnings	26,857.64	43,859.58	270,089.09	219,302.36
Net Income	17,001.94	226,229.51	(50,786.73)	206,634.38
Total Equity	78,454.58	304,684.09	253,897.36	460,531.74
TOTAL LIABILITIES & EQUITY	**115,741.26**	**400,097.16**	**253,897.36**	**460,630.40**

Business Financial History

Over the last three years this clinic has done well at caring for patients. A deep dive into financials and various service contracts may reveal some changes that should be considered. This clinic functions well with no long-term debt, and realistically, little to no short-term debt. It has avoided relying on any one specific source of income, and instead become involved in multiple pay-for-performance contracts. With the thoroughness of the clinicians and a strong quality assurance team, those contracts have allowed the clinic to invest in resources to help patients. And this initiative is intended to expand those resources.

INNOVATIVE ELEMENTS AND EXPECTED BUSINESS OUTCOMES

1. **Why and how does this innovative idea positively impact the health of your population and the organization?**

Daily the providers within this clinic see at least one patient with some need that a traditional primary care office is not equipped to handle, lest it be giving them a phone number or business card. While that is a start, the patient may not have the understanding or ability to make the needed call; or may just be embarrassed or ashamed to do so. Through this initiative, by utilizing a 'warm hand-off', by actually introducing a patient with needs to a live person that can help him or her, the patient is exponentially more likely to receive the help he or she needs. The potential benefits of this plan to any one patient include, most importantly, treating the whole person. They include meeting the physiological needs and safety needs of the individual. Carried out further, there is potential of meeting the patient's need to belong socially and his or her need for self-esteem.

> The clinic should reap the benefit of increased health of its patients. It will certainly benefit by building relationships with community leaders and should become known within the city because of this. In fact, the positive impact to the clinic lies primarily in reputation – an innovative solution to meeting the underlying needs of an ill or injured patient. The expected positive reputation could later be used as a catalyst for growth if or when the owners decided to expand.

2. **What challenges did you encounter during this process and what have you learned?**

One of the challenges in this process has been determining what amount of detail seems to be appropriate for this presentation. When gathering statistics, it was surprising to learn that poverty has been decreasing, the opposite of what was expected. Another surprising fact, not reflected in this presentation, is the homeless rate among children.

The biggest two challenges were within the plan itself, though. One was figuring out the financing for this initiative. The other was defining an evaluation process.

3. **Next steps to put project in action**

The biggest challenge to implementation will be gaining the buy-in of the business owners. They are typically very supportive of innovative ideas. Currently there are some pressing projects that need to be completed, though, that could push planning and implementation to a later date.

ADDENDUM: OTHER FACTORS

1. Provide additional elements and key considerations that have not been addressed in part I-IV but are essential for this new business model

During the planning process careful consideration should be given to a revision of any intake forms for new patients, and a new information form for existing patients. Since the current EMR has the capacity to store and report on certain demographic and/or socio-economic data, it would be helpful to find a strategy to gather the information deemed appropriate.

It should be noted that this plan heavily relies on volunteerism and/or paid staff from entities outside of the clinic. With that in mind it would be wise to write into any collaborative agreement a code of conduct for all parties involved in patient care.

2. Should the plan be to "contract" the business, review the alternative options, potential savings, and potential results if this action is not taken. (Note: downsizing requires a very specific business plan that address other market factors and general business requirements.

There is currently no plan to contract this business.

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