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Financial and Regulatory Considerations for a Nurse Owned Medical Clinic

Bruce Fox and Paula O’Bear

Southern Adventist University

Financial and Regulatory Considerations for a Nurse Owned Medical Clinic

Introduction:

There are many reasons why nurse practitioners (NP's) may consider starting their own clinical practice. Some of those reasons may be a desire to have more control over how patient care is delivered, more control over career, and the ability to earn more money. With a looming physician shortage on the horizon, combined with the implementation of the Affordable Care Act that will increase the need for more primary care providers, and will provide opportunity for the entrepreneurial minded NP to start their own clinical practice.

The physician shortage is projected to be about 96,000 by the year 2020 (HRSA, 2005) and over 150,000 by 2025, with about 35,000 to 44,000 of them primary care physicians (Dill and Salsberg, 2008). The Patient Protection and Affordable Care Act (ACA) passed in Congress in 2010, expands health care coverage to an estimated 32 million Americans who were uninsured or underinsured with the an anticipated increase in the demand for primary care services. Jacobson and Jazowski (2011) join other physicians and, organizations such as the Institute of Medicine (IOM), in advocating that nurse practitioners and physician assistants fill the primary care provider gap this physician shortage will create.

Presented is a review of the literature pertaining to a Nurse Managed Health Clinic (NMHC), possible nontraditional sources of capital, sources of revenue, federal and state regulations, and a sample business plan. It is important to note that regulations, nurse practitioner scope of practice, and prescribing privileges vary greatly state by state. Seventeen states allow nurse practitioners to practice and prescribe independently; all the others require some level of physician supervision (Pearson, 2010). The information presented focuses on opening a nurse

owned health clinic in Georgia, a state with one of the more restrictive scopes of practice for nurse practitioners.

Theoretical Framework

The Patient Centered Medical Home (PCMH) is a model of health care delivery that was developed to replace fragmented delivery of care, and strengthen the relationship between the clinician and the patient. The concept was first introduced by the American Academy of Pediatrics in 1967, and initially referred to a central archive for medical records. The academy later expanded it to include family-centered, accessible, continuous, comprehensive, and coordinated care. In 2007 the American Academy of Family Physicians (AAFP), The American Academy of Pediatrics (AAP), The American College of Physicians (ACP), and the American Osteopathic Association (AOA), released the Joint Principles of the Patient-Centered Medical Home. The principles in this statement include;

1. The patient has a personal physician.
2. The personal physician leads the team that takes responsibility for the ongoing care of the patient.
3. The personal physician takes responsibility for all the patients' health care needs arranging care with other qualified professionals in all stages of life.
4. Care is coordinated across all elements of the complex health care system.
5. Enhanced access to care through expanded hours and communication between patients and staff.
6. Payment appropriately recognizes the added value of the PCMH (American Academy of Family Physicians et al., 2007).

In 2010 the National Committee for Quality Assurance (NCAQ) amended the PCMH statement by changing “Personal Physician” to “Primary Care Clinician” allowing nurse led medical homes access to grant money under the ACA (Scudder, 2011).

The Agency for Healthcare Research and Quality (AHRQ) defines the PCMH as encompassing five functions and Attributes:

1. Comprehensive care:
 - a. The PCMH uses a team of care providers to meet a large majority each patient’s needs. The team maybe a large practice with many different health care providers, or a small practice that builds a virtual team linking many providers in the community.
2. Patient-Centered:
 - a. At the core of the PCMH is the relationship between the primary care provider and the patient. The PCMH practice actively supports patients in learning to manage and organize their own care at the level they choose.
3. Coordinated Care:
 - a. The PCMH coordinates care within the health care system, in areas such as home health, specialty care, hospitals, and community services.
4. Accessible Services:
 - a. The PCMH is accessible with expanded hours, and around the clock telephone or electronic access to a member of the practice team.
5. Quality and Safety:

- a. The PCMH is committed to quality and quality improvement by using evidence-based medicine, and implementing quality improvement activities (Agency For Healthcare Research And Quality 2012).

The concept of the PCMH provides an excellent model for developing a successful NMHC. The concepts of caring for the whole person with an emphasis on patient education are core principles of the nursing model of patient care and of the PCMH.

Literature Review

For this systematic review, both quantitative and qualitative studies were included. The inclusion criteria for the studies dictated that the primary care providers were advanced practice nurses (APNs), must be practicing in a nurse-managed primary care health setting, and outcomes must be focused on cost analysis and financial reports. Exclusion criteria included private office settings, or studies that examined health care providers that were not advanced practice nurses such as physicians, or studies of APNs not practicing primary care, or cost analysis related to physician managed clinics.

Study Design

The study designs of the included articles were reviewed and the level of evidence they contributed to the literature was determined. A search of the literature revealed a lack of level 1 quality systematic reviews regarding nurse managed health clinics and funding sources. Due to the diverse funding options facing nurse managed health clinics and the different types of nurse managed health clinics it is difficult to obtain published studies on these topics. A national nurse managed clinic investigation was only initiated in 2004 when the Institute for Nursing Centers (INC) survey began collecting uniform data from these clinics in an attempt to track financial

stability of NMHC (Pohl 2009). Due to the lack of organized reportable data by nurse managed health centers, only level V and level VI studies are available. Descriptive retrospective studies were done on information reported by numerous nurse managed health clinics. Studies were clustered to evaluate the primary outcomes of nurse managed health clinic funding and reimbursement data.

Sample

A purposive sampling was used in all the studies based on the small number of nurse managed health clinics. None of the studies found included primary care nurse managed health clinics from other countries. The chance of some cross-over within studies is possible due to the small number of NMHC's, the loose organization and identification of these clinics, and the short amount of time that the data has been collected. Although the studies looked at different financial aspects of NMHC's, an overall conclusion of payer mix and funding base was appointed. The sample population was chosen through the following nurse managed health clinic organizations: National Nursing Centers Consortium (NNCC), comprised of community health nurse managed health clinics, and the Institute for Nursing Centers (INC), a national database for NMHC.

Successful Nurse Managed Health Clinics

Hansen-Turton in 2004, evaluated NMHCs in urban and rural areas across Pennsylvania through a grant awarded in 2002 by the Centers for Medicare and Medicaid Services (CMS) to the National Nursing Centers Consortium (NNCC) to demonstrate the success and independence of nurse managed health clinics in underserved areas of the state. A total of fifteen NMHCs were originally included, but narrowed to eleven through exclusion criteria. These clinics were used as a safety net for some of the millions of Americans that are currently under insured and in

need of affordable primary health care through ANPs as primary care providers. One of the clinics was a NMHC for migrants and 99% of that population was reported to have no insurance. These clinics are strategically managed, geographically placed and use the patient-centered medical home (PCMH) model for their population's health care needs. The ANPs providing care in these clinics coordinate care for their patients through fostering partnerships with their patients in the PCMH model (Hansen-Turton T.,2004).

Sheridan Health Services (SHS) in Colorado was first established as a school based clinic located at a public middle school in 1995 and managed by the University of Colorado College of Nursing. One aspect of the Affordable Care Act of 2010 recognized and awarded federal grant money to clinics whose focus was underserved populations, such as SHS nurse managed health center. As one of ten nurse managed health clinics awarded federal funding to expand and reach more diverse populations, SHS in March 2011 opened an expansion of their clinic to serve adults at a local mental health campus to offer primary medical care concurrently with behavioral services already being provided. The SHS nurse managed health clinic adult expansion is a safety net for recently uninsured or unemployed and have sliding fee scales to reduce financial barriers to care, and healthcare is provided regardless of anyone's ability to pay for it (Burke, 2012).

Vonderheid's study reviewed six Academic Nurse-Managed Centers (ANMCs) grouped in the Michigan Academic Consortium (MAC) compiled of four public Michigan universities, the schools of nursing within these universities, and their nine total ANMCs founded by the W.K. Kellogg Foundation and examined the financial sustainability of the ANMCs. There was a wide variation in populations served, number of patient encounters, size of the clinics, and sources of revenue with five of the ANMCs primarily using fee for service payment. The MAC

based the successes of these clinics on a solid business plan, financially sound management, well secured capitated contracts and a strong supply of third-party payers that allowed the clinics to bill nurse practitioner care as primary care providers, a necessity for future financial success and stability (Vonderheid,2003).

Physician shortage

Dill, M.J. and Salsberg, E.S. 2008, examined the projected shortage of physicians by the year 2025. They projected a shortage of over 124,000 patient care physicians by the year 2025, with 46,000 of these being a projected shortage of primary care physicians. A shortage of primary care physicians is predicted to result in longer wait times to get appointments, increase in visits to the emergency departments, longer work hours for physicians and many patients not getting needed primary care. The authors felt that these shortages will lead to physician and patient frustration. The authors proposed inter-professional teams, made up of other clinicians and health professionals, to improve access and more effectively use the limited physician supply.

Jacobson and Jazowski (2011) discussed the Patient Protection and Affordable Care Act and the acts effect on primary care access and delivery. This article was supportive of physicians and medical organizations overriding their long-standing opposition to non-physician practitioners (NPP) such as nurse practitioners and physicians assistants as primary care providers to help ease the pain of the primary care shortage. The suggestion was made that physicians need to re-evaluate the delivery of primary care, granting routine care to NPP while concentrating their responsibilities on more complex patients and oversight of the assignment of new primary care patients. Also discussed was the Affordable Care Act's focus on wellness and prevention and the opportunities created for physicians in their primary care practice.

Laurant et al in 2005 examined how the increasing demand for primary care services, limited supply of physicians, and increasing pressure to contain costs could be eased by shifting care from physicians to nurses to reduce cost and physician workload while maintaining quality of care. Laurant et al reviewed sixteen studies and found that health outcomes for patients, process of care, resource utilization and cost displayed no appreciable differences when shifting the care to nurses. Advanced practice nurses can produce as high quality care and achieve as good health outcome as doctors in primary care.

Sources of Funding for NMHC

The Institute for Nursing Centers (INC) developed a standardized national survey to collect financial data from NMHCs regarding reimbursement and funding. Pohl (2010), examined three years of data from 42 individual NMHCs included in the sample. The overall framework of the clinics was similar with many being academic-owned clinics that focused on primary care health management for uninsured and underserved populations in their areas.

Revenue category findings were as follows:

Source:	Year 1	Year 2	Year 3
Patient Care Revenue	38%	42%	35%
Federal/State grants	39%	31%	41%
Non-operating revenue(subsidies)	23%	27%	24%

Most clinics surveyed had difficulty adjusting for their sliding scale fees, bills not paid, “charitable work”, or professional courtesy purposes and finding which area to report these values in. When the financial data was analyzed, it was found that many NMHCs were heavily subsidized by their sponsoring institutions and were operating at a deficit, making them financially unstable (Pohl, 2010).

Hansen-Turton in 2004, evaluated NMHCs in urban and rural areas across Pennsylvania through a grant awarded in 2002 by the Centers for Medicare and Medicaid Services (CMS) to the National Nursing Centers Consortium (NNCC) to demonstrate the success and independence of nurse managed health clinics in underserved areas of the state. Along with funding and reimbursement to these clinics to sustain their operations, demographics of patients and other quality measures were reported. Insurance status of the NMHC's patients were reported and included: 35% uninsured, 40% Medicaid, 17% commercial health insurance, and 9% received Medicare benefits. One of the clinics was a NMHC for migrants and 99% of that population was reported to have no insurance. Total financial reimbursements for the eleven NMHCs were obtained and reported as one entity with 37% of the revenues for the NMHC being received from Medicaid managed care plans, 23% from private foundations, 23% coming from government contracts and grants, 6% from private donations, 6% from Medicare reimbursements and 5% from private pay or other sources. These clinics are strategically managed, geographically placed and use the patient-centered medical home (PCMH) model for their population's health care needs. The ANPs providing care in these clinics coordinate care for their patients through fostering partnerships with their patients in the PCMH model (Hansen-Turton T.,2004).

In 2011, Pohl et al compared NMHC and Federally Qualified Health Centers (FQHC) and reported funding and reimbursement findings for both. For the purpose of this review, NMHC findings will be the focus. Data was gathered from four years of annual NMHC INC national survey data (clinical and financial data) that included 42 NMHC total with not all clinics reporting in the same years. Overall, the study found NMHCs vary greatly in terms of size with many being very small, location, and reimbursement which is one limitation mentioned in the study. It stated generally, funding for NMHCs come from the communities they serve and are

not limited to university schools of nursing, foundation grants, and the HRSA Bureau of Health Professions, Nursing Education, Practice, Quality, and Retention grants (in 2010, the HRSA designated \$15 million for 3 years of funding for ten NMHCs without provisions for renewal).

Revenue was broken down into reimbursement from patient care (including self-pay, third party reimbursement, fee-for-service, capitated payments, and contractual payments for services) at 40% or less over the four years; other operating funds from primarily grants (In 2008-2009 24% from federal grants, 9% from state/local grants, 10% from private/foundation grants, and 4% as other); and non-operating funds mainly composed of donations and subsidies from universities, 20% -27% on average. For the time period examined, 15%-21% of NMHC revenue came from contracts such as Medicaid; these payments are limited for NMHC due to reimbursement based on coding levels and Medicaid fee schedules. In states where APNs are not recognized as primary care practitioners NMHCs are only reimbursed at 85% of the physician's rate from Medicaid (PohlJ. T.,2011).

Bailey et al, 2009 found the Philadelphia's Family Practice and Counseling Network (FPCN) are making a difference through the work of APNs in their three NMHC in the Philadelphia area, modeling the way primary care is delivered to the medically underserved, whether insured or not (privately insured 7%, Medicaid 37%, Medicare 8%, and those with no insurance 46%) (Bailey,2009). The FPCN coordinates care for their patients through a system of holistic care involving primary care, wellness, and prevention of disease. The clinics utilize resources such as APN's, nutritionists, diabetic health educator, physical therapists, and mental health professionals to provide comprehensive care to their clients. The FPCN consider three strategies as the reason for their financial stability. First, early in their service, the FPCN concentrated their care on residents of public housing and secured specially earmarked funding

for this federal program. The FPCN received the support of a local nonprofit investor, Independence Foundation and has committed support from them. Additionally, the APNs at the FPCN clinic became active in state policies and championed changes in legislature and commercial insurance providers in the area to credential APNs as primary care providers, promoting more revenue for the clinics (Bailey,2009).

Reimbursement for NMHC

Gaedeke, 2003, discussed the complicated procedure of Medicare billing for NPP and the issues of reimbursement for the NPP. The Balanced Budget Act of 1997 (BBA) liberalized coverage of NPP services by Medicare. This article discussed the need of NPP to have their own national provider identifier (NPI) allowing the NPP to bill Medicare directly and the process to qualify as a Medicare practitioner. Medicare continues to require an APN to have a collaborative relationship with a physician regardless of state APN scope of practice. Medicare reform is another integral part to increasing funding for NMHCs. Currently, regardless of the state the APN is licensed in, Medicare requires a collaborative relationship with a physician for APN reimbursement of any kind, and reimburses APNs at 85% of what they reimburse physicians for the same care and services (Gaedeke Roland, 2003).

In the Health Policy Brief by Cassidy, 2012 reimbursement is examined for APN. Medicare pays nurse practitioners practicing independently eighty five percent of the physician rate for the same services. Medicaid fee-for-service programs reimburse certified pediatric and family practice nurse practitioners directly, but rates are variable and some states do pay nurse providers and physicians the same rate. Many managed care plans require a designated primary care provider, but do not always recognize nurse practitioners as primary care providers. The National Nursing Centers Consortium performed a survey in 2009 and found nearly half of the

major managed care organizations did not credential APNs as primary care providers. This lack of credentialing plays a major role in restricting reimbursement for APNs (Cassidy, 2012). In the state of Georgia, APNs are eligible for Medicaid reimbursement from the Department of Community Health and are reimbursed at 90% of a physician's payment (Georgia Department of Community Health, 2012).

The Centers for Medicare and Medicaid Services published guidelines for NPP billing in July 2010. The qualifications for nurse practitioners are:

- Be authorized by the State in which the services are furnished to practice as a nurse practitioner in accordance with state law.
- Be certified as a nurse practitioner by a recognized national certifying body with established standards for nurse practitioners.
- Possess a master's degree in nursing.

In the Balanced Budget Act of 1997, Congress removed limitations which ultimately led to nurse practitioners being able to serve as primary care providers outside of restricted geographical areas based on need. The Balanced Budget Act also established that nurse practitioners could provide quality primary care independently of a physician's supervision and earned them the right to bill under their own billing numbers and receive 85% reimbursement of physician fee schedules arranged by Medicare for the same services. Although this Balanced Budget Act also authorized state Medicaid plans to recognize nurse practitioners as primary care providers, it neither required nor demanded such changes (Kaiser Commission on Medicaid and the Uninsured, 2011).

Nurse practitioners must enroll in the Medicare program to be eligible to receive payment for covered services provided to Medicare beneficiaries. This is done by submitting Form CMS

855B to CMS or by accessing the Internet Based Provider Enrollment, Chain and Ownership System (PECOS). The provider will obtain his/her national provider identifier (NPI) from the Centers for Medicare and Medicaid Services (CMS), which is a 10-digit identification number issued to each health care provider in the United States by the CMS and is used by commercial healthcare insurers as well. This is done online at <https://nppes.cms.hhs.gov>. When receiving Medicare payment, the provider agrees to the Medicare allowed amount and will not bill the beneficiary for anything above that amount. Services are paid at 85% of the Medicare Physician fee schedule amount when billed through the APN's NPI.

Collaboration is required by CMS. Collaboration is a process in which a nurse practitioner has a collaboration agreement with a physician that establishes a method for medical direction and appropriate supervision based on the laws of the state in which the services are performed. In the absence of state laws, documentation by the nurse practitioner identifying relationships the NP has with physicians to handle issues outside their scope of practice. There is no requirement that a collaborating physician be present when services are performed by the nurse practitioner nor be evaluated by the physician (CMS,2010).

The services of the nurse practitioner can be billed as "incident to" which would reimburse the practice 100% of the fee schedule. Many nurse practitioners decide not to use incident to billing due to the strict rules including:

1. The physician must physically be in the office when the APN renders care
2. The APN could not see any patients new to the practice
3. The APN could not see established patients with any NEW problem.

Incident to services are performed under the physician's direct supervision, this means the physician must be present in the office suite and immediately available for direction and

needed assistance throughout the patient encounter. It is not feasible in most primary care offices for this to occur, therefore it is not commonly used for NPP billing (CMS, 2010). This allows more productivity (patients seen per hour) by all providers within the clinic and decreases exposure to more frequent audits by Medicare since it is so complicated to abide by the incident to rules (Reimbursement Task Force, 2012).

Billing requirements for CMS include mandatory assignment, or accepting the Medicare allowed amount as payment in full and being unable to bill from the beneficiary any amount other than unmet deductible and /or coinsurance amounts. Nurse practitioners can bill directly to the Medicare program for their services or reassign payments to an employer. An NPI must be obtained for this to occur (CMS, 2010).

Hansen-Turton and associates, 2008, published findings regarding barriers to NMHC reimbursement for APN services. Denial of APNs credentialing as primary care providers by managed care organizations is a common issue with reimbursement and is based on varying rationales. There is a direct correlation between APNs prescriptive independence and managed care credentialing policies. It was concluded that, for NMHCs to successfully provide primary health care to areas where physician access is limited, these primary care APNs must be placed on equal financial footing with primary care physicians.

Nurse practitioners are allowed to practice independently with independent prescribing privileges in seventeen states in the United States of America. The rest of the states require some form of collaboration or supervision by a physician (Pearson, 2010). The American College of Physicians found that appropriately trained nurse practitioners within their scope of practice can produce as good health outcomes, and give as good quality care as primary care physicians (Laurant et al., 2005). The American College of Physicians Policy Monograph (2009) recognizes

that the expanding role of nurse practitioners has been a point of contention in the medical community. In this position statement the American College of Physicians (ACP) list seven positions regarding NPs and physicians related to primary care. The basic position of the ACP is that although they have different levels of skills and training physicians and NPs have the same goals of quality patient centered care. NPs within their scope of practice can provide access to quality care for patients who may have difficulty accessing care with the decline in the primary care workforce. State and federal policy changes need to occur to recognize APNs as primary care providers and have a uniform scope of practice for APNs to succeed in providing for the population with fair and equal funding and reimbursement. APNs must demand equality from commercial and federal insurers, for their high-quality patient outcomes, safety, and affordability (PohlJ. T.,2011).

Recognizing and qualifying APNs as primary care providers for reimbursement is one problem that is based on the state to state differences in the scope of practice for APNs. Some states allow APNs to practice to the full extent of their scope of practice and make it easy for managed care organizations, Medicaid, and commercial insurers to recognize them as primary care providers, increasing reimbursement significantly. For those APNs working in states with limited scopes of practice, APNs are restricted with their billing of services and dependent on physician billing for reimbursement of their care. Managed care organizations assign reimbursement based on physician supervision, with 78% of managed care organizations credentialing NPs as primary care providers in states that allow NPs to practice independently of physicians, compared to 17% in states that require physician supervision. Prescriptive authority plays a similar role with managed care organization reimbursement state to state. “Managed care company credentialing and reimbursement policies are the single biggest barrier for NMHC

practice that exists today” (Hansen-Turton, Ritter, Rothman, & Valdev, 2006). Some federal regulations such as Any Willing Provider (AWP) and Any Willing Class of Providers (AWCP) laws that prohibit such discrimination, but are never enforced by state and federal governments (Hansen-Turton, Ritter, Rothman, & Valdev, 2006).

In establishing an independent practice all of the challenges of starting any small business are present. Carolyn Buppert in her book “Nurse Practitioners Business Practice and Legal Guide” details many aspects of the role of the nurse practitioner. Sections of the book detail considerations in the startup of a nurse owned clinic, including physician supervision, startup and operational cost, business structure and business planning (Buppert, 2012). Shirey (2007) presents a framework for a business plan and a brief description of each element, and Villanueva-Baldonado and Barrett-Sheridan (2010) provide a sample of a business plan for a neurosurgical ICU.

Private insurance companies are separate from the process of Medicare credentialing and may require their own credentialing process. There are no state statutes that mandate third-party reimbursement for APNs, however most private insurers reimburse APNs at various percentages of physician payments (Phillips 2005). One private insurer, AETNA, will pay APNs at 85% of the contracted payment for physicians, consistent with the CMS and also allow “incident to” billing per CMS guidelines (“Aetna office links,” 2010).

Application of PCMH in a newly developed NP clinic:

The PCMH concept of comprehensive care will be addressed by practitioners within the clinic focusing on the patient and their family. The clinic will strive to meet the majority of the patient’s physical and mental health needs and focus on prevention and wellness. Both acute and chronic illnesses will be handled by the clinic short of emergency treatment which will be

coordinated for the patient if necessary with local emergency services. With practitioners focusing on general pediatric illness, adult medicine, and a limited amount of women's services being offered including routine pap smears, screening breast exams and family planning services, the clinic will focus on the comprehensive care of the entire family. Although the practice will start small with only two full time practitioners and two part time physicians, a team approach will be utilized linking providers within the community for other services not offered within the clinic at this time.

A patient-centered approach toward each patient of the clinic will consist of evaluating each patient's unique needs, personal values, cultural beliefs and ideas, and preferences. Fostering support of each patient's self-care efforts and involving each patient and their family in the individual's plan of care will be the goal of each practitioner in the clinic. Communicating with each patient how the PCMH works, the responsibilities of the patient and provider, and what each can expect from the other is important to the success of the relationship. Focusing on encouraging healthy practices, reducing risk factors, and setting self-care goals and care plans will foster trust and self-care. Shared decision making will guide therapies and treatment modalities and encourage an open and supportive relationship between the primary care providers at the clinic and the patient. Information on preventive measures and support for maintaining a healthy patient and family will be supplied at each visit. The clinic will make available information regarding opportunities within the local medical community of education such as safety, diabetes management, and various support groups.

The clinic will coordinate care through the PCMH by arranging services for the patient including home health, physical therapy, psychological care, specialists, and community services. The goal of the clinic will be to connect the patient with needed services across the

healthcare system and utilize resources outside the clinic as appropriate. The practitioners will advocate for the appropriate services needed by the patients and arrange for such services not provided directly by the clinic. Community resources will be utilized by the clinic to make care more accessible for the patient.

Accessible services will be available at the clinic by having extended hours, weekend hours, and holiday hours. Patient's will have the option of scheduling appointments with providers at the clinics or have the option of walk in appointments for acute needs. There will also be on-call availability of providers for urgent needs unable to wait until the next business day. Patients will be notified by telephone of upcoming appointments and diagnostic results and also have telephone calls returned in a prompt and timely fashion. E-mail will be utilized to communicate information between provider and patient, to request refills, and maintain open lines of communication for accessibility of providers. Every measure possible will be taken to assure patient's access to a member of the clinic team when they need them. Shared decision making is vital to the PCMH model and will be facilitated by utilizing many forms of communication to access each other. The patient will be reassured that members of the clinic are available through numerous avenues.

A shared commitment to quality, safety, and quality improvement between patients and the clinic will assure the best outcomes for the patient. Improving patient safety through information and reviewing patient's medical records with them can help detect errors in prescribing medications, dietary changes, and treatment modalities. The more empowered the patient is in the decision making concerning their personal health, the better the health of the patient. Trust is fostered through patient safety and the value of quality improvement within the clinic and the patient must have an active involvement in each. Surveys to evaluate access to

services, evaluate care received, and areas for improvement are one way to involve patients in quality improvement. Without assessing the needs of the patients and families cared for in the clinic, even the best intentioned processes of the medical home policy will miss the target resulting in care centered around the clinic or provider instead of true patient-centered care.

Sample Business Plan:

When deciding on starting a practice putting together a business plan forces a realistic look at what resources will be required for start-up and operations. This allows the potential nurse entrepreneur to evaluate if opening the practice is feasible. The cost estimates and reimbursement estimates were arrived at by interviewing several primary care practices in the area where the clinic will be established. It is very difficult to find out what the amount of reimbursement is for various services as it is negotiated differently for each practice. Several clinics were surveyed and due to nondisclosure clauses in their contracts they were hesitant to give specific information. The consensus was that a patient encounter with a 99213 paid \$70.00 and a 99203 code paid \$85.00 from Medicare.

A formal business plan starts with a cover page and table of contents. The cover page is usually the business name and address and the owners names. If the plan contains proprietary information the cover page will sometimes contain a confidentiality statement for the reader to sign before reading the plan. After the Table of Contents the next item in the business plan is the executive summary. The executive summary is a synopsis of the business plan with the intention of interesting the reader in investing in the clinic.

Executive Summary

The Southern Practitioner Group Primary Care Clinic (SPGPCC) is a new business with a planned opening in the spring of 2013. The clinic will be located at 1234 Any Street, Any City,

Georgia. The clinic is located on a busy thoroughfare in the county of Catoosa which is designated as a medically underserved area by the Health Resources and Services Administration.

The clinic is designed as a Patient Centered Medical Home providing primary care medical services to adults and children over the age of two. Also provided will be urgent care services for minor injuries such as sprains, minor lacerations, and minor acute illnesses. The clinic will also provide basic gynecologic services such as annual exams, pap test, pregnancy testing, and birth control, to normally healthy women. The clinic will also support the needs of disabled persons and older adults through home visits and nursing home visits.

To accommodate clients, the clinic will be open extended hours during the week and limited hours on the weekend. Clients will be seen by appointment and walk-ins are welcome. Medical services will be provided by a group consisting of two physicians and four nurse practitioners.

The business strategy of SPG Primary Care Clinic is to provide one stop family centered medical services at competitive prices to the underserved population of Catoosa, and surrounding Georgia counties. Competitive pricing will be supported by a simple physical plant and outsourcing of lab and imaging procedures. The convenience of a medical home that meets the basic medical needs of the entire family combined with the ability to access care during extended hours should make our clinic the preferred provider of health care in the area.

The Primary Care Clinic Business Concept

The clinic seeks to establish a firm base of clients by following the principles of a patient centered medical home. Medical services will be provided for, simple acute and chronic medical conditions, minor medical emergencies, and basic gynecological services. The goal of the clinic

is to provide a medical home for patients throughout their life span by providing services for children, adolescents, adults, and older adults, with home visits for patients too frail to travel to the clinic and visits to patients in extended care facilities. When patients require the services of a specialist or sub specialist referrals will be made and the provider from the clinic will assist in coordinating care.

The clinic will provide convenient access for working patients through extended evening hours on weekdays, and limited hours on weekends. An added convenience is the location of the clinic on a major thoroughfare with ample free parking. This is in line with the goal of encouraging families to establish the clinic as their main source of medical services, and to establish a firm base of returning clients.

The clinic will provide competitive prices for services, accepting private insurance, Medicare, and Georgia Medicaid, discounts will be given for cash payment. Modest office furnishings and outsourcing of lab and imaging services will keep startup cost and operation cost low.

Organizational Plan

The Southern Practitioner Group Inc. is a corporation formed to provide capital for the Primary Care Clinic and to provide a legal framework for the operation of the clinic. The corporate shareholders are the primary care providers for the clinic. Dr. S is a physician licensed to practice in the state of Georgia with XX years of experience in primary care and emergency medicine. Dr. C is a physician licensed to practice in the state of Georgia with XX years of experience in primary care. There are four certified nurse practitioners in the group all licensed in the state of Georgia. Mr. K has XX years of experience as a Nurse practitioner. Mrs. O, Mrs. L and Mr. F are recent Family Nurse Practitioner graduates from the Southern Adventist University

School of Nursing. Dr. S and Dr. C have entered into collaboration agreement with the nurse practitioners, and are their supervising physicians as required by Georgia law.

Market Analysis

There are three other primary care clinics on the thoroughfare where the Primary Care Clinic will be located with a total of 12 primary care providers in those clinics. The Primary Care Clinic is located on the main road to Hutcheson Medical Center, a community hospital serving three counties in Northwest Georgia. The three counties served are Catoosa, Walker, and Dade with a total population of approximately 145,000. All of these counties are considered underserved by the Health Resources and Services Administration. The Primary Care Clinic fronts US 27 near Battlefield Parkway. Georgia Department of Transportation 2003 daily traffic volume statistics list this area as one of the busiest in the three county area.

Marketing Plan

The primary method of advertising will be by word of mouth from satisfied clients. The startup budget will include 3 months of billboard advertising and a week of newspaper advertisement announcing the opening of the clinic. Prominent signage will be placed on the store front of the clinic.

Capital Requirements

The following is a list of items required for business startup and their related expense:

Legal Fees	\$5,000
Insurance Fees (liability).....	\$3,000 (\$4 million coverage)
Insurance Fees (malpractice)	\$5,000/provider/year
Insurance Fees (workers comp).....	\$2,000
Security Deposits (1 st month's rent).....	\$4,000

Renovation Cost	\$50,000
Equipment Cost	\$100,000
Medical Supplies	\$20,000
Pharmaceuticals	\$2,000
Regulatory and Permit Fees	\$1,000
Advertising	\$5,000
Miscellaneous Cost	\$10,000
Total	<u>\$207,000.00</u>

Monthly Operating Expense

The following is a list of estimated monthly operating expenses:

Rent	\$4,000
Cleaning services	\$300
Utilities	\$1,500
Supplies	\$4,000
Hazardous Waste Disposal	\$300
Legal and Accounting Fees	\$300
Total Non-salary Expense	<u>\$10,400.00</u>

Annual Salaries

Physician 1 FTE	150,000
Nurse Practitioner 3 FTE	240,000
Medical Office Assistant 3	84,000
Office Manager	50,000

Billing and Coding	50,000	
Receptionist	22,000	
Social Security/Medicare, contributions	(33%)	\$197,000
Total Salaries		<u>\$793,000.00</u>
Total Operating Expense		<u>\$1,010,400.00</u>

Breakeven Analysis

The clinic expects to start with a low number of patients and to steadily expand that client base throughout the first year of operations. A minimum number of employees will be hired at startup and the number expanded to meet demand as the business grows. The physicians and NPs will work part time at the clinic increasing their worked hours as the client base grows. The fixed operating expenses per month are \$10,400.00, with salaries for minimum staff at \$11,500.00 for a total of \$21,900 for monthly expenses. With average revenue per visit estimated at \$70.00 it will take 312 visits per month to break even. It is expected that the number of visits to financially breakeven will be reached by the first 90 days of operations.

Conclusions

This literature supports nurse practitioners as providing safe and competent primary medical care. National statistics project a large shortage of primary care physicians in the near future linked with a growing demand for primary care services. The literature shows increasing support for the use of nurse practitioners to meet the demand. These facts make it a good environment for the nurse practitioner entrepreneur.

The ability for the nurse practitioner to practice independently varies greatly by state, but there are nurse practitioner run clinics in every state. Seventeen states allow nurse practitioners to practice without physician supervision or collaboration, with independent prescribing authority. Many other states are considering loosening restrictions on nurse practitioners. This business plan was developed for the state of Georgia which has one of the most restrictive scopes of practice for nurse practitioners, Teegardic and Williams (2012) in The Atlanta Journal-Constitution report that the Georgia legislation is considering loosening the restrictions on nurse practitioner practice.

Starting and running your own business is another skill set you will need to learn, and is barely touched on in most NP programs. However they are skills that can be learned and, there are many resources for entrepreneurs wanting to start their own small business. NMHCs are also lacking in business prepared nurse leaders who have business knowledge and leadership to provide business plan and direction to make NMHCs successful. Schools of Nursing need to start providing more education for APNs in business and legal matters of the profession. Most APNs feel comfortable caring for patients but have no idea about reimbursement, the importance of coding, billing, or fiscal plans. Business tactics should be an integral part of the education of APNs today (Vonderheid S. P., 2009). A great place to start is your state's Small business Development Center. Some of the information for this article was found at <http://www.georgiasbdc.gov> insert your states' name for Georgia and it should take you to your states website.

NMHC have already proven that without the financial support of the medical community and government, they can provide low cost, high quality primary care consistent with care provided by primary care physicians, despite numerous roadblocks with funding, recognition of

profession, and reimbursement. The bottom line is, by 2014 when millions of Americans are added to the already overstretched primary care healthcare system as we know it, ANPs stand poised and ready for the challenge. The goal of NMHCs is to support changes and initiatives to increase public funding and reimbursement for their services to be able to reach the growing demand through education and legislation.

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