

A HEALTH CENTER IN WEST SIDE PARK?

ASSESSING HEALTH NEED AND HEALTH CARE MODELS

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EXECUTIVE SUMMARY

During the Spring 2001 semester, students from Rutgers Department of Urban Planning and Policy Development completed a Studio course on Community Development. The goal of the studio was to provide technical assistance to two community-based organizations in Newark's West Side Park neighborhood. The organizations—Corinthian Housing Development Corporation and the Tri-City Peoples Corporation—wanted help in planning a health center for the neighborhood. Corinthian held a grant to begin building a center and Tri-City runs a small health center. The studio marked the continuation of a five-year effort of Rutgers Center for Urban Policy Research and the Rutgers Community Outreach Partnership Center in the West Side Park area.

The studio's main task was to provide relevant information to help the organizations to decide whether or not to build the health center. All parties understood from the outset that such a center, though potentially important to West Side Park, was difficult to conceive and operate and was fraught with financial and organizational risks. Several important issues were addressed:

Health Needs

- There are substantial amounts of healthcare services available in the neighborhood, given the proximity of hospitals and other providers. However, there is a paucity of primary care, OBGYN, asthma care, and pediatric care, those services most needed by West Side Park residents. Residents and community leaders also indicated that there is a dire need for eye and dental care, especially for children.
- There are serious health problems in the area, including asthma, lead poisoning, hypertension, and diabetes. There are high rates of low birth weight, infant mortality, premature births, and neo- and post-natal mortality.
- Community residents emphasized the need for outreach, education, and culturally appropriate services to meet the needs of men, women, children, and seniors.
- Because of high poverty, low rates of insurance, inconvenient hours and uninviting settings at hospitals and healthcare centers, a lack of health education, and substantial cultural and language barriers, many local residents do not have sufficient access to healthcare.

Healthcare Models

Five medical models were studied: Federally Qualified Health Care centers (centers that are designated by the federal government and receive federal funding to provide healthcare), Nurse Practitioner-run practices, hospital-based health centers (centers that are established by hospitals and are run either on-site or off), volunteer doctor-run

practices, and stand-alone centers—those run by the CBOs themselves. The costs and benefits of each model were studied and the CBOs were given the option of choosing one of following three models.

The Nurse Practitioner-run Practice:

- Advantages include experienced practice managers and access to federal Health Resources Services Administration (HRSA) funds targeted specifically for nurse practitioner practices. Additionally, nurse practitioners value health promotion, spend more time with patients than doctors, and are oriented toward health outreach and education.
- Disadvantages include an increased reliance on grants in comparison with Federally Qualified Health Centers, a preference on the part of some residents for doctors rather than nurse practitioners, and some occasional problems making referrals and getting x-ray results that are sometimes only released to doctors.

The Federally Qualified Health Center (FQHC):

- FQHCs have extensive experience providing healthcare and have well-trained and experienced staff to manage reimbursements. FQHCs access a wider income stream which includes federal grants, the state charity care pool, and increased capitation rates. Additionally, the federal government requires that FQHCs provide comprehensive health services directly or through partnerships.
- However, FQHCs place less emphasis than nurse practitioners on community outreach and health promotion. In addition, they may be less interested in working in partnership with community organizations. Additionally, even though FQHCs qualify for a wider income stream, they are not insulated from changes in health policy.

Stand-alone Health Center

- Since stand-alone health centers are operated directly by CBOs, community organizations have more control over healthcare provision. However, the increased control comes at a substantial price in increased financial risk. Without the federal grant dollars that support the FQHC and nurse practitioner models, stand-alone models depend on reimbursement income and grants.

Healthcare Reimbursement

- The roles of managed care and the federal-state reimbursement system were examined to gauge the ability of a community health center to serve the community and survive financially.
- The researchers emphasize that because of the high number of people without health insurance and because health reimbursements do not cover the cost of providing health services, to remain financially viable, all of the healthcare models will require income from grants and private and public reimbursement.

- Given the policy shift to managed care insurance, all health center models will require an experienced staff to negotiate managed care contracts and secure timely reimbursement.

Building Design and Occupants

- The researchers studied the kinds of tenants that might be attractive to the development of the health center. The use of some of the building for community activities—including education and after-school activities was discussed.
- Attention was focused on the design of the center, emphasizing the importance of inviting space, playrooms for children, and cultural artwork. Several design options were presented.

Finally, the researchers recommend that Corinthian HDC and Tri-City take the following next steps to develop the healthcare center:

- Decide what type of health center is appropriate for the neighborhood.
- Identify the healthcare provider.
- Identify sources of construction funding.
- Formulate a community outreach strategy in partnership with the healthcare provider.
- Identify tenants that complement the health center.

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INTRODUCTION

This report is the product of the Community Development Studio, Department of Urban Planning and Public Policy, which worked in cooperation with the Rutgers Community Outreach Partnership Center (RCOPC) at the Center for Urban Policy Research (CUPR), Corinthian Housing Development Corporation and Tri-City Peoples Corporation.

CUPR has been working with community organizations in the West Side Park neighborhood for more than five years. Through its COPC, Rutgers works closely with community actors to identify community research priorities. For the past two and a half years, RCOPC has worked with the West Side Park Neighborhood Empowerment Council (NEC) of the Urban Coordinating Council (UCC) to identify projects that could benefit from university and community partnerships. The NEC identified the need for a neighborhood healthcare center as a priority and requested Rutgers' assistance in its development.

Two community organizations, Corinthian Housing Development Corporation and Tri-City Peoples Corporation took the lead on this project. The two organizations initially proposed to redevelop a site on 16th Avenue and 19th Street (570-576 South 19th Street and 308-310 16th Avenue) as a community health center. The New Jersey Home Mortgage Finance Agency (HMFA) currently owns the land and will be shortly issuing a request for proposals for that land's development.

Corinthian received a grant of 250,000 dollars in 1998 to build a community health center. Originally, Corinthian planned to locate the health center near its offices on 11th Street near Springfield Avenue but this site was problematic because of the cost of removing an existing structure and potential environmental issues. Recently, the organization has reconsidered this site as a possible alternative. The proposed building that will house the health center, on either site, will be 25,000-30,000 square feet with two stories.

The goal of both community organizations is to improve access to healthcare. However, each organization approaches this from a different perspective and with different goals that have evolved over the course of the project. Corinthian HDC is a non-profit developer. While Corinthian wants to ensure that community needs are met, it also wants to make sure that a health center is a viable business. If Corinthian develops the site, they need to ensure that their tenants can pay the rent. Tri-City Peoples Corporation is primarily a social service provider, although it has formed partnerships with developers to provide housing. Tri-City was initially interested in expanding their current health center, which is located adjacent to the parcels at the 16th Avenue and 19th Street site.

Further complicating the process, both organizations have experienced significant staff turnover during the course of the project, which has led to changing opinions about the type of health center and where it should be located. Studio students and faculty also needed to continually make efforts to establish new relationships between the university and community actors and remain flexible as new goals and agendas were established.

New leadership at each organization has also complicated the development of a partnership between the two organizations. The goals of the previous directors differ from those of the current directors.

Initial proposed site on 16th Avenue and 19th Street, West Side Park, Newark.
View from 19th Street looking East.



To provide Corinthian Housing Development Corporation and Tri-City Peoples Corporation with information to assist them in making a decision about whether the plan to build and operate a healthcare facility in West Side Park is a viable one, the studio sought to find out several things. This included identifying the existing supply of health services, remaining health need, identifying what type of healthcare community residents and organization leaders want, what barriers residents face in accessing healthcare, health concerns among ethnic groups living in the area, and potential health center models and providers. Studio participants also explored healthcare policy to explain the reimbursement process and determine how that will affect the community's selection of healthcare providers and the financial viability of models. Students also looked at what other tenants would be good partners for a healthcare center, expected rental income, and building design.

This report is both an end and a beginning. The students have provided both organizations with an extensive body of information that Corinthian HDC and Tri-City can use to inform their decision making.

Research Plan

To conduct the feasibility study, students divided into five working groups to examine the vision for the health center, to identify potential healthcare models, to identify health needs, to estimate the potential for rental income and possible tenants, and to understand healthcare reimbursement.

Vision

Because a healthcare center in West Side Park should be of service to the residents who live in and around the area, it was our goal to discover what those residents might desire in such a center. It was important to identify community health needs and concerns so that the studio could address these important issues. To develop an accurate picture of the West Side Park community, its residents, and their healthcare needs, we conducted personal interviews and focus groups with community leaders and residents.

We conducted personal interviews with staff at Tri-City Peoples Corporation and Corinthian Housing Development Corporation, Michelle Sindab-Blocker 17th Street School nurse, Judy Diggs PTA head, Casto Maldonado director of FOCUS (a Newark Hispanic Center for Community Development), and other community development leaders and professionals familiar with the health needs of the community.

We held two focus groups with West Side Park neighborhood residents. At these meetings, residents voiced their concerns regarding their health conditions and the availability and lack of health services. Focus groups also provided an opportunity to interact with “hard-to-reach” populations who are often overlooked or forgotten. Immigrant groups, people who speak foreign languages, or small populations are often categorized as hard-to-reach. In West Side Park, Latinos and Haitians are considered hard-to-reach.

We supplemented our field interviews with research that explores healthcare disparities including *Increasing Access: Building Working Solutions* report prepared by Meyer and Silow-Carroll, *Racial and Ethnic Disparities in Access to Health Insurance and Health Care* by the UCLA Center for Health Policy Research and the Henry J. Kaiser Family Foundation, and “Community Health Center Feasibility Study” prepared by Kathe Newman and Phil Ashton (Meyer and Silow-Carroll 2000; UCLA Center... 2000; Newman and Ashton 2001).

Models

The goal of this group was to identify, describe, and outline the costs and benefits of different healthcare models. We talked with healthcare professionals and surveyed the potential range of community healthcare models. We identified providers who use these models, created a semi-structured interview instrument, and interviewed the providers to learn about how the models work, what the assets are for each model and what difficulties they face. The interviews were conducted over a period of two months.

We looked at the following types of healthcare models and interviewed the providers listed:

- **Federally Qualified Health Center (FQHC)**—Health centers designated by the Federal government Health Resources Service Administration as community health centers that receive federal dollars to supplement the provision of healthcare to the underserved.
 - ❖ *Newark Community Health Systems*: Bob Russell, Newark Community Health Center, PO Box 1960, 741 Broadway, Newark, NJ 07104.
- **FQHC Look-Alike**—Before health centers can become FQHCs and receive Federal 330 dollars, they have to apply to become FQHC look-alikes.
 - ❖ *Jewish Renaissance Foundation*: 149 Kearny Avenue, Perth Amboy, NJ 08861-4700
- **Volunteer Doctor**—Health centers that are run by and or staffed by doctors, often retired, who volunteer their time and abilities.
 - ❖ *Jewish Renaissance Foundation*: 149 Kearny Avenue, Perth Amboy, NJ 08861-4700 (note: this Volunteer Doc model is an FQHC look-alike)
- **Nurse Practitioner Practices**—Health centers that are run by nurse practitioners.
 - ❖ *Rutgers College of Nursing*: Judith B. Pollacheck, Ph.D., R.N.C.S., ANPC; Director, NCFC Health Center, 75 Halsey Street, Newark, NJ 07102
- **School-Based**—Health centers that are located in a school and provide services to the entire community.
 - ❖ *St. James High School*: Gerard Colman, Newark Beth Israel Hospital
- **Hospital-Based**—Health centers run hospitals.
 - ❖ *St. James High School*: Gerard Colman, Newark Beth Israel Hospital
- **Stand-alone**—Health centers that do not share affiliation with any other groups or organizations
 - ❖ *Tri-City Peoples Corporation Health Clinic*: Judy Favors

At each appointment, we administered a survey questionnaire that focused on the following aspects of the healthcare center:

- General Information – date opened, services offered, hours of operation, service area, number of visits/patients
- Organizational aspects – type of agency, management structure, partnerships entered into
- Operational aspects – size of facility, number and function of rooms, services offered, staffing, hours, equipment needs/costs, administrative needs/costs, overhead costs, relationships with other businesses, financing
- Practitioners – type of practitioners, ethnicity and linguistic issues of providers, number of providers, other medical personnel
- Licensing and legal issues – qualifications, liability and malpractice insurance

- Funding – FQHC status, consolidation grants, NJ state grants, private funding, funding for specific services
- Community issues – reception by community, needs of local potential patients, community involvement, local partnerships

Next, we analyzed the costs and benefits of each model. We looked at costs and benefits in terms of whether the model would meet the needs of the community in the provision of services, relationship to existing community organizations, community outreach, and financial viability.

Identifying Health Needs

Initially this group was the marketing group. However, we quickly discovered that it is necessary to select a model for providing healthcare before conducting a marketing study. Because each model has its own characteristics, intricacies, and issues relating to the type of health services provided, capacity, client profile, and sources of gap financing that would be sought, to attempt a marketing study without first knowing how the health center intends to operate is a classic case of “putting the cart before the horse.”

We believe our role is to provide information to enable Corinthian HDC and Tri-City to select the healthcare model and provider they think will best meet community needs. In lieu of conducting a full marketing study and selecting the model for the neighborhood, this group identified healthcare demand in West Side Park and surrounding communities. We examined the literature on disparities in the provision of health services to low-income and non-white populations, incidences of disease at the state, county, and city levels, and the demographic profile of the target area that might indicate high health risks and/or barriers to accessing healthcare. We also inventoried, to the degree possible, existing health services and estimated how effectively they serve the area.

The project team met with experts who have performed market feasibility studies to determine the target area and thus the population who would be most likely to use the proposed health center. Certain assumptions were made in this process. As a rule of thumb, for financial feasibility, one unique visitor (a unique visitor may generate several visits to a health center in a given year, therefore visitors are not to be confused with the number of visits) is needed for every square foot occupied by a health center (e.g. a 6,000 square foot facility would need 6,000 unique patients).

Another assumption is that a health center will capture approximately 10 percent of a given population within two years' time (e.g. a population of 60,000 would generate 6,000 unique visitors in two years). Several factors will undoubtedly affect the numbers generated by these assumptions. These include the number and types of existing health services and doctors, outreach to poor and non-white communities including enrolling all qualified Medicaid and New Jersey Family Care persons, and overcoming other barriers to health care. The final assumption was based upon information given by the Director of Corinthian who estimated the health center would occupy approximately 6,000 square feet of a proposed building. Depending on the model of the healthcare center and the

needs of other potential occupants of the building—which might vary—it was understood that the actual size of the center might change.

Starting at the proposed site for the health center, we mapped a series of circular areas with increasing radii, calculating the population of each until we reached an area populated by the 60,000 residents required to ensure feasibility under this model. We demarcated a circular target area one-mile in radius from the proposed site with roughly 62,000 residents according to 1998 Claritas census estimates.

Population counts of $\frac{1}{2}$ and $\frac{1}{4}$ mile away from the building site were estimated using census tract maps and buffer capabilities of Arcview. For census tracts that fell partially within the buffers of $\frac{1}{2}$ mile and $\frac{1}{4}$ mile, we assumed population was distributed equally within the census tract. For example, if a census tract fell 30 percent within the $\frac{1}{4}$ mile buffer and 70 percent outside the $\frac{1}{4}$ mile buffer and the population of the census tract was 1,000, we assumed 300 people were within the $\frac{1}{4}$ mile buffer for that census tract.

While this constituted the primary target area, later analyses from focus groups suggested that people might be willing to travel further for healthcare from providers they trust. For this reason, we also used a target area with a three-mile radius from the proposed health center. Using the theoretical assumptions of a gravity model, that willingness to use a facility decreases exponentially with increasing distance, we estimated a distance that, with public and auto transportation, people would be willing to travel to reach a health center. Though this larger target area could just as easily have had a two-mile or five-mile radius, statements from our experts led us to believe that a three-mile radius would be a reasonable assumption for capturing the populations that might be willing to use the center. For each of the target areas, we obtained demographic data to determine health profiles that included poverty, race, and education, which, according to the healthcare disparities literature, may act as barriers to accessing healthcare.

Healthcare Policy and Insurance

This group explored the intricacies of New Jersey healthcare policy, the implications of providing services in a managed care environment, and how different providers locate resources to serve people who are uninsured. The goal of this working group was to research the various ways that healthcare is financed in New Jersey. This included examining current health policy on public health insurance and the uninsured, and determining how private insurance works. A significant amount of background information was collected through academic policy research. Specific questions about how to coordinate reimbursement with the latest developments in New Jersey healthcare policy were explored through interviews. These included interviews with hospital and health center staffs that perform billing, a healthcare advocate, and a foundation representative. We also analyzed hospital discharge and census data to determine what types of insurance will likely be seen by the health center.

Rental Income, Building Location, and Design

In collaboration with the other groups and the community organizations, the rental income group explored the most appropriate uses for the remainder of the building that is

not used by healthcare. Current possibilities include day care, after-school programs, relocating an existing computer lab, and much needed CDC office space. We created maps using ESRI's Arcview GIS software. We found pharmacy, optometrist, and optician data using yellow page resources on the Internet. These locations were subsequently "geocoded" onto a map of Newark and the surrounding area using street map information. Maps of Newark, street maps, and bus routes were obtained from the University.

3-D Design and Building Layout

The base maps were drawn in AutoCad 2000 with lot configuration and dimensions obtained from a parcel map digitized by the Newark department of engineering. The series of site renderings were created in 3D Studio Viz using the AutoCad drawings as a guide for accuracy of scale and measurement. Conversion from 2D site map to 3D model is a multi-platform process involving (among others) AutoCad, 3D Studio Viz, Photoshop, and Illustrator. This process involved several steps including creating a crude massing model, applying building and environmental textures, and lighting the completed model. The final step involved positioning cameras at various locations within the model.

PROFILE OF THE POPULATION AROUND THE LOCATION OF THE PROPOSED HEALTH CENTER

Health Profile: From the Neighborhood

Students interviewed community residents and community leaders to learn about their specific health concerns and needs, what types of services they would like the health center to offer, and to learn in general what type of health center they would like in West Side Park. It became clear that West Side Park residents would like to have several special services offered at the healthcare center. Complying with these requests is strongly recommended to recognize and validate the needs of the target population.

Most frequently, West Side Park residents stressed the need for adequate and affordable dental care. Many children and adults have cavities and/or missing teeth. Few dentists are located in the target area, and insurance rarely covers their services. Proper oral hygiene and annual cleanings can be as important as medical check-ups.

Similarly, eye care is a concern for the community. Particularly among school children, poor vision can greatly affect one's development and quality of life. Not only are exams costly, but also glasses are very expensive. The 17th Street School nurse noted that many children lose their glasses at the beginning of the year and struggle to learn throughout the rest of the school year because parents cannot afford to buy another pair of glasses (Interview with 17th Street school nurse 2001).

Ongoing concern for women's health, prenatal care, and postnatal care are prevalent in West Side Park. Moreover, all young children should be offered necessary immunizations and screened for lead poisoning, which is a common problem in West Side Park. Additionally, health services for men are overlooked. Treating women without giving equal attention to men only treats half of the problem. Particularly for cases of sexually transmitted disease, both men and women need to receive treatment and preventative education. In addition, cancer screenings should be offered for both men and women.

The residents of West Side Park also note that their elderly population is in need of more age-specific care. One particular challenge in treating the older population is increased language and cultural barriers. Many elderly living in the West Side Park area are immigrants, and although they may have lived in Newark for the better part of their lives, they may not be proficient in English or comfortable with medical exams. In addition, some are not able to read which makes it more difficult for them to read literature distributed about the health services. Additionally, many elderly have heard rumors or "urban legends" about doctors or hospitals—stories about a neighbor who died after visiting the emergency room or getting a flu shot, for example. As a result, some are afraid to seek medical attention themselves. Therefore, it will be necessary to approach them with sensitivity and understanding.

Asthma treatment and education were specifically mentioned as a concern of West Side Park residents. Many parents have children who suffer from asthma or have to cope with

breathing problems on a daily basis themselves. One resident said that the only place to take her grandson when he has an asthma attack is the hospital emergency room. Teaching the community how to have better and healthier lives with asthma, providing inhalants or prescriptions, and helping to prevent its onset would decrease the rate at which residents use hospital emergency rooms for asthma treatment.

Residents expressed a desire to see “wellness” services offered. Recognizing the relationship between physical health and general well being, focus group participants cited the need for health education. Often, people may not know how to properly care for themselves or their children. Providing education, known as health promotion, about hygiene, nutrition, first aid, and so forth could help to decrease community health risks.

The 17th Street School nurse cited fears that the only well-balanced meals school children receive are those served in the school cafeteria. Parents and caregivers should be educated about healthy eating and balanced diets. Counseling services were also suggested. Learning how to cope with life situations such as pregnancy and difficult family circumstances, and providing a willing listener could help community residents feel more confident and capable, thus improving their mental wellness and physical health.

The numerous community requests for dental and eye care services show that the community has more far-reaching and less obvious health concerns. Additionally, there is a need for specialized and comprehensive healthcare for men, the elderly, women and children. Community members pointed to asthma treatment as a major need, particularly for children, and prostate cancer screenings for men. And, lastly, wellness programs should be provided in the healthcare center, as treating the whole person is equally important to curing and preventing illness. Such requests demonstrate the level of awareness that the West Side Park community has for their own conditions, and their understanding that health is more than treating a sick individual.

Race and Ethnicity

Racial and ethnic health disparities are significant despite a general improvement in health status across the country. People of color have higher incidences of infant mortality, diabetes, cardiovascular disease, cancer screening and management, HIV/AIDS, childhood asthma, and lead poisoning, and lack childhood and adult immunization (UDHHS, NIH 2000).

The health needs of African Americans, Latinos, and Haitians are extremely important and should be taken into consideration when deciding what services will be offered at the new health center. As Mr. Casto Maldonado, the director of Focus Health Center stated, “health is tied into culture.” The proposed health center will serve a diverse ethnic population and should address the needs of these three major groups (Interview with Casto Maldonado 2001).

West Side Park is primarily African American, but it has a growing Latino population and a nearby Haitian population in Irvington. It is important to recognize that these three groups have common health concerns and that they also have specific health needs pertaining to their own ethnic and racial communities.

In our discussions with the African American community, interviewees told us that the most pressing issue for adults and children is access to dental and eye care. Many parents cannot afford to pay for eye care or for glasses; therefore, the children's sight suffers and has an adverse effect on their schoolwork. Toothaches are also a problem among children and adults who cannot afford dental care. At times children are in school with toothaches but there is very little the teachers or school nurse can do to help.

Other health issues that are prevalent in the African American community (particularly for children) are asthma, common colds, malnutrition, seizures, lice, "pigeon toe" feet, and lead poisoning. Many of these are widespread issues that are a result of the inner city environment; others are a result of a lack of preventative education and/or care. Among the young adult population, interviewees expressed a need for education about sexually transmitted diseases and preventing teenage pregnancy. Seniors raised arthritis as a significant health issue.

The Latino population in West Side Park is a mix of different nationalities: Dominicans, Puerto Ricans, and Central and South Americans. Although some health needs are culturally specific, overall Latinos share some common health problems. According to our interviews, among adults, diabetes, cancer, heart ailments, and infectious diseases such as tuberculosis are the most common health problems. Teenage pregnancies are a health problem that is also affecting the Latino community. Moreover, many pregnant women cannot afford or are not educated about the need for pre-natal care, putting their babies at risk. Among children, the most common health issues are behavioral problems such as being overactive and malnutrition.

The Haitian population shares some of the same health needs that African Americans and Latinos have such as diabetes, the need for dental care, hypertension, and illnesses due to poor nutrition and high blood pressure. Haitians also expressed that lacking insurance and limited access to healthcare providers were important barriers.

Health Profile: From the Data

The following section covers health issues faced by people of color and people who are poor. Each section identifies how a community health provider can reduce racial and ethnic health disparities in health status.

Asthma

Asthma is one of the most serious childhood illnesses (Gibson 1996). African American children are more likely to be hospitalized for asthma than whites and African American and Latino children are less likely to receive medication to prevent future hospitalizations (Addressing Racial and Ethnic... 2000).

Asthma tends to affect the lives of more blacks and Hispanics. Blacks are three times as likely as whites to be hospitalized from asthma and three times as likely to die from the disease. The racial differences in asthma prevalence, morbidity and mortality are highly correlated with poverty, urban air quality, indoor allergens, and lack of patient education and inadequate medical care (Asthma and Allergy Foundation 2001).

Asthma is a significant problem in Newark and in the West Side Park neighborhood. A survey of Newark school nurses revealed that nearly 98 percent of nurses thought that asthma is a serious health problem (Cornell Student Project 2000/2001). This is supported in West Side Park. According to Tri-City's health center staff, public school nurses see unusually high rates of childhood asthma. City and county level data support the nurses' observations. Essex County accounted for nearly a quarter of the total number of children statewide, ages 0 to 19, who were hospitalized for asthma. More than half (57%) of those children were under the age of five. Newark's asthma rate increased 27.6 percent from 1998 to 1999 making the city a "critical area of need" (Gateway 2000).

Environmental conditions such as pollution and indoor air irritants are thought to be causal factors for asthma. West Side Park is near a number of major highways, which increases neighborhood pollution, housing is old, and there is considerable debris from renovations and buildings that are torn down because of redevelopment efforts.

Community Based Health Provider

- *Health Education.* A community based health provider could provide asthma education and outreach and explain treatment options.
- *Advocacy.* A community health provider could work closely with other neighborhood organizations and institutions to reduce the interior irritants and external pollutants that contribute to the prevalence of asthma.

Cancer Screening and Management

The national cancer death rate for African Americans is 35 percent higher than for whites. Death rates for specific types of cancer such as lung cancer and prostate cancer are 27 percent and 50 percent higher, respectively, for African Americans than for whites (USDHHS, NIH 2000).

Researchers believe that the disparity in cancer death rates is attributed to African Americans not receiving care early enough to diagnose cancer and treat it. For example, "The length of time between an abnormal screening mammogram and the follow-up diagnostic test to determine whether a woman has breast cancer is more than twice as

long in Asian American, black and Hispanic women as in white women” (Addressing Racial and Ethnic... 2000, 2).

Community Based Health Provider

- *Public Health Education.* Education about diet, exercise, and screenings is important to reduce cancer death rates. In a focus group, community residents pointed out that some residents are illiterate and cannot read public health literature. Community organizations can work closely with these residents to provide accessible health information.
- *Outreach.* Encouraging people to be screened for cancer is an important first step. In a focus group, community residents explained that some residents fear screening because they think it would hurt. Other residents choose not to be screened or to receive treatment. A community health provider can reach out to these populations to explain the screening process.
- *Develop Partnerships.* Community health providers can work closely with major medical institutions to offer screenings and to ensure that residents receive follow-up treatment within a reasonable amount of time.

Diabetes

Diabetes is a significant disease in poor communities of color. The incidence of diabetes in African Americans is 70 percent higher than in whites; for Latinos, it is almost twice that of whites (USDHHS, NIH 2000). Death rates attributed to diabetes are three times higher for African Americans than for whites (Brown et al 2000).

The incidence of diabetes as the cause of death in Newark in 1997 was nearly double that of the state (5 percent compared with 3 percent for the state of New Jersey) (NJDHHS 1997). Tri-City’s health center staff identified diabetes as one of the most significant issues they face in treating seniors (Interview with Fran Gray and Pam Moore 2000).

Without adequate access to health care, people with diabetes have higher risks of complications including kidney disease, amputations, and visual impairment. With adequate treatment and lifestyle changes, the risk of these complications is reduced.

Community Based Health Provider

- *Public Health Education.* A community based health provider can provide education to community residents about diabetes. For those who have been diagnosed with diabetes, learning how to live with the disease through diet and exercise is important to reducing complications. Community organizations can work closely with individuals to discuss life style changes and to ensure that those diagnosed with diabetes are regularly checked for complications.
- *Outreach.* Community organizations can work with grassroots institutions and organizations such as churches to conduct outreach. The American Diabetes Association’s African American program works with churches to run Diabetes Sundays. The goals of the program are “To create awareness

that diabetes is a serious disease. To inform the congregation that African Americans are at high risk for developing diabetes...and...To inform the congregation that early diagnosis and treatment can make a difference and related complications may be prevented or delayed” (American Diabetes Association, no date).

- *Treatment.* Providing primary care for people at the community level with diabetes increases the chances that people will return for follow-up visits, thereby allowing physicians to monitor the disease and its complications.

HIV/AIDS

HIV/AIDS is a significant health issue in communities of color. In 1997, Blacks and Latinos made up 65 percent of reported AIDS cases. AIDS is the leading cause of death for African American men between the ages of 25 and 44 and the second leading killer of African American women in that age group (Brooks 2000). In addition, twenty percent of new AIDS cases through June 1998 are attributed to Latinos who make up 11 percent of the population (Rivera-Larroy 2000).

There is a close relationship between substance abuse and HIV/AIDS. “According to the Centers for Disease Control and Prevention (CDC), injection drug use accounted for 36 percent of all AIDS cases among both African American and Hispanic adults and adolescents in 1998, compared with 22 percent of all cases among white adults and adolescents” (“HIV/AIDS and Drug Use... 2000, 2).

There are racial disparities in HIV/AIDS treatment. Whites are more likely than African Americans to receive treatment (Hewlett 1999). Half of all people who are HIV positive are not receiving care in the United States. The federal government is addressing HIV/AIDS in minority communities by funding community organizations. Community outreach is critical to educate residents about how to prevent the spread of HIV/AIDS. The federal government is also supporting increased education and treatment of substance abuse and mental health. The director of the Office of HIV/AIDS policy in the federal Health and Human Service Office stated “Our goal is to identify high-risk populations; target them for testing; and move those that are positive, once tested, into a continuum of care and services” (Brooks 2000). As of June 2000, 8,537 people in Essex County were living with HIV/AIDS; 4,993 are men and 3,544 are women (Gateway 2000). Ten percent of deaths in Newark are attributed to HIV infection, compared with 1 percent for the entire state (NJDHSS 1997).

Community Based Health Provider

- *Public Health Education and Outreach.* Community organizations can reach community residents and work closely with neighborhood organizations and institutions to provide public education to slow the spread of HIV/AIDS, and to encourage people to receive treatment.
- *Provide HIV/AIDS screening.* Community organizations can encourage community residents to be tested for HIV/AIDS. This is particularly

important for pregnant women since research has shown that by treating pregnant women with medication and treating their infants immediately after birth, it is possible to reduce an infant's chance of contracting HIV (Hewlett 1999).

- *Ensure Continuing Care.* Community based organizations can work closely with people who have HIV/AIDS to ensure that they receive medications and attend their medical appointments. They can also work closely with other community organizations to ensure that people with HIV/AIDS receive social and economic support, which has been shown to be a factor in people's continuing follow-up treatment, which is important to slowing the spread of HIV/AIDS (Hewlett 1999).
- *Ensuring Access to Medication.* Treatment for HIV/AIDS is costly but public health programs cover much of it. Increasing enrollment in these programs can facilitate access to medication. For those who do not qualify for public health programs, community based organizations can facilitate access to medication by linking people to pharmaceutical company compassionate use programs (Hewlett 1999).
- *Comprehensive Care.* The spread of HIV/AIDS is closely related to substance abuse. Community organizations can work closely with local agencies and medical centers to develop collaborative strategies to address "interrelated health and behavior problems" (Quander 2000).

Immunization

Adult immunization is important to reducing complications from the flu and pneumonia. Childhood immunization is important for preventing and reducing vaccine preventable diseases. The U.S. Centers for Disease Control recommends that children receive adequate doses of the recommended 4:3:1 immunization series—4 doses of tetanus, diphtheria, and pertussis vaccine, 3 doses of poliovirus vaccine, and 1 dose of the measles-mumps-rubella vaccine (www.cdc.gov). It is most beneficial for children to receive 80 percent of these vaccines before age two (Gateway 2000).

There are immunization racial and ethnic disparities. By 24 months, 79 percent of white children receive the series compared with 74 percent of African Americans and 71 percent of Latinos (USDHHS, NIH 2000). Newark's immunization rate is far lower than the U.S. and New Jersey averages. In Newark, only 66 percent of children ages 19-35 months received the 4:3:1 series in 1998 compared with 81 percent in the U.S. and 85 percent in New Jersey (ACNJ 2000).

Table 1. Percentage of Children Aged 19-35 Months who Received the 4:3:1 Vaccination Series 1995-1998

| Year | United States | New Jersey | Newark |
|------|---------------|------------|--------|
| 1998 | 81% | 85% | 66% |
| 1997 | 78% | 78% | 70% |
| 1996 | 78% | 78% | 63% |
| 1995 | 75% | 76% | 60% |

Source: ACNJ 2000

Community Based Health Provider

- *Public Education.* Public education is necessary to inform community residents about the importance of vaccinating children with adequate doses, preferably before the age of 24 months. Seniors need to be educated about the importance of receiving vaccines.
- *Vaccinations.* Community based health providers can provide vaccinations and work closely with parents to ensure that children receive all of the appropriate vaccinations and adequate doses at the appropriate ages. They can work closely with seniors to provide flu vaccines, teach them about the need for the vaccines, and improve accessibility by working with other CBOs and CDCs to provide transportation for them.

Infant Mortality

The rate of infant mortality is used throughout the world to measure community health. In the U.S., there are distinct racial disparities in infant mortality rates. The African American infant mortality rate is more than twice that of whites and Hispanics (USDHHS 1997, NIH 2000). Infant mortality rates in Irvington and Newark are 13 percent compared with less than 5 percent for whites in New Jersey (Gateway 2000). Infant mortality is related to a number of factors including birth weight, maternal age under 17 or over 34, prenatal care, genetics, poverty, nutrition, and substance abuse (USDHSS, ORMH 1999; Gateway 2000).

Low Birth Weight

Eighteen percent of babies born to mothers in West Side Park in 1997 had low birth weights compared with 8 percent statewide. Almost four percent had very low birth weights compared with less than 2 percent for the state (Gateway 2000, NJDHHS 1997).

Prenatal Care

More than 45 percent of mothers in Irvington and Newark did not receive adequate prenatal care in 1998. In the West Side Park neighborhood, only 39 percent of pregnant women received prenatal care during their first trimester in 1997 compared with 81 percent in New Jersey. Fourteen percent of West Side Park mothers received no prenatal

care during the duration of their pregnancies compared with 1 percent in the state (Gateway 2000, NJDHHS 2000).

Sexually Transmitted Diseases (STDs)

STDs pose a number of health risks which include “some cancers; infertility; pelvic inflammatory disease; ectopic pregnancies; spontaneous abortions; pre-term labor; and rupture to membranes. In addition, there are serious risks to newborns delivered to mothers with untreated STDs” (Gateway 2000, 34).

In 1998, there were 2,978 cases of Chlamydia, 2,779 cases of Gonorrhea, and 294 cases of Syphilis in Essex County. Essex County accounted for almost 30 percent of the state’s cases of adolescent STDs in 1998. Almost half of Essex County’s cases of Chlamydia (46%), 30 percent of the cases of Gonorrhea, and 24 percent of the cases of Syphilis were in youth aged 0-19 (Gateway 2000).

Community Based Health Provider

- *Public Health Education and Treatment.* Health education and treatment for both partners could be provided at a community health center. Accessing health care for youth is often an issue and a community level health institution provides ease of access; nurses from local schools can refer students.

Lead Poisoning

Lead poisoning is a significant issue for children under 6 years of age because it can affect their development. It is also an issue for women who are or who may become pregnant because lead can affect the fetus. Children in poor communities of color are at an increased risk of lead poisoning. According to the Alliance to End Childhood Lead Poisoning, “In the U.S., children from poor families are eight times more likely to be poisoned than those from higher income families. African American children are five times more likely to be poisoned than white children” (Alliance to End Childhood Lead Poisoning 2000).

Factors that increase the chance of having a high exposure to lead include housing age, the percentage of children under the age of six living in poverty, and the number of housing units with low-income residents. People living in housing built before 1950 are at increased risk because there were no restrictions on the amount of lead in paint until 1950. Paint manufacturers reduced the amount of lead in 1950; the federal government eliminated its use in paint in 1978. Children can ingest paint chips. They can also ingest dust from their clothes, shoes, toys, and the general environment (Source: Environmental Defense Scorecard 2000).

Children in West Side Park are at an increased chance for lead poisoning. More than 50 percent of the housing was built before 1950. More than 35 percent of the households are

low income and nearly 60 percent of the children under six were living in poverty in 1989 (U.S. Bureau of the Census 1990).

Lead pipes are another source of lead poisoning. The lead levels in Newark's drinking water were recorded at above acceptable limits in 1992, declined below the limits in November of 1997, and in March-April 1998, inched back towards the acceptable limit (0.0126 mg of Lead per 1 L of Water compared with acceptable limit of 0.0150) (ACNJ 2000).

Pollution from cars and airplanes is another source of lead in the environment. The West Side Park neighborhood is located near a number of busy highways including the Garden State Parkway, Springfield Avenue, I-78, the New Jersey Turnpike, and Routes 1, 9, and 22. It is also near Newark International Airport (Gateway 2000).

Twenty-eight percent of the children who test positive for lead in the state live in Newark (ACNJ 2000). In Newark, 622 children tested positive for lead in 1995, 656 in 1998, and 456 in 1999 (ACNJ 2000). These data are difficult to interpret however, because until recently, no data were kept on the total number of children tested. There is no way to determine whether the proportion of children testing positive is increasing or decreasing.

Community Based Health Provider

- *Public Education.* A community health center could educate community residents about reducing lead poisoning risks and about the importance of screening children.
- *Nutrition Counseling.* A community health center could provide nutrition counseling. Vitamin intake influences how the body absorbs lead. For example, calcium and foods rich in iron reduce lead absorption while high fat foods increase it (Gateway 2000; Alliance to End Childhood Lead Poisoning).
- *Lead Screenings.* Community health centers can provide lead screenings. Many private doctors do not do lead screenings in their offices. Instead they refer people to labs making it that much more difficult for children to be screened.

Cardiovascular Disease

Heart disease is one of the leading causes of death in the U.S. and coronary heart disease mortality was 40 percent higher for African Americans than for whites in 1995 (USDHHS, NIH 2000).

Community Based Health Provider

- *Public Education.* Education about diet and exercise are important to reduce the incidence of cardiovascular disease.

Nutrition

Nutrition including healthy eating and exercise is an important issue for infants, children, youth, pregnant women, and adults. For adults, obesity can contribute to elevated blood pressure, heart disease, and kidney disease (USDHHS, Office of Women's... 2000).

Community Health Provider

- *Public Education.* Community based health providers can work closely with community residents to ensure that infants, children, youth, pregnant women, and adults receive adequate education about nutrition and exercise.

Dental Care

Even though tooth decay is an easily preventable disease, many children have tooth decay resulting in high cost and missed school. Tooth decay can be prevented with “regular dental cleanings and checkups, the use of sealants, and appropriate diet and healthcare” (Kenney, Ko, and Ormond 2000, 1). Low-income children have high rates of tooth decay because they lack adequate access to dental care, lack insurance, have less educated primary care givers, or suffer from poor health. Not all dentists accept Medicaid and not all dentists treat children, which further narrows the pool of providers. In New Jersey in 1997, 27 percent of children two years and older had no dental visits in the previous year and 60 percent had fewer than two visits in the previous year (Kenney, Ko, and Ormond 2000).

Community Health Provider

- *Public Education:* A community health center can work closely with community residents, day care centers, schools and other local organizations and institutions to teach parents and children about oral hygiene, nutrition, and the importance of regular dental visits.
- *Dental Care.* A community health center could include a pediatric dentist or could provide access to one on a special basis.

Environmental Hazards

West Side Park neighborhood residents are subject to a number of environmental hazards. The substantial redevelopment in West Side Park Neighborhood includes demolition of houses, apartment buildings, and public housing projects. There doesn't appear to be much of an effort to contain construction debris that may include asbestos, lead, or other toxic particles. Additional environmental concerns include tires that are discarded in the neighborhood. In addition, some community residents burn fires to keep warm. One interviewee observed, “Men stand around barrels burning stuff. Who knows what they're breathing in?” (Interview 2000). What is burned may contribute to health issues. Pollution is also a concern for neighborhood residents since the neighborhood is located near a number of major highways and Newark airport.

Community Based Health Provider

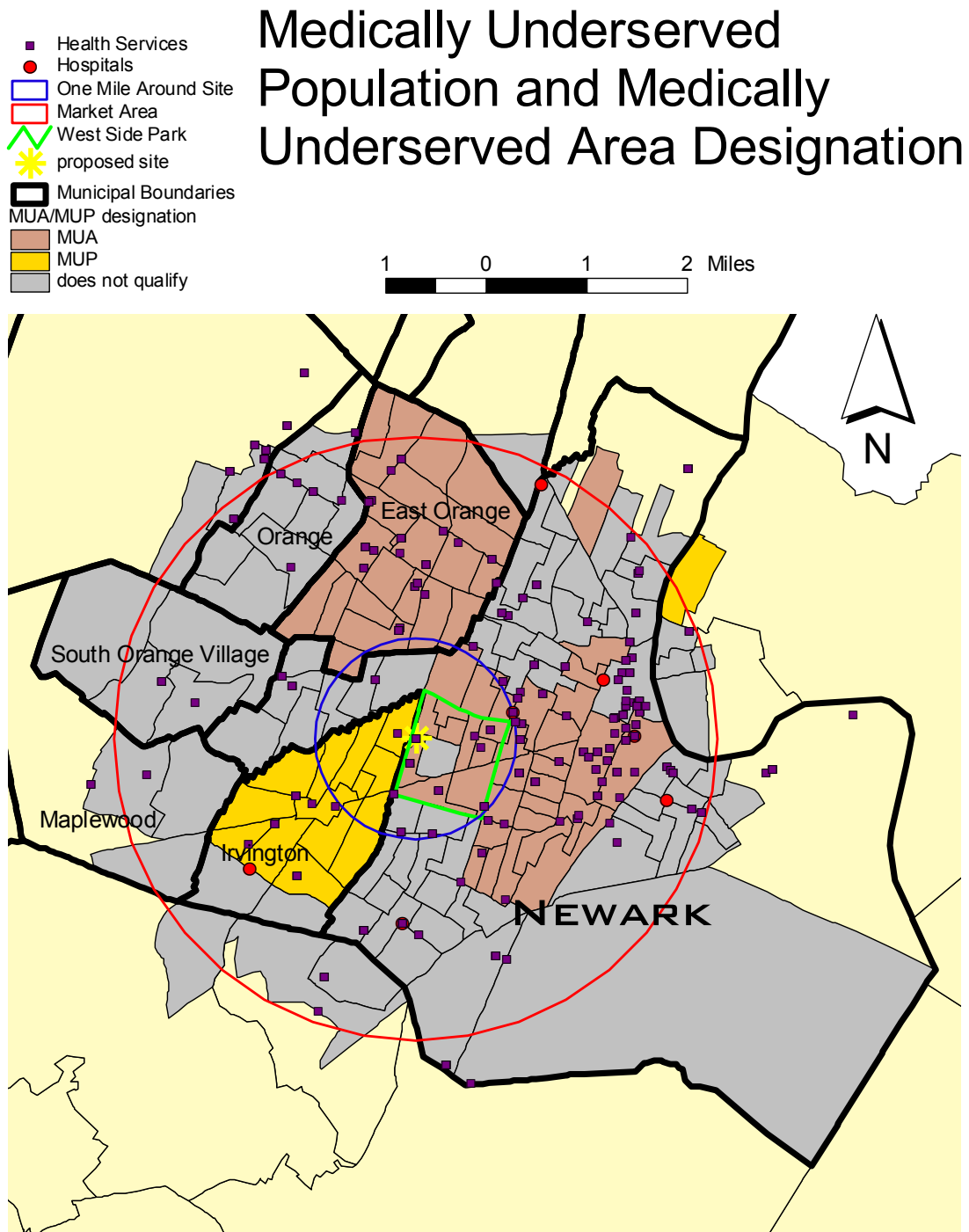
- *Advocacy.* Recognizing that there are environmental health issues, community organizations can work together to advocate reducing environmental hazards.
- *Public Education.* Community organizations can provide public education about the hazards of lead paint, interior allergens, and other environmental hazards.

EXISTING HEALTHCARE SERVICES

There are six hospitals and university medical centers in the area, including UMDNJ, Newark Beth Israel, St. James Hospital and Irvington General Hospital. There are also 140 providers of some form of healthcare, which offer a range of services including primary care, general, and family practice, obstetrics and gynecology, HIV/AIDS treatment, drug and alcohol treatment, and mental health services among others.

Even though at first glance, it appears that there is an adequate supply of services in Newark, understanding supply and access to healthcare is more complex. Evaluating access to healthcare services involves more than counting the number of doctors affiliated with particular hospitals, health centers, and private doctor's offices. Understanding what types of services are provided, how many doctors actually provide these services, and what economic and cultural barriers people face in accessing healthcare are critical to fully understanding healthcare access.

Despite what looks like a wealth of health services in the region, almost 70 percent of the census tracts within the one-mile target area and 45 percent of the tracts within the three-mile target area are designated as Medically Underserved Areas (MUA) or Medically Underserved Populations (MUP) due to their poor health profile and poverty levels. MUAs and MUPs are federal designations based upon four criteria: the ratio of primary medical care physicians per 1,000 population, the infant mortality rate, the percentage of the population living below the poverty line, and the percentage of the population age 65 or over. These criteria are used to determine an area's Index of Medical Underservice (IMU) which shows how "underserved" an area or population is (USHRSA, Bureau of Primary Health Care 2000).



Barriers to Accessing Existing Healthcare Services

To look beyond the number of services offered and MUA/MUP designations, the visions group held interviews and focus groups with community residents and community organization leaders to find out what barriers residents of West Side Park and neighboring communities face in accessing existing healthcare services. Interviews were informed by a literature review on the racial and ethnic barriers to accessing healthcare.

Residents and community leaders identified the following as barriers to accessing healthcare in West Side Park and surrounding neighborhoods:

- Level of poverty and education
- Culture and language
- Lack of insurance
- Health education
- Lack of transportation
- Inconvenient hours
- Long waits at hospitals
- Uninviting medical settings

Poverty

Poverty stands out as the single most important factor responsible for poor health. Poverty affects health in its own right: just being poor increases one's risk of ill health. Poverty also contributes to disease and death through its second-order effects. Poor people, for instance, are more likely to live in unhealthy environments. The interactions of disease agents, individual susceptibility, behavior (which often reflects education), and local environmental condition all bear heavily on health outcomes (Poverty, Health and Environment, World Resources Institute 1998-99).

The analysis of data relating to poverty levels¹ in New Jersey, Essex County, and the target area reveals that as we get closer to the site of the proposed health center, poverty levels increase. It is well known that healthcare is expensive and an indigent population cannot afford the costs of healthcare services in urban areas. In the target area, 41 percent in the one-mile area and 76 percent in the three-mile area are below 100 percent and 200 percent poverty levels respectively. (See table 2).

¹ The poverty level is defined as \$16,660 for a family of four as per US Census Bureau guidelines set in the year 1998. Poverty levels have been used using 1998 Claritas Population Estimates.

Table 2. Poverty Level of Target Areas

| Level of Poverty | New Jersey | Essex County | 3 mile Target Area | 1 mile Target Area |
|------------------------------|-------------------|---------------------|---------------------------|---------------------------|
| 100 % poverty level or below | 9 % | 17 % | 19 % | 41 % |
| 200 % poverty level or below | N/A | 30 % | 49 % | 76 % |

Source: 1998 Claritas population estimates

Lack of Health Insurance

Insurance barriers include working but not qualifying for insurance and not accessing available public health programs (Meyer and Silow-Carroll 2000). In 1998, more than 44 million Americans did not have health insurance. Lack of health insurance is linked to poverty and plays a major factor in compounding disparities in health status; this is especially true for ethnic and racial minorities who are most likely to be poor and uninsured. More than a third of Latinos (37%) and almost a quarter of African Americans (23%) are not insured compared to only 14 percent of Whites.

Of people who are working, people of color are less likely to have employee-based healthcare than Whites. These higher uninsurance rates can be attributed largely to low rates of job-based insurance: only 53 percent of African Americans and 43 percent of Latinos are covered by job-based insurance, compared to 73 percent of Whites (Brown et al 2000). Often people with low paying jobs make too little to afford insurance but make too much to qualify for public insurance. In a focus group, one West Side Park resident commented that even being one dollar over minimum income requirements would eliminate a person from public insurance coverage despite the fact that without such coverage becoming uninsured is likely.

Public Health Education

Education about diet, exercise, and the importance of regular screenings is important to reduce incidence of disease and death rates. Some groups explained that some residents are illiterate and therefore cannot read public health literature. It is essential that such literature is multi-lingual and community organizations work closely with all residents to provide accessible health information.

Cultural and Language Barriers

Cultural and language barriers were identified as one of the factors that made healthcare inaccessible to the community. First-generation immigrants, particularly, speak very little English, if any at all. Moreover, women from certain ethnic groups were uncomfortable being treated by male doctors. In focus group meetings, we learned that some residents of West Side Park are undocumented and they cannot get legal access to healthcare. Healthcare providers find it extremely difficult to reach and treat such individuals (Focus Group and field interviews 2001).

Lack of Transportation

Many residents rely on public transportation to access healthcare services. This can be a barrier to accessing medical institutions as it takes time and money to get to places. In one focus group meeting, residents complained that transportation became an even larger barrier to accessing healthcare when several different centers must be visited to get treated (Focus Group 2001). Most of a day can be spent transferring buses, and waiting for rides, to get to a hospital or doctor who is located across town. As the directors of Tri-City's current health facility explained, people would rather wait a few weeks to be seen at the community health center instead of going to a major medical institution. By virtue of being located in the neighborhood, a community health provider is physically more accessible for neighborhood residents (Newman and Ashton 2001).

Inconvenient Hours

Since many people work, it is necessary to provide services in the evenings and on weekends. Residents complain that they have difficulty accessing the major medical centers (Focus Group and field interviews 2001). To use the free centers, they must take time off from work, which can be a significant financial burden. An effective community-based health center can provide more accessible hours and more flexible scheduling to reduce inconvenience and lost work time (Newman and Ashton 2001).

Uninviting Medical Settings

Another factor that may prevent residents from accessing healthcare is the treatment meted out to them by staff members. Waiting rooms are shabby, bathrooms are inadequate requiring people to carry specimens through crowded waiting rooms, and the office staff is less than welcoming (Newman and Ashton 2001). These features turn patients away from the health centers.

HEALTH CENTER MODELS

Community health centers come in many varieties. They can be geared to serve certain segments of the population, they depend on different sources for their funding, they operate in a wide variety of ways, and each has different reimbursement streams. With so many choices, how will the organizations and community know which model is best for them?

We examined different types of community health centers and looked specifically at the following:

- General aspects of health center operation
- Organizational structure and health center management
- Daily and long-term operation
- Potential types of practitioners
- Licensing and legal issues
- Funding issues
- Interaction with the surrounding community

Following is a description of the different health center models. Each model is described and explained, a case study is presented of a health center that uses that model, and finally the costs and benefits of each model are outlined. The models presented provide a range of options that we believe will provide guidance to the community organizations in establishing their health center.

Federally Qualified Health Center (FQHC)

A Federally Qualified Health Center or FQHC is a health center that meets guidelines established by the Federal Health Resources Service Administration, Bureau of Primary Health Care (HRSA-BPHC), is established as a Community Health Center, and receives Federal 330 dollars that supplement its provision of health services.

Before becoming an FQHC, health centers generally have to operate for a year to demonstrate to the federal government that they are capable of providing the necessary range of services to the appropriate client base. After the trial period, if they have performed adequately, they can receive federal 330 dollars to supplement their provision of services.

Although somewhat different in composition and in the nature of services offered, FQHCs all target the healthcare needs of the medically underserved within their respective service areas. In addition, they must serve areas that the federal government has identified as areas that are medically underserved areas (MUAs) or medically underserved populations (MUPs). The Federal Human Resources Services

Administration (HRSA) determines how many FQHCs are needed to serve a particular area. Currently, there is one FQHC in Newark.

FQHCs are required to provide a comprehensive range of services directly or through relationships with other providers. Typical services include internal medicine, obstetrics, gynecology, pediatrics, geriatrics, medical and surgical sub-specialties, laboratory, podiatry, pharmacy, x-ray, dental, and mental health services. All FQHCs are staffed with board-certified physicians from a broad array of medical specialties. Fifty-one percent of FQHC boards must be users of the health center.

FQHCs receive reimbursement through many sources and receive enhanced capitation rates. FQHCs negotiate better agreements with managed care companies compared with other health providers. In addition, FQHCs are qualified to use Presumptive eligibility to see uninsured patients. Presumptive eligibility means they can see patients who are likely to qualify for Medicaid and can get reimbursements even if the patients are in the Medicaid eligibility process. In New Jersey, FQHCs also qualify for a set aside portion of the state Charity Care dollars, normally reserved for hospitals. FQHCs generally still apply for public and private grants to support specific projects and to ensure that those without health insurance are seen.

The wider reimbursement stream and the guarantee of supplemental federal dollars make FQHCs more financially stable than some of the other health provider models. However, FQHCs, like hospitals and other health providers, are not immune to changes in health policy. The shift to managed care took some FQHCs by surprise as they lost patients and had to learn the ropes of a new type of reimbursement. Managed care company consolidations also affect this model since they are largely dependent on securing patients who have public and private insurance. When managed care companies consolidate, patients can be shifted meaning that the FQHC might no longer be listed as the primary health provider which reduces the income to the FQHC until it can regain its client base.

If the community organizations are interested in this model, they could partner with an existing FQHC, which could open a satellite office in their neighborhood. FQHCs need federal approval to open satellites but the approval process is much easier than the approval process for the original designation.

Newark Community Health Systems

Newark Community Health Systems, which has three locations in Newark and one in East Orange is Newark's FQHC. We visited the East Orange site, which is an impressive facility. Doctors see 20-30 patients for primary care each day, an average of 25 OB/GYN patients daily, and it has an equally active pediatric department. The East Orange Primary Health Center is open five days a week, from 9-7pm, and may provide evening and weekend hours if they have enough patient interest and they can secure staff who are willing to work at those times.

It offers comprehensive services, including general medical care, dental care, obstetrics, gynecology, in-house laboratory facilities, ophthalmology, ear/nose/throat services, podiatry services, HIV care, nutritional care and financial counseling. To fill the needs of each of the specialty areas, East Orange has twelve examination rooms; each specialty area has its own exam rooms and waiting area.

East Orange has a substantial on-site staff, with three internists, one pediatrician, one dentist, one pediatric dentist, two OB/GYN, one registered nurse, one nurse practitioner, one lab technician, one social worker (for food referrals, HIV and financial counseling), two nurse's assistants, two clerical workers, one medical secretary, and one in-house biller.

East Orange is run locally by an on-site administrator and the director of Newark Community Health Systems is in charge of the majority of daily administration of their health centers, for example, scheduling, development of new-patient recruitment plans, and communication of system-wide goals to in-house staff. The East Orange Center rents its building but has complete control over it. This center came into existence about eight years ago.

East Orange has a diverse clientele, the largest proportion of its clients are a mix of African-American, Latino, West Indian and African. To reflect the needs of their patients, East Orange recruited doctors who speak English, Spanish, French, and Creole. Having bilingual doctors decreases the need for translators in the exam room and helps to keep the doctor-patient relationship confidential.

Because the diversity of their patient base can also make it difficult to build and maintain new doctor-patient relationships, East Orange recognizes the need for outreach, and does creative outreach efforts by mail. East Orange also sends doctors and staff from the health center out into the community regularly, to visit churches, beauty and barber shops, schools, and other community gathering places, to increase their chances of communicating with hard-to-reach individuals in the community. Doctors will go out and talk to the community about the importance of child immunizations and preventative care.

The East Orange Health Center is supported by a wide range of funding sources including the 330 Community Health Center dollars (FQHC), public and private reimbursements, grants, State Charity Care dollars, and cash payments. Even though the center states that the cost of appointments for the uninsured range from 20 to 60 dollars, they will not turn patients away.

Costs and Benefits

If a health center can get federal dollars, its challenges for start-up and success through the first five years will be dramatically lessened. This allows for flexibility in hiring of a variety of medical providers—physicians, nurses, and dentists, specialists—that will attract and retain a larger client base than will a smaller center. This also allows for more leeway in offering charity and/or free care to those community members who may need it.

These dollars not only affect the variety of services provided—they also give room for more quality care. The more dollars that are available, the more choices there are for recruiting the most qualified health professionals including bilingual doctors and doctors who are competent and comfortable dealing with a diverse patient load in a medically underserved area.

Currently only one FQHC is permitted for Newark. In addition, Newark Community Health Systems is the existing FQHC. There is competition to attract patients for the survival of any health center. Moreover, it would likely be difficult to secure another FQHC designation for the city due to the power of the existing FQHC. If Corinthian and Tri-City would like to create an FQHC, currently they would need to become a satellite of Newark Community Health Systems. Technically any FQHC could open a satellite at this location but considering the power of Newark Community Health Systems that is unlikely.

There are positive and negative aspects to this venture. While avoiding many of the start-up difficulties (by becoming part of an existing system), Corinthian and Tri-Cities might give away more local control than is desirable for an area that has already experienced much hardship at the hands of external forces and organizations. Administration would be outside of Corinthian and Tri-Cities' control.

The following questions are important for community organizations to consider:

- Is Newark Community Health System willing to aggressively reach out to the hard-to-reach population in West Side Park and the surrounding service area?
- Does Newark Community Health System want to help community residents to be highly involved setting goals and creating activities for the health center?
- Will Newark Community Health System help to recruit a pool of healthcare providers who will be well matched to the needs of the West Side Park community?
- Is Newark Community Health System dedicated to educating their patients about the need for individuals to seek preventative care—not just offering care in an emergency?

Only by carefully weighing this scenario and talking at length with the head of Newark Community Health Systems, can it be determined whether this move could be beneficial for the community.

FQHC Look-alike

To qualify to become an FQHC, health centers first apply to become FQHC look-alikes. This means that they submit the application to become an FQHC look-alike and meet many of the federal guidelines but do not receive the full financial benefit. This is a trial period. An FQHC look-alike can get reimbursement from public and private insurance but it does not have as many guaranteed funding sources as an FQHC and may have to fight harder to get these reimbursements.

Jewish Renaissance Foundation

Jewish Renaissance Foundation in Perth Amboy runs the Jewish Renaissance Foundation Health Center. Originally, the Foundation ran only a volunteer doctor health center model. They have recently been awarded FQHC look-alike status. Their new health center will begin operating in June 2001 and will offer primary care services. The health center is starting small in a renovated private doctor's center of 1500 square feet. They will expand in the next two years to a bigger space of about 25,000 to 30,000 square feet and increase their range of services to include optometry, dentistry, and possibly a pharmacy.

Their board consists of 51 percent users and 49 percent non-users (local professionals), which is one of the criteria to become an FQHC. There is a great deal of diversity on their board. Three members are Latinos, three are African Americans, one is Asian American, and one is White. The diversity reflects the demographics of the area they serve. In Perth Amboy, the dominant population served is African American, Hispanic, and Asian Indian. In addition, many people do not have health insurance. The services provided will be available to adjacent communities as well and Alan Goldsmith, the executive director of the foundation, estimates that the new center will treat about 10,000 patients annually.

The center will operate from eight in the morning to eight in the evening on weekdays and eight to five on the weekends. It has the advantage of being served by volunteer doctors in the network maintained by the foundation. In addition, the foundation will continue to refer its patients through its volunteer network of specialist doctors. The center will also have one full time doctor, one part-time nurse practitioner, one retired family practitioner once a week, and one full time nurse for overall management.

The staff to be hired will be bilingual speaking both English and Spanish. This is an essential component of health centers that operate in communities with diverse populations. The presence of one full time physician is required by the FQHC criteria that are to cosign off on what the nurse practitioner does.

The center enjoys tax-exempt status. It still has to acquire a laboratory license and Medicaid and HMO licenses. The center will run on state and other grant money; however, the health centers usually get the money only three to six months after it is approved by the state.

The new center will continue its occasional school based programs and outreach programs. While the start up cost was low for this type of facility since it is starting small with plans for future expansion, much of the cost is administrative cost. The annual operating cost is 450,000 dollars and they expect to break even in two years. This includes insurance costs, which depend on the grants and state funds. The center has four exam rooms, one waiting room, administration area, lab, x-ray room, and a rest room.

The center will have referral arrangements to the volunteer doctors who are in the network, dentists, treatment centers, laboratories, and pharmaceuticals. This networking has been cost effective for this health center.

Nurse Practitioner Practice

Nurse Practitioner (NP) practices are a new type of medical practice. For many years, nurse practitioners had to have a doctor on staff in order to practice or to receive public and private reimbursement. A new category of nurse practitioners—advanced nurse practitioners—can run their own practices without a doctor on site. They form a partnership with a doctor who is available on call to answer questions that are beyond the scope of practice of the NPs. Doctors also approve their plans and assist with end of the year reviews. Nurse practitioners can refer patients to specialists and write prescriptions for medications.

Nurse practitioner practices place a primacy on health promotion—health education and wellness. In addition, they typically spend more time with their clients than doctors. NPs have slightly lower salaries than doctors do and they receive 85 percent of the reimbursement a doctor would get for the same service. If a doctor is on site at least 20 hours a week, then they get the same reimbursement as doctors because they are billed under the doctor's number rather than the Nurse Practitioner's number.

Elizabethport Community Health Center

Elizabethport Community Health Center is a Nurse Practitioner practice run by nurse practitioners that are on the Rutgers School of Nursing faculty in Newark. The practice has two sites, one in Elizabethport and another in downtown Newark and they are opening a site in Camden. The relationship with the University gives stability to the center and increases its range of services. The university covers some of the insurance costs and students from a variety of areas do their rotations in the center.

Faculty also need to maintain a set number of practice hours that they can fulfill at the center. The center partners with the Pharmacology school to receive low cost medications for their clients—typically a very expensive part of a providing healthcare.

The Elizabethport health center is on the second floor of a building that houses community programs and it is connected with a walkway to a recreation facility. The health center is a relatively new facility with two exam rooms—one adult and one pediatric. They also have a large room, which they use for exercise, screenings, and research projects. They are fortunate to reside in a building that is owned by the City of Elizabeth, who has allowed them to be there rent-free. The city handles maintenance of the building free of charge.

There are three NP's in-house on a part time basis; these nurses will also do home visits. There is a medtech who does room set up and patient preparation, a full-time receptionist, and a full-time in-house biller. The majority of patients who utilize Elizabethport are Spanish-speaking, and two interpreters are on staff for patients that need them. Elizabethport offers only general medical services, and refers patients to local specialists for any other needs. OB/GYN patients are referred to Beth Israel hospital.

Nurse practitioner practices are relatively new and the NPs are finding that occasionally they have problems referring clients and getting x-ray results. Some specialists do not like to take referrals from Nurse Practitioners and some x-ray firms will only send x-ray results to doctors. This can cause problems for patients, but it is not an insurmountable obstacle. As the NPs establish relationships with surrounding institutions, these problems should lesson. They also have the option of using their referral doctor if they run into any problems.

The center is open Mondays from 9-6, and Tuesday through Friday from 9-5. The center has the capability to open for two more evenings per week, and Saturday mornings if there is a communicated patient need. The health center receives an average of 20-25 visits per day; their busiest times are after 10 am, after school and after work hours.

This nurse practitioner center has been successful in receiving Federal HRSA grants from the Division of Nursing that support nurse practitioner practices. In addition, the Rutgers NPs are on the forefront of the development of NP practices. They are also applying to become an FQHC look-alike and HRSA officials are very interested in supporting the development of FQHC NP practices. If the Elizabethport location becomes an FQHC, conceivably, the nurse practitioners could open an FQHC satellite in West Side Park.

Costs and Benefits

A Nurse Practitioner site might be a very good option. Because Nurse Practitioners work on a lower pay scale than a physician does, this would lower operating costs. In the event that it becomes necessary to employ a physician, that physician might not have to be employed full time (or, could even be a volunteer, in the case of the Volunteer Doctors Model seen previously).

Another benefit to this model is the quality of care given by a nurse practitioner. Nurse Practitioners have the reputation for being excellent at their craft. More often than not, they take more time with their patients than physicians traditionally do, to assure patient understanding and comfort with the exam procedure and follow-up care. In the Elizabethport model, Nurse Practitioners do home visits, which is a strong asset to any community with a substantial population of hard-to-reach clients. NPs take the time to teach people how to care for themselves, which is often a critical component of healthcare in poor communities.

A third benefit is that although Nurse Practitioners may not be able to offer every type of healthcare, it may be a great asset to a new health center to make relationships with local specialists to build their reputation and even expand their client base. Regardless of the primary intent of giving quality healthcare to a Medically Underserved Area, a health center's basic need is to remain funded in order for its doors to remain open. Developing local relationships with other neighborhood specialists could assist the new center in their first few years of start-up, by widening their service area.

The relationship with the University is both positive and negative. Nurse Practitioner models can receive some federal funding but, as seen in Elizabethport, there is a strong reliance on their relationship with a larger entity—such as a University in their case—to make up for the money that is not provided by grants. Patients are occasionally seen by students (because of the University affiliation), and in this case, a relationship was formed with the School of Pharmacy at Rutgers to get low-cost medicine for patients. However, as we see with most medical models, unless you are fortunate enough to receive a bulk of federal dollars, your existence as a medical center will always depend on strong relationships with larger entities, or a variety of smaller grants and donations.

Relationships with larger entities might give away control about how the center is run—local decision-making would be more available in this site than when choosing an FQHC model, but the community organizations will need to choose their partner carefully to ensure that they are satisfied with the level of community control.

Volunteer Doctors

Volunteer Doctors is a model through which services are provided by a group of volunteer doctors specializing in various health needs. This can be operated as a stand-alone model or as part of any of the other health models.

Jewish Renaissance Foundation

This innovative health program is designed by the foundation to access free medical care for the uninsured ‘working poor’ in New Jersey and was started four years ago. The Jewish Renaissance Foundation has established a ‘medical safety net’ by organizing a volunteer network of physicians, dentists, treatment centers, and pharmaceutical companies who provide in-kind services, equipment and supplies as needed on case-by-case basis.

About 300 doctors in the New York and New Jersey area are a part of this network and each of them agree to see about three to five patients per year in their own offices. Referrals are made through health fairs, the media, and clergy. The patients call the foundation and the foundation schedules an appointment with a doctor. The main problem is the clients often don’t show up for their scheduled appointment.

School-Based Health Center

School-based health centers operate in school buildings. In many cases, these centers are open to the public and the school. Because these centers utilize empty space at schools, they are a good way to provide services without having to rent or build an entirely autonomous facility. It is, however, comparatively difficult for school-based models to get reimbursements both from public and private sources.

St. James High School Health Center

Newark Beth Israel Hospital runs the St. James High School Health Center at a private preparatory school in Newark. The center, which has been open for three years, offers a wide variety of services including geriatrics, OB/GYN, and pediatrics. Although students are welcome to use the center, the center was established primarily to serve the community. The health center pays minimal rent to the school for its space. In return for the low rent, the health center provides medical services to the school free—such as eye and ear screenings, and basic school-nurse type care. The center is tax-exempt.

The health center is open 9-5, Monday through Friday. There are no weekend hours, but the center offers special events on the weekends such as screenings and blood pressure testing. Much of the health center’s ongoing costs are administrative. These costs include the significant burden of insurance, which is also borne by the hospital. The center has no x-ray machines, no labs, no radiology, and no other ancillary testing facilities. For these types of services, patients are referred to Beth Israel Hospital.

Nurse practitioners (usually two) staff this center. Visiting doctors from the hospital go to the center on set schedules to offer different types of

services. The pediatrician may visit on Tuesdays and Wednesdays and the gynecologist on Mondays and Fridays. There is always one physician on duty at all times.

Even though the community wanted the health center, it is underutilized. To attract patients, the health center advertises with local churches and community groups. The health center, like many other health centers has a 30 percent no-show rate. This makes managing the center difficult in terms of scheduling. How much overbooking should you do? What if you overbook and everybody shows up?

Hospital-Based Health Center

Hospital-based health centers can usually be combined with some other form of health center. School-based centers, nurse practitioner centers, and stand-alone centers are all examples of centers that can be run by hospitals. Because they are hospital-run, hospital personnel usually staff them. Hospital-based models receive insurance since the administrative billing and contracting work is handled by the hospital. However, centers that are off the main premises of hospitals do not qualify for state charity care dollars.

St. James High School Health Center

This school-based model is also a hospital-based model because Newark Beth Israel Hospital runs it. Because the hospital operates the center completely, the hospital and the hospital's board of directors control the administrative and operating aspects of the center. However, the hospital board is made up of community members and local business leaders, so in a sense, the "broader community" runs the health center.

Newark Beth Israel is a non-profit organization whose mission is to serve Newark's healthcare needs. As a result, not all of the hospital's ventures have to be financially profitable. St. James health center operates at a loss. Since the health center is operated as part of the hospital's mission to serve the community, the health center has support as long as Newark Beth Israel Hospital chooses to support it. If the health center becomes a very large drain on the hospital's ability to provide care, it could be closed. In addition, other hospitals and university medical systems have closed their clinics because they were operating at financial losses.

Because the center is hospital based, it operates on an insurance-based system. If patients have no insurance, they are required to pay a bill. There is no sliding fee scale and no free care. All patients are billed. However, whether or not the patients pay their bills is another question. If a patient does not pay the bill, the hospital takes a loss. Because the center is backed by the hospital, finances are not a big worry if a patient does not pay, since it is within the hospital's mission to provide care to the

community. However, if not everyone paid, the center would have to close. As a result, payment of bills is highly encouraged.

Since the center has no x-ray machines, no labs, no radiology, and no other ancillary testing facilities, patients who need these services are often referred to the hospital. The fact that a larger hospital is available to the patients is one of the benefits of this type of model.

Costs and Benefits

A hospital-based structure has many benefits. A hospital partnership has the advantage of teaming up with an already successful operation. The hospital would play a major role in developing and running the center and would use its own knowledge and capital to reduce the initial costs involved with setting up the center and it would provide a stable financial base.

Because hospitals are already in the healthcare business, and already provide a wealth of services to the larger community, they are in a much better position to offer services to smaller communities than other organizations. Additionally, the hospital can provide staff for the health center. This would eliminate the expense and uncertainty of trying to find permanent doctors or nurse practitioners. Since these doctors and nurse practitioners are already employed by the hospital, they are simply “going to work” on the days they are at the center.

These benefits however, come at some costs, in terms of the freedom and autonomy of the local center. Because the center would be administered by the hospital, people outside of the community would ultimately make the decisions regarding the center. This would mean less direct local control by those in the community as opposed to the Nurse Practitioner or stand-alone models.

Another negative aspect of hospital control is that the center could close if it became a burden to the hospital or if the policies of the hospital changed. In addition, due to the changes in healthcare and the high cost of providing care in poor communities, many medical schools and hospitals are no longer interested in supporting community health centers at a financial loss. Hospitals have to use their State Charity Care dollars on site which means they cannot be transferred to patients they see at a community clinic. Moreover, once a health center is established as a hospital based center, it may be harder to re-start the center if it needed to be shut down by the hospital. Since the center would have come to depend on the resources of the hospital, it may be harder to find equivalent resources from another source.

Although hospital based models provide a certain amount of financial security and offer a good deal of expertise, these benefits may not outweigh the costs of less local control and less charity care. Although we strongly recommend this model because of its financial viability and available expertise, it may fall short of the community’s expectations.

Stand-alone Health Center

A stand-alone health center is a health center, which is not federally qualified and operates on its own, from fund raising to selecting services and recruiting staff. Stand-alone health centers in poor communities are open to a high level of financial risk. They do not have access to the wide financial reimbursement stream of the FQHCs or the special grants for NP practices. This would be a grant driven center. If the center wanted to accept public and private reimbursement, it would need to master the complex web of public and private insurance reimbursement. The cost involved in managing the reimbursement is very high and, in some case, it will have to be outsourced for proper management.

Tri-City Peoples Corporation Health Center

Tri-City Peoples Corporation, a community non-profit social service provider, currently runs a small stand-alone health center, which provides health services to women and children. It offers primary care, OB/GYN, screening, STD treatment, nutritional counseling, and immunization with very limited hours.

The health center is funded by grants primarily from the health department and community development block grant dollars. Since not all sections of the population are served by this center, and services are not offered in the evenings or on weekends, there is demand for a bigger facility with extended services in the area.

Costs and Benefits

The stand-alone model offers the most freedom and flexibility; it also involves the most risk. This model has the highest degree of local control and decision-making. The only restriction on the types of services is the availability of funding and expertise. Stand-alone centers can select from the different types of health providers. They could incorporate a volunteer doctor model or hire nurse practitioners. They could operate in an independent site or as part of a larger institution such as a school. Currently Tri-City Peoples Corporation provides some services through partnerships with UMDNJ. These types of partnerships are possible with many different health entities, which enables a small health center to diversify the services it offers and to increase access to existing services.

The risk associated with a stand-alone facility is substantial. Stand-alone facilities involve a large amount of initial funding since a facility like this would not have the financial backing of a larger organization. In addition, it would be constantly struggling to maintain a constant flow of grant dollars to remain financially viable. Many of the centers that operate this way employ grant writers. The success of this model would, in great part, be dependent on hiring sophisticated practice managers and billers who can negotiate managed care contracts and ensure that all claims are paid.

Dental Care

In field interviews and focus groups, there was a nearly universal request for increased access to dental care. Because of the different nature of treatment given by a dental facility, in contrast with a medical facility, the dental model cannot be directly compared to the other models. We included dental as a model to explore the feasibility of including dental facilities as part of the health center.

We interviewed Dr. Jerome Silverstein of the UMDNJ Dental Center at University Hospital in Newark to learn about the costs involved with providing dental care. We quickly learned that there are few dental practices within community health centers because they are very expensive. Dr. Silverstein estimated that a two-chair facility might cost between 125,000 and 250,000 dollars depending on the quality of the equipment. Besides the usual chair and desk, x-ray machines, special plumbing, air compression devices, gas dispensers, and anesthetic equipment are necessary. Staff costs are also high. A recent dental school graduate may require up to 80,000 dollars per year for full-time employment. We could expect to pay 30 dollars an hour for a hygienist or 12 to 13 dollars an hour for a dental assistant.

Insurance for a dentist ranges between 3,000 and 25,000 dollar per year. Because a dental facility at a health center may require more extensive work (such as general anesthesia), the insurance costs may be near the top range. The likely need for general anesthesia or IV sedation is the main reason why some of these costs are so high. This is needed in cases where patients have health problems that may interfere with treatment such as people who have built up a tolerance to local anesthetics because of drug use. As a result, they often need to be put under general anesthesia, which increases risks especially for people with health problems such as tuberculosis or malnutrition.

Rather than provide dental care directly, the community health center could work with local dentists to ensure access for their patients. For those with Medicaid, the health center could refer patients to local private practices that accept Medicaid. For uninsured patients, the health center could establish a stipend fund to give participating dentists in exchange for care. The way this works is as follows: the health center and the dentist agree on a price per capita per month. For simplicity, we will estimate that it is 10 dollars per person per month. The health center would send a 500-dollar check to the dentist every month for 50 people. Most basic services and emergency care would be treated at no additional cost to the patient. The dentist receives this money whether the patients go or not. The health center could also work with a group of volunteer dentists who would agree to see a set number of patients per month, pro bono. This type of volunteer practice is more costly for dentists than for doctors because dental visits often require additional supplies—not only labor costs.

There are a few difficulties with this type of relationship. First, there are not many dentists in the area and not many who accept Medicaid. And providing care for people who do not have dental insurance would require securing grants to provide this care. Another option may be to form a relationship with other centers and share the cost of hiring a dentist—also a costly and logistically challenging proposal.

UNDERSTANDING HEALTHCARE FINANCING

A critical part of understanding the feasibility of opening and running a health center is determining how it will finance its daily operational costs. One would think that in the best-case scenario, the center would provide health services and be reimbursed for the cost of those services. In order to serve the community, the center may not see a profit, but it might be able to operate on the reimbursement income. Thus, the central research question around health insurance reimbursement was: can the center expect to remain financially viable if run exclusively on public and private insurance reimbursement? The short answer is no. While each health center model will be subject to very different reimbursement streams, none of them can operate without leveraging dollars from alternate sources, whether it is through grants or the financial support of a major partner, such as a hospital.

Reimbursement: The Nuts and Bolts

Healthcare policy is a large, unwieldy area of research, but it is important to understand because it impacts the amount of funding a health center can expect from public and private reimbursement. The Health Policy Primer in Appendix D provides detail about the health policy issues likely to impact a center in West Side Park, including information on the uninsured, private insurance, Medicaid, Medicare, NJ FamilyCare, and prescription drugs. Here, in the body of the report, we explain how reimbursement is collected, what it means for a healthcare center, and we provide an overview of the specifics of various reimbursement scenarios, such as fee-for-service and managed care capitated rates.

Managed Care

A major focus of healthcare policy that directly impacts reimbursement is the rise of managed care. In both public and private insurance programs, the managed care model attempts to cut healthcare costs by relying on the health insurance company to "manage" the healthcare of individual members. This "management" is carried out by a Primary Care Physician, or PCP.

In the managed care arena, basic primary healthcare is no longer fee-for-service (the traditional payment method when a patient or her health insurance company paid a bill each time she visited the doctor). Instead, the reimbursement will most likely come in the form of capitated rates, paid monthly to the patient's PCP. This monthly payment is relatively small (\$4-\$26) and is meant to cover all visits to the provider by this patient. In theory, this monthly payment gives the doctor an incentive to provide preventative healthcare in order to keep costs down, since the doctor receives no additional money if the patient comes in several times a month. If the patient goes to a doctor who is not their official PCP for primary healthcare, the doctor providing the services will not be paid for that visit by the managed care company since they are not the designated PCP. Visits to specialists such as obstetricians or cardiologists remain as fee-for-service under managed care.

While many private insurance companies have used a managed care model since the 1970s, Medicaid and Medicare have only recently begun to move their recipients into managed care organizations. Medicaid and Medicare contract with private insurance companies to provide managed care to their recipients. The government then pays the private company a capitated rate each month to serve their recipients, and the private company in turn pays a capitated rate to the private doctors or centers who are Primary Care Providers for those recipients.

NJ FamilyCare, New Jersey's new public insurance program, designed to meet the needs of uninsured families who do not qualify for Medicaid, is entirely managed care. When people sign up for NJ FamilyCare, they choose the private managed care company through which they will receive coverage. They receive a card from this company and choose their PCP, just as with private managed care insurance. The only difference with private insurance is that rather than an employer or individual paying to be member of this managed care company, the government is paying for this patient to be a member.

According to the billing staff interviewed at the Plainfield FQHC, Medicaid recipients in New Jersey are encouraged to join a managed care organization within one year of becoming enrolled in the program. The Reimbursement group heard from Judy Pollacheck, a nurse practitioner who is the director of two practices in downtown Newark and Elizabethport, and others, that welfare recipients who have Medicaid are generally required to sign up with a managed care organization.

In Essex County, Medicaid and NJ FamilyCare recipients are much more likely to be in managed care than Medicare recipients. As shown in the tables below, of people eligible for Medicaid and NJ FamilyCare in Essex County, 71 percent participate in a managed care organization. Of those eligible for Medicare, only 9 percent participate in managed care. For Medicare clients, the center can generally expect to deal with a fee-for-service system, which means increased billing administration, but potentially higher reimbursement compared with capitated rates. For Medicaid and NJ FamilyCare clients, table 4 reveals the managed care organizations with which the center would most likely need to have relationships.

Table 3. Enrollees Per HMO in Essex County, Medicaid and NJ Family Care Managed Care

| HMO | Number | Percent of Total Enrolled in HMOs |
|------------------------------|---------|-----------------------------------|
| Aetna/US Healthcare | 27,274 | 30.8% |
| Americaid/Amerigroup | 5,366 | 6.1% |
| Horizon-Mercy (HMO Blue) | 34,307 | 38.7% |
| Americhoice(MHS) | 8,234 | 9.3% |
| Physician's Health Service | 3,702 | 4.2% |
| University | 9,741 | 11.0% |
| Total | 88,624 | |
| Total Eligible | 124,370 | |
| Percent Enrolled of Eligible | 71% | |

Source: NJ Department of Human Services, NJ Care 2000.

Table 4. Number of Enrollees per HMO in Essex County, Medicare Managed Care

| HMO | Number | Percent of Total Enrolled in HMOs |
|------------------------------|---------------|--|
| Aetna/US Healthcare | 4,159 | 45.1% |
| Amerihealth | 45 | 0.5% |
| Horizon-Mercy (HMO Blue) | 3,272 | 35.5% |
| Oxford | 1,293 | 14.0% |
| Americhoice(MHS) | 162 | 1.8% |
| Total | 9,219 | |
| Total 65+ Population | 105,544 | |
| Percent Enrolled of Eligible | 9% | |

Source: NJ Department of Human Services, NJ Care 2000.

Policy Intersects With Practice

So, what does managed care mean for a health center? Several points are critical. First, Ellen Lambert at the Healthcare Foundation of New Jersey relayed that “reimbursement follows licensure.” Before a doctor can receive managed care reimbursement, she must be licensed, or credentialed, as a PCP by each managed care company whose patients she hopes to serve. For example, if you are a doctor and want to see patients who have Aetna/US Healthcare, you need to be part of Aetna/US Healthcare’s network, so the patients can select you as their PCP. In order to be part of the network, you apply to be licensed by them.

For any health center model that wants to consider including primary care physicians, the credentialing process is an important cost. The Plainfield FQHC and Newark Beth Israel Hospital retain staff for this purpose. Though the size of that staff reflects the size of these healthcare institutions, and the fact that new doctors are often brought in, any doctor who wants to bill to a certain insurance company must fill out a complicated application and wait approximately 6 weeks while it is processed by the managed care company. Only after becoming part of Aetna/US Healthcare’s network would you begin to receive reimbursement from them if their patients chose you.

The credentialing process is separate and apart from negotiating your capitation rate with managed care companies. Once credentialed, you then negotiate with Aetna/US Healthcare to determine the capitated rate you will receive for each of their patients who selects you. This negotiation will involve the demographics of the area where the center is located, because capitated rates are based on geographic areas and vary by the age of the participant. Managed care contract negotiation could be a considerable cost to a small health center. Particularly since if you contract with Aetna but then want to see patients from Amerigroup as well, you must go through this entire process of credentialing and negotiation with Amerigroup.

The second critical point is that if patients have managed healthcare insurance, only their PCP will be paid the capitated rate. Another general practitioner who sees this patient

will not be reimbursed. Often, specialists need to insure that the patient has a referral from their PCP or they will not be reimbursed. Every health center visited in the course of this study warned that you must make sure any patient you see has your provider on their managed care card, and you have them on your roster (showing who you were paid for) for that month, or you are essentially seeing them for free. The health center must be aware that people are constantly changing their health insurance provider and even being changed without their knowledge. The health center must keep careful track of whom they see versus whom they are being paid for on a monthly basis.

While the credentialing process can be a considerable cost, the more patients for whom the center receives a capitated payment, the lower the cost of billing. Lori Sarappa, Operations Manager in Newark Beth Israel's Physician Practice Services advised that the insurance mix of patients determines the center's administrative billing needs. For example, if the center sees a number of Medicare patients, they will need to administer billing for each service and visit, requiring a lot of staff time. However, if the center is seeing mostly Medicaid managed care patients, (who have officially named a doctor at the center as their Primary Care Physician), the capitated payments will come in each month without as much of a need for submitting and following up on claims.

Partial Reimbursement is the Norm

It is also critical to understand that health services are hardly ever reimbursed in full. Under managed care, the capitated rate over the course of a year might cover the cost of only a couple of office visits, even though the patient comes in ten times. Even though there will be patients who you are paid for but never see, the capitated rate is small enough that it is unlikely these monthly payments will cover all costs. Janet Hunt-White, the Director of Billing at the Plainfield FQHC, noted that many people think their five-dollar co-payment when they see a doctor is a "nominal fee." In actuality, that co-payment can be very important for a health provider who is not being paid much to see you.

Fee-For-Service Reimbursement

Under fee-for-service insurance, the amount a doctor might charge for a service is likely higher than she expects to be paid, and a doctor must accept a Medicaid or Medicare payment as payment in full. The Reimbursement group often heard that Medicaid and Medicare offer the highest rates of payment. According to the billing staff at the Plainfield FQHC, private insurance might reimburse from 50 to 80 percent of services. At the same time, Ms. Sarappa at Newark Beth Israel said that private insurance often set their rates based on Medicaid or Medicare rates.

In describing the relationship between insurance companies and healthcare providers, one billing manager said the insurance company is always thinking "what can we do to deny the claim," while the provider is always thinking "what can we do to trick them into paying?" Not only are reimbursement rates low, but also centers and doctors have to fight with insurance companies to be reimbursed.

Every health center faces different reimbursement scenarios based on their status, client population, and contracts with health insurance companies. The bottom line is that a health center must budget with the understanding that no matter what an actual visit or service might cost, they will not be reimbursed for that full cost.

Reimbursement Timeline

Health centers cannot rely on quick turn around for reimbursements. Once a person comes in for a fee-for-service visit or a visit not covered by capitated rates, a claim must be sent in to the insurance company. Kathy Suber, a Supervisor at the Patient Accounting Department at Newark Beth Israel, reported that managed care companies must pay a claim within 90 days, as long as it has no mistakes and is clear. Recently the law was changed to 30 days; however, Ms. Suber's colleague at Beth Israel, Ms. Sarappa, noted that this deadline is hardly ever met. By law, Medicaid must pay within a year, and Medicare must pay within 18 months. In addition, the "fight" for payment usually occurs for a majority of claims, with Sarappa reporting that at least 50-60 percent of the claims will be initially denied.

Staffing Considerations

To participate in health insurance reimbursement, a center needs staff with expertise in dealing with insurance companies, filling out and filing claims, and appealing claims that are denied. As mentioned above, larger practices also have staffs that are knowledgeable in the credentialing process, so doctors can become eligible to receive funds from managed care plans. Ms. Hunt-White at the Plainfield FQHC estimated that a center seeing 20 patients a day needs a billing staff of four. This includes two "front-end" staff members, who do reception and initial billing records—including checking patients' health insurance cards. The center would also need two "back-end" staff to submit claims and deal with claims that are returned without payment. Ms. Sarappa said she recommends hiring staff with at least 3 years of experience in health insurance reimbursement, since they need to understand all the complex aspects of reimbursement.

Insurance Makeup of West Side Park and Surrounding Areas

Likely Public Insurance Eligibility

To estimate the total population eligible for public insurance programs, such as Medicaid, Medicare, and NJ FamilyCare, census data on age and poverty was studied. The eligibility for these public insurance programs is based on age and poverty levels. In the three-mile target area, 19 percent of the population is below 100 percent of the federal poverty line. Technically this portion of the population would be eligible for Medicaid. However, the group has no way of knowing what the status of these people are—whether they have insurance from a job, (not likely, but possible) or other considerations.

NJ FamilyCare has complex eligibility criteria based on family size and income, which can go up to 350 percent of the federal poverty level if a family is very large. Due to the eligibility levels, dependence on family size and income, it is impossible to predict exact numbers of people. However, it is known that within the three-mile radius, almost 50 percent of the population is under 200 percent of the federal poverty level. For all families with one or more children, at least the children are likely to be eligible for

FamilyCare if the family has an income less than 200 percent of poverty. In general, when a health center is deciding what managed care companies to contract with, it is likely that in a market area with this low-income profile, it would be wise to contract with those companies listed in the tables above who serve Medicaid and NJ FamilyCare clients.

Substantial Uninsured Population

It is expected that there will be a significant portion of the client base that is uninsured in West Side Park. In nearby East Orange, at the Newark Community Health Center's site, approximately 15 percent of their patients are uninsured. In 1997, almost twelve percent of New Jersey's non-elderly population was uninsured (Haley and Zuckerman 2000). We expect that since the implementation of NJ FamilyCare, fewer people are uninsured. We also expect that the demographics of West Side Park might lead to a higher number of uninsured, since those most at risk for being uninsured include families under 200 percent of the federal poverty level and racial and ethnic minorities (Hoffman and Schlobohm 2000).

Providing care to the uninsured, especially those who cannot afford to pay for healthcare services, is difficult. Charity care is the term for healthcare to those who have no insurance and cannot afford to pay any fees. The state government provides a certain amount of charity care funding, also called unreimbursed care, to hospitals and FQHCs to treat the uninsured. For a patient's visit to be covered by charity care, they must provide proof of income. The Newark Community Health Center is an FQHC, and they have a sliding fee scale that they use with uninsured families. The scale ranges from twenty to sixty dollars, depending on family income.

If a center is not an FQHC, but they want to treat uninsured patients in their community, they need to find alternative funding. For example, Ellen Lambert of the Healthcare Foundation of New Jersey, described the Archangel Center, which is open once every two weeks and serves mainly uninsured patients. It is run mainly through donations from a sister church. Grant funding may be used for serving the uninsured, as may volunteer doctors.

Grant Alternatives to Reimbursement

As with the web of private and public insurance, grant funding for health centers is varied and dynamic. In general, grants to treat populations with specific health needs such as lead, diabetes, or breast cancer will come from public sources. The New Jersey Department of Health and Senior Services administers grants to non-profit organizations for treatment programs that target underinsured and uninsured populations, urban neighborhoods, and high-risk populations such as teens and pregnant women. Flow-through state block grants, with the dollars originating from the federal government, are a typical funding relationship, and in fact, most community health centers will rely largely on federal and state dollars.

In addition to federal and state sources, there is a wide range of funding opportunities from private foundations. Grants for the operation or initiation of a community health

center will likely come from larger national foundations, like the Robert Wood Johnson Foundation or the Hearst Foundation. Private corporations frequently develop related foundations like the Alcoa Foundation or the Johnson and Johnson Foundation. Typically, these grants will target innovative programs, treatments, and ways of using health education and treatment as a community development tool. Please see Appendix F for an in-depth guide to grants and grant-makers in the healthcare arena.

BUILDING LOCATION, DESIGN, AND OCCUPANCY

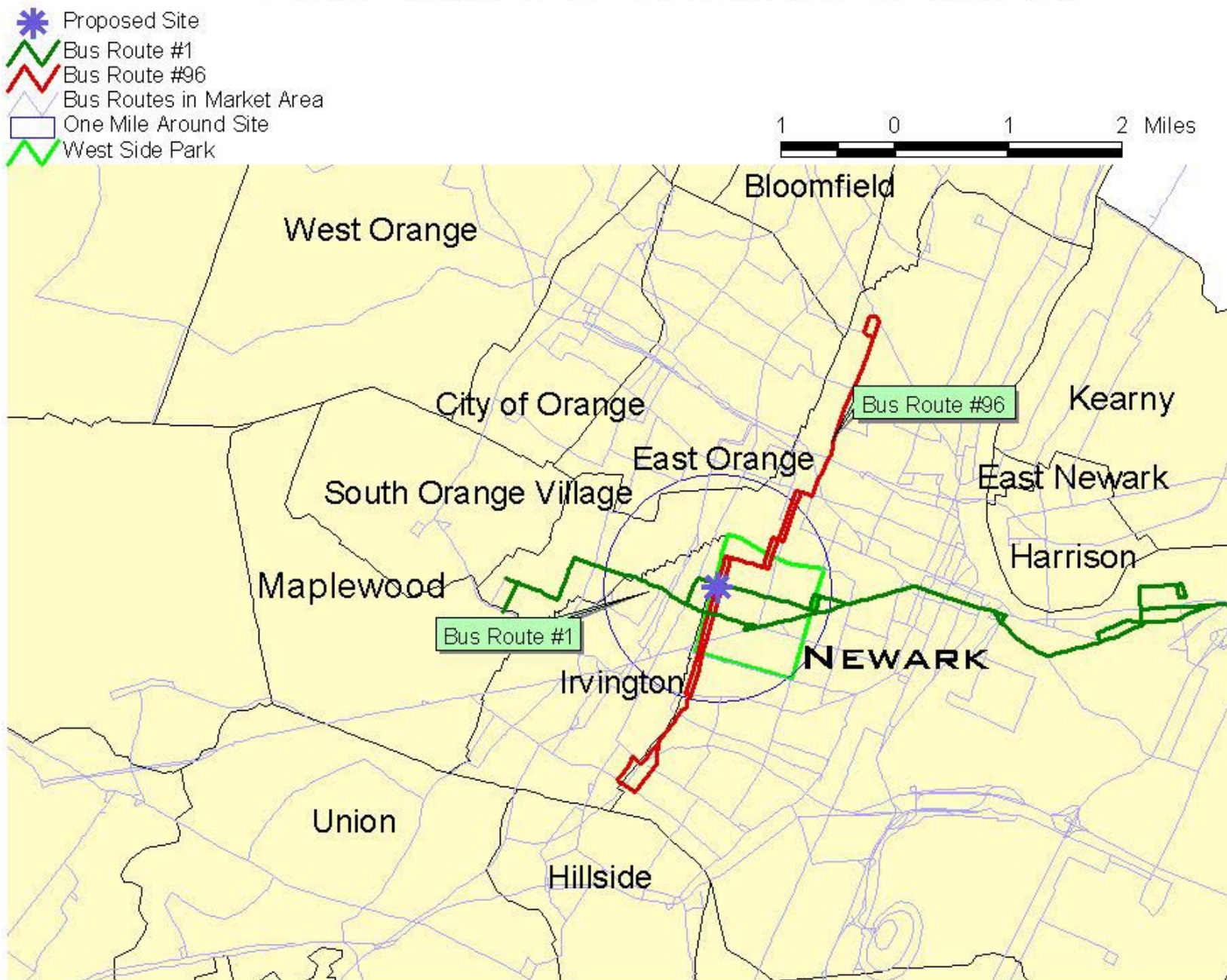
Location

The location of the health center has been the most significant factor delaying the health center's development. When the studio began the project, Corinthian HDC and Tri-City were planning to respond to an RFP from the NJ HMFA for a plot of land located at the corner of 19th Street and 16th Avenue in the West Side Park neighborhood. The other site that is currently being reconsidered is on 11th Street off Springfield Avenue, adjacent to Corinthian HDC's offices. The size of the proposed building, at either location, is between 25,000 and 30,000 square feet. The building will contain two floors including an elevator bank and two stairwells. According to the Americans with Disabilities Act, any building that has a health center has to have an elevator.

Since the studio began with the assumption that the building would be located at 16th Avenue and 19th Street, the analysis is for that site. However, much of this analysis can be applied to another location. The 16th avenue site provides access to a large population using many different travel modes. There are more than 15,000 residents within walking distance of a half mile of the building site and more than 4,000 within a quarter mile of the building. The building is also accessible to cars. The site is located within a half mile of two main roadways, Springfield Avenue and South Orange Avenue that lead into and out of downtown Newark. Sixteenth Avenue, where the building is located, is considered a popular alternative to these two roadways and provides a direct route from a major corridor in Irvington to downtown Newark. While a further study of trip generation and traffic studies should be performed, the group does not anticipate the building site to cause major traffic problems for the area.

The 16th Avenue site is also accessible using public transportation. The following map shows bus routes around the site area. The #1 bus route stops at the corner of 16th Avenue and 20th Street, providing easy access to the building site for people who live along that route. The #1 bus route travels west to Irvington and east towards downtown Newark and into Kearny and Jersey City. Other bus routes stop within walking distance of the center (e.g., the #42 18th Avenue bus stops within two blocks) providing good public transit access to the building site from various parts of Newark, especially from the east and west (less service is available going North/South although the #96 bus stops within two blocks on 18th Avenue).

BUS ROUTES IN MARKET AREA



ROADWAY SYSTEM IN MARKET AREA

-  Proposed Site
-  One Mile Around Site
-  West Side Park
-  Springfield, South Orange & 16th Avenues
-  Interstate Highways
-  Road Network

1 0 1 2 Miles



Occupancy

There are many options for building tenants. The mix will ultimately depend upon the willingness of organizations to occupy space combined with community organization efforts to rent space to organizations and businesses that will best compliment a health center. We explored a few scenarios combining potential tenants.

The first scenario is the pharmacy scenario. Corinthian has had ongoing discussions during the last few months with the Walgreens pharmacy chain, which has expressed an interest in developing a pharmacy at the 16th Avenue site. The pharmacy would require 11,000-14,000 square feet. Since the pharmacy must be located on the first floor of the building and since we are assuming a two-story building of 28,000 square feet, the pharmacy would assume all of the first floor rentable space of the building.

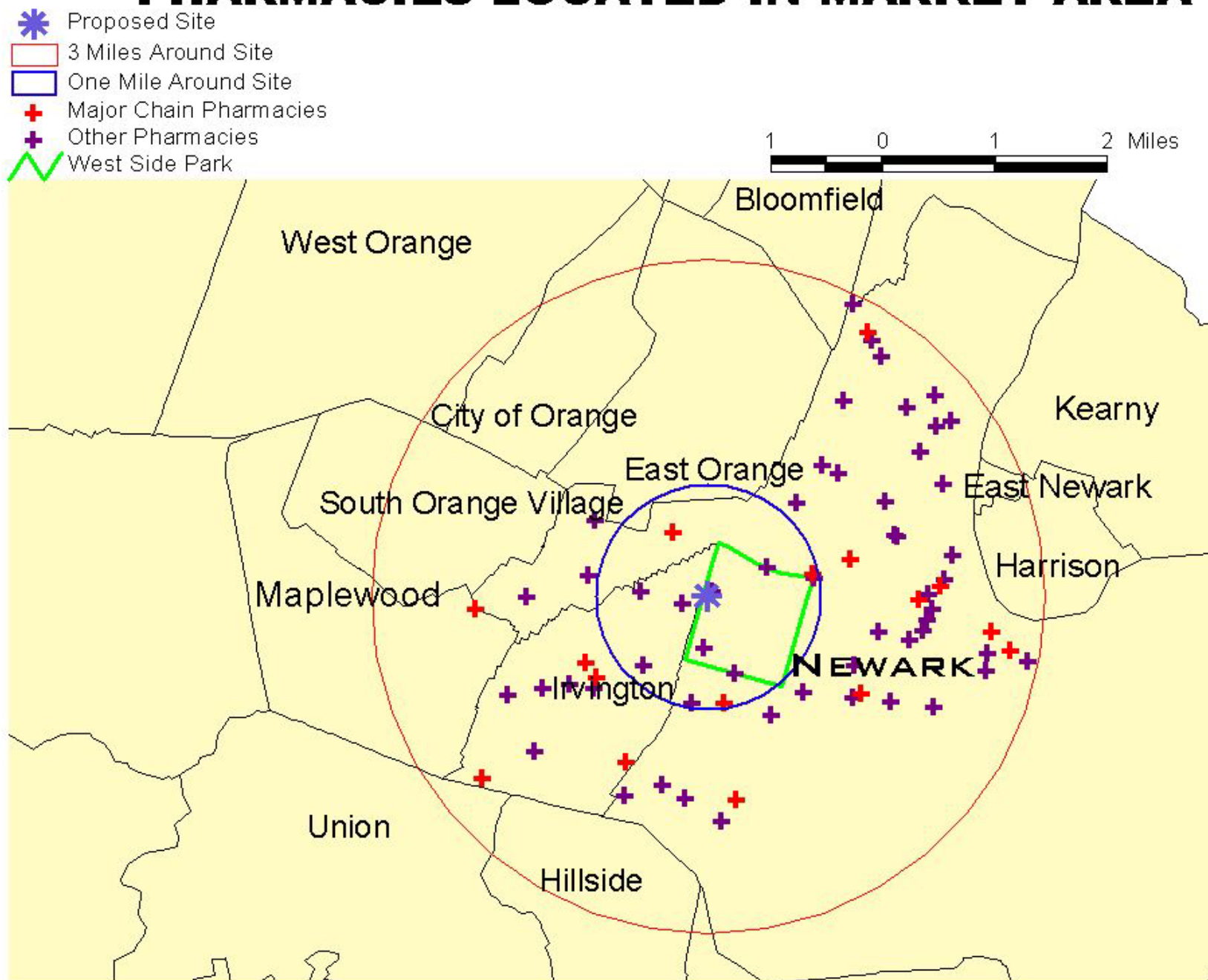
The following map provides information on the location of pharmacies located within a three-mile radius around 16th Avenue site. One small neighborhood pharmacy is located across the street from the building site. If Walgreens agrees to locate at the proposed building site, they would likely put that pharmacy out of business. Community residents and community organization leaders have expressed dissatisfaction with the current pharmacy. However, Corinthian HDC would prefer to not displace this pharmacy. A major chain such as Walgreens might be more likely to leave the area if times get difficult. Walgreens can provide a major positive economic impetus for the neighborhood and potentially increase the availability of goods at lower prices than is currently available. However there is a concern over displacing small businesses, especially those that have been in the neighborhood for decades (a trend of major losses in small businesses should not develop).

Assuming Walgreens agrees to lease the first floor space, the second floor will include the health center, which will require between 5,000 and 8,000 square feet depending on the healthcare model. Other potential tenants are: Corinthian HDC's computer lab, which is estimated for 1,000-2,000 square feet. Corinthian has stated that an after school recreation center could be placed in the building and this will require another 2,000-3,000 square feet. Additional space required for infrastructure (e.g., elevators, stairs and hallways) and administration leaves little if any room for any additional tenants.

If Walgreens decides not to lease the first floor space, a second scenario is an 11,000 square foot childcare center. Tri-City has suggested that it has considered expanding its current childcare program and estimates that it needs 11,000 square feet. There is additional money available for childcare because of the Abbott court cases.

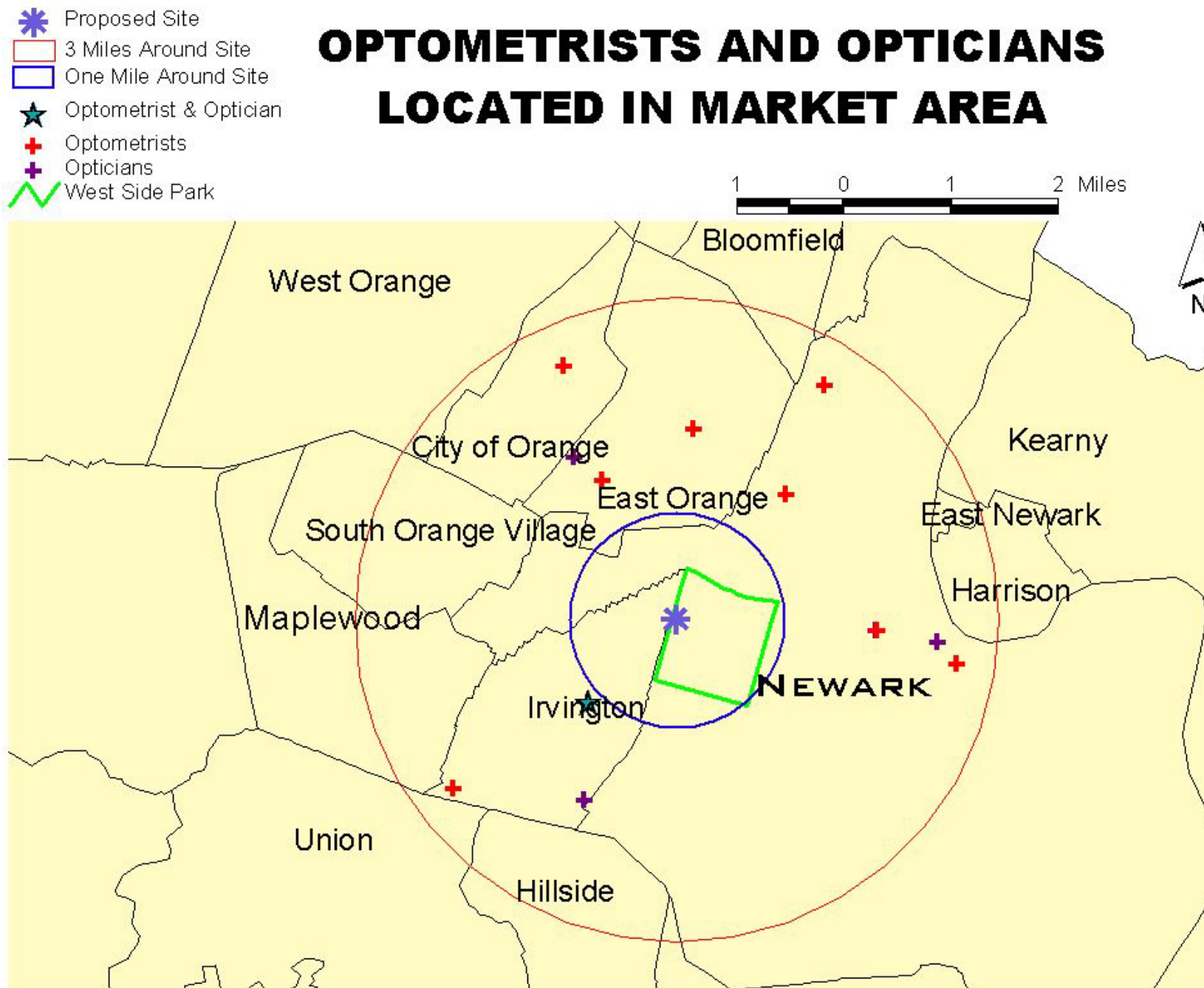
Since a childcare center would be located on the second floor, the entire second floor tenants from the pharmacy scenario would be located on the first. Since a first floor location has positive design implications for the health center because the health center is more immediately visible and more inviting to the visitor, this scenario might increase the probability of success for the health center although the pharmacy scenario might have a greater rental income potential.

PHARMACIES LOCATED IN MARKET AREA



Assuming either a pharmacy or a childcare center largely occupies the building, there will not be much leftover space for other tenants. Any leftover space will probably consist of only 1,000-3,000 square feet. Some possibilities for this limited amount of space might be a small quasi-government office such as a welfare office, WIC office (Special Supplemental Nutrition Program for Women, Infants, & Children), or an unemployment office. These tenants create a high degree of traffic and provide services needed by the surrounding community. One potential use for any leftover space would be an optometrist and optician office. A small office that includes an optometrist and a small optician's office could fit in an area of about 1,500 square feet. The following map shows that there are only nine optometrists and five opticians within three miles of the building site (one of these sites slightly over one mile away from the building site contains both an optometrist and an optician) and most of those are located in the eastern and northern areas around the building site. Anecdotal evidence suggests that the neighborhood would welcome an optometrist and/or optician in the area.

OPTOMETRISTS AND OPTICIANS LOCATED IN MARKET AREA



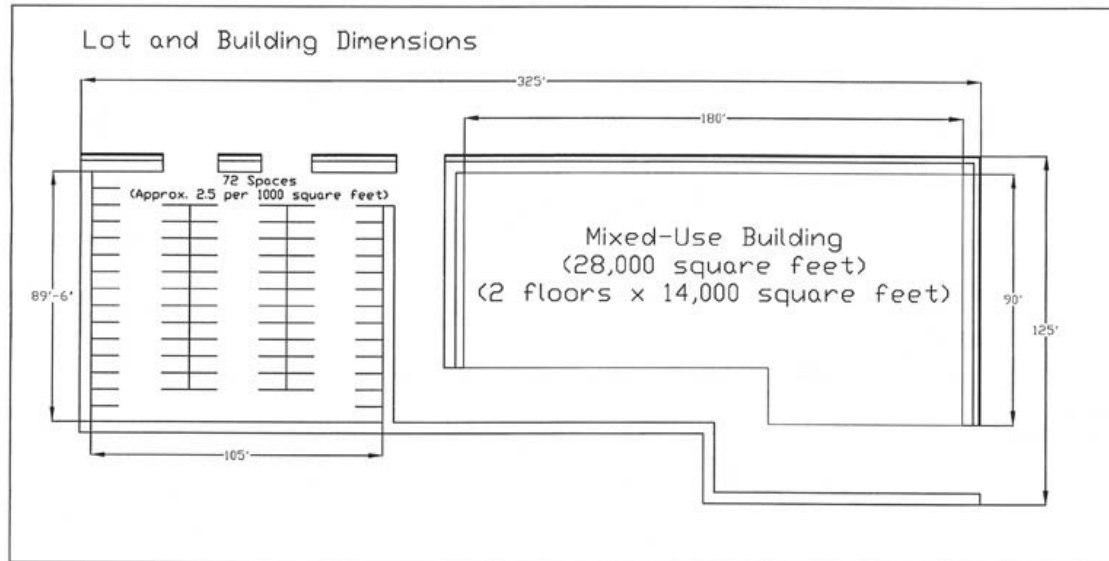
Building Design

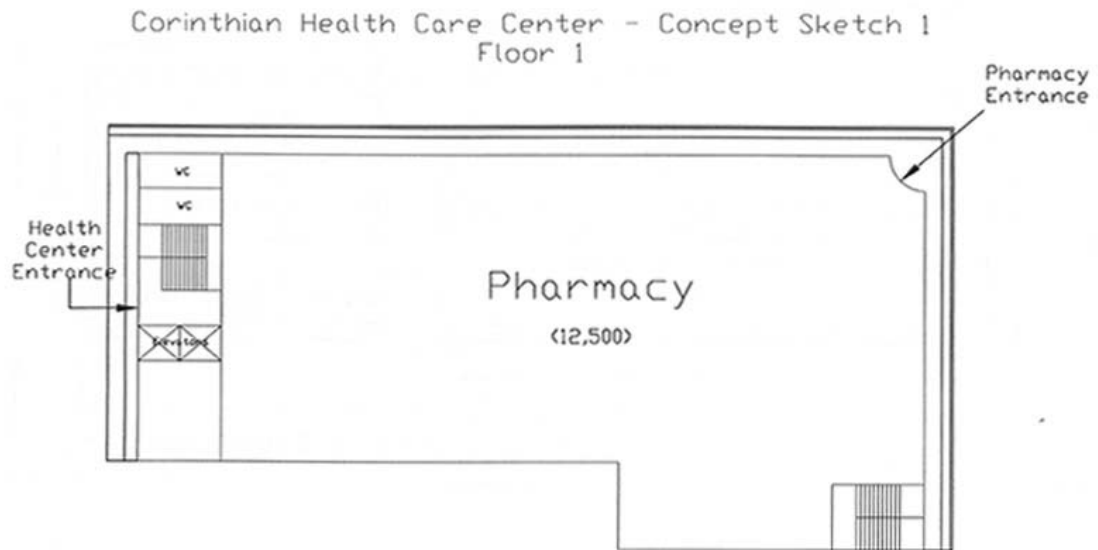
The following series of concept sketches were prepared for exploring a range of possible design alternatives based upon building size, internal use configuration, and the physical situation of the building within the proposed site. These sketches do not represent the complete range of design possibilities. They are intended only to demonstrate a few basic design scenarios.

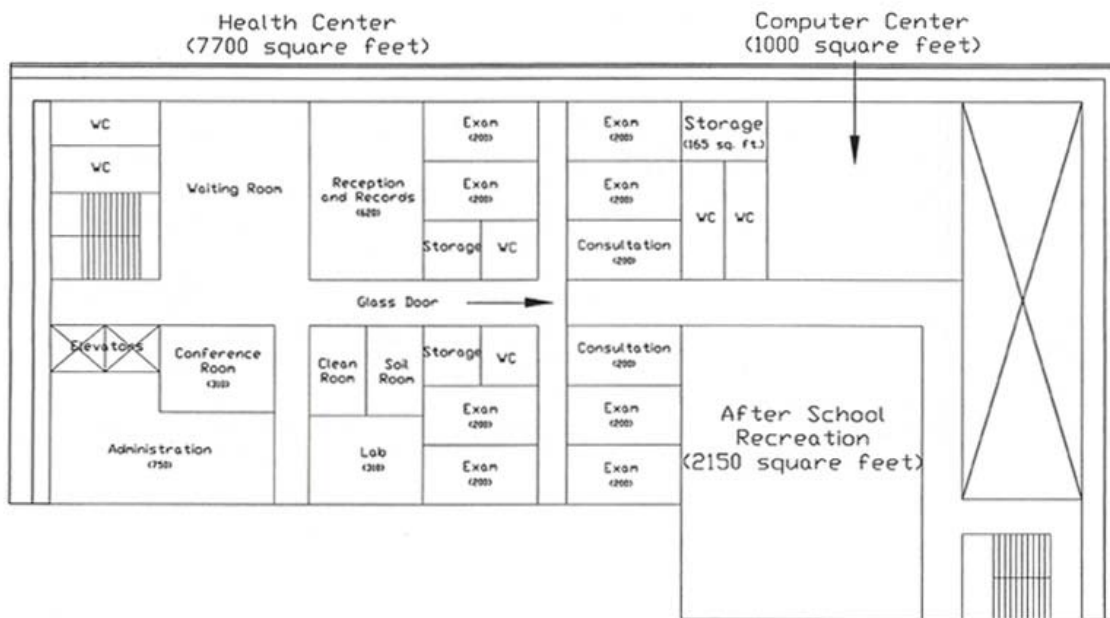
The first two sketches explore the possibility of situating a two-story, 28,000 square foot building (14,000 square feet x two floors) on the corner of 19th Street and 16th Avenue with a parking lot behind the building. This design is intended to bring the building as close to the corner as possible in order to encourage pedestrian access. The lot is directly accessible from 19th Street and from 16th Avenue via a side access lane. Both of these designs feature a 7,700 square foot healthcare facility, a 1000 square foot computer center, and a 2150 square foot after school recreation center. The first sketch places these three facilities on the second floor with a 12,500 square foot pharmacy on the first floor. The entrance to the pharmacy is situated on the corner of 16th avenue and 19th street with the entrance to the healthcare facility situated in the rear of the building adjacent to the parking lot. The computer center and after school recreation facility would be accessed from the stairwell in front of the building. The second sketch places the healthcare facility, computer center, and after school recreation facilities on first floor with a child care facility and office space on the second floor. The layout of the second floor can be made to accommodate any desired combination of facilities based upon a relative spatial mix of uses. Both designs place the elevators in the rear of the building in close proximity to the healthcare facility and stairwells on either side of the building. This layout could easily be modified to place an elevator on both sides the building.

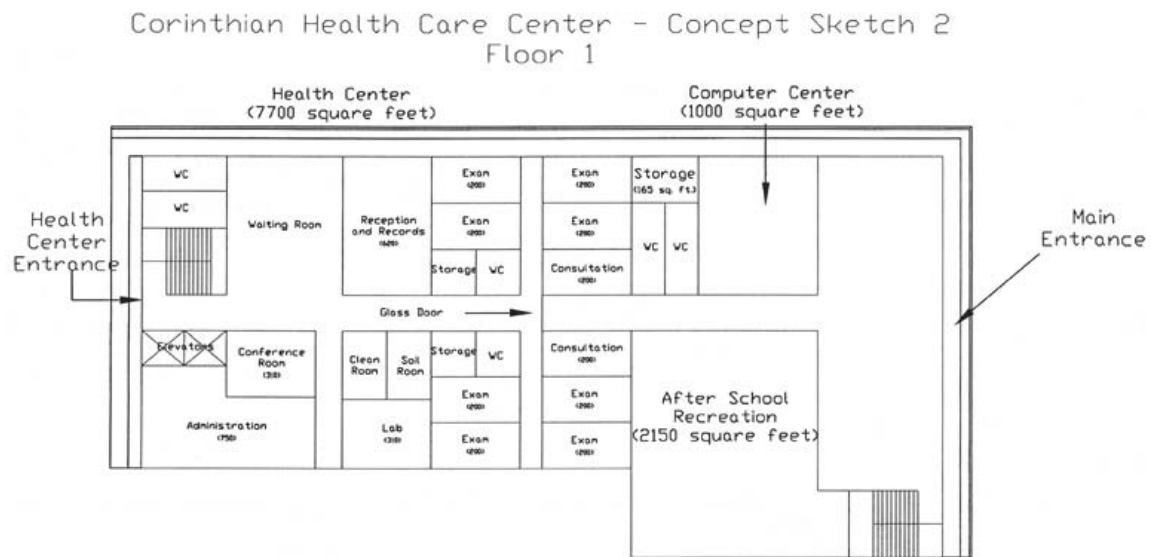
The second two sketches feature a 26,600 square foot building (13,300 square feet x two floors) with a parking lot on the corner of 19th Street and 16th Avenue. The lot is directly accessible from both roadways and features a separate area for staff parking. In both layouts, a pharmacy of approximately 12,000 square feet is situated on the first floor with main entrance and elevators located in front of the building off the parking lot. The stairwells are located on either side of the building. As with the first set of sketches, elevators could be placed on opposite sides of the structure. Sketch three features a healthcare facility of 6000 square feet, an after school recreation facility of 2500 square feet and an expanded computer center of 2500 square feet on the second floor. Sketch 4 features a 3000 square foot facility with a combined 3200 square foot computer center and after school recreation facility on the second floor. The remaining space might be devoted to offices or some other compatible use or set of uses. The rear entrance in this design would be for service and emergency exit purposes only.

Building Dimensions for Concept Sketches 1 and 2

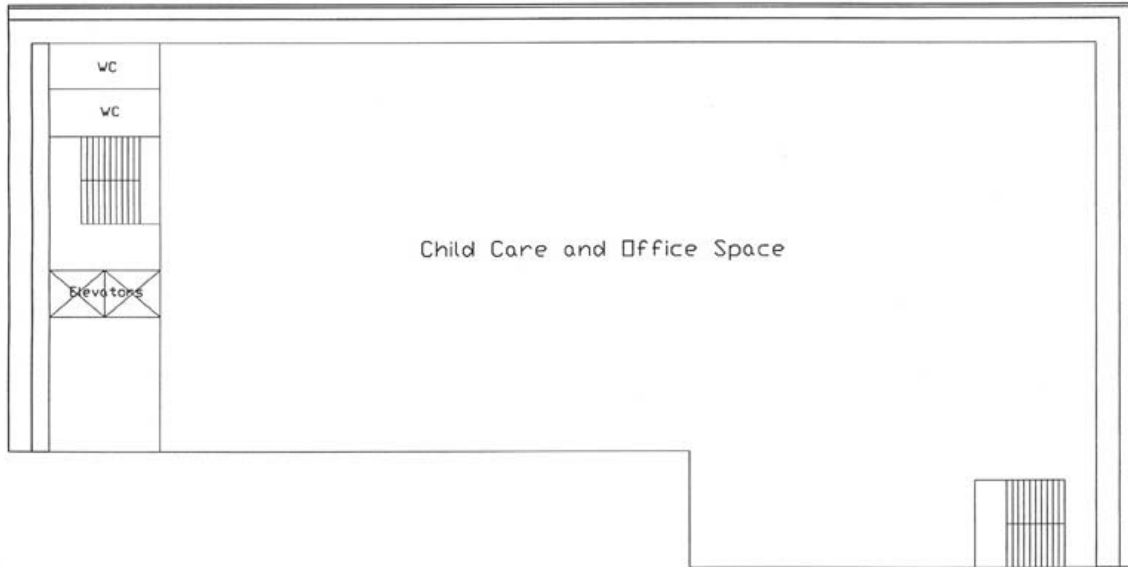




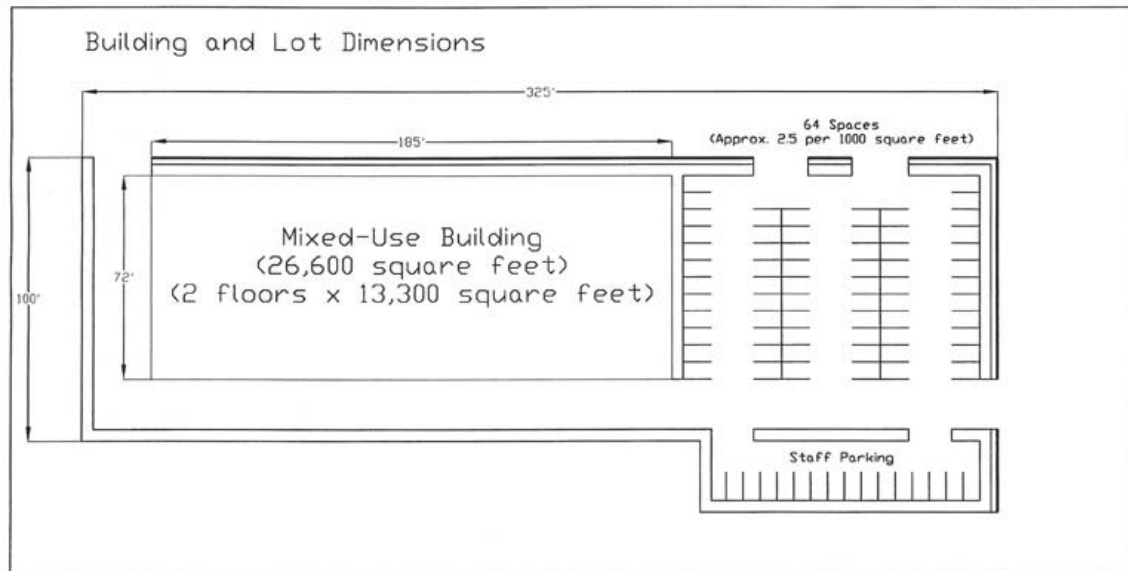
Corinthian Health Care Center - Concept Sketch 1
Floor 2



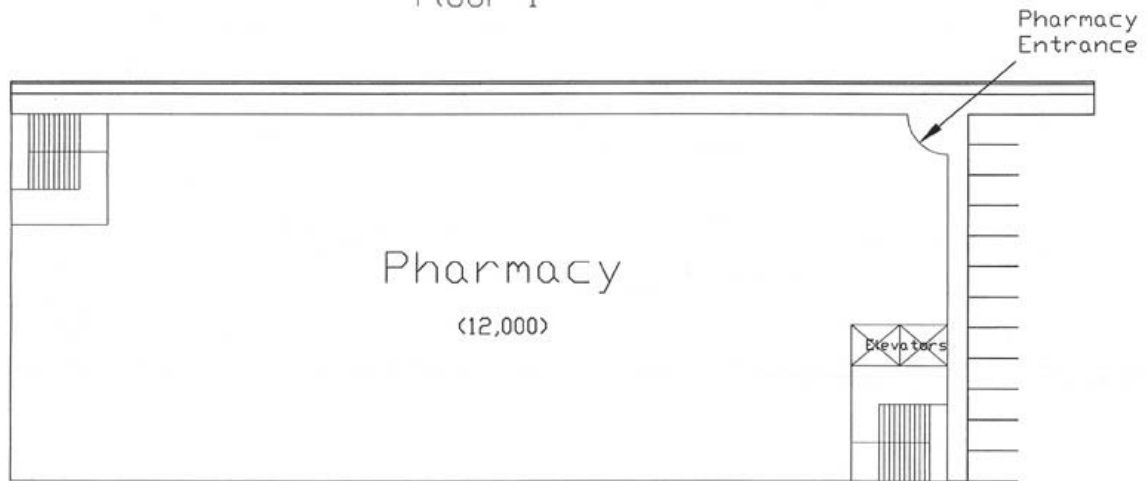
Corinthian Health Care Center - Concept Sketch 2
Floor 2



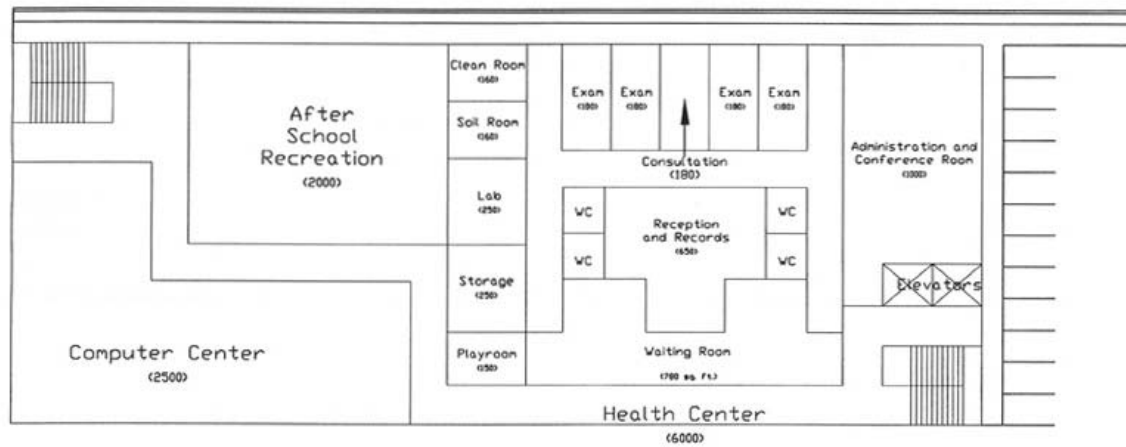
Building Dimensions for Concept Sketches 3 and 4



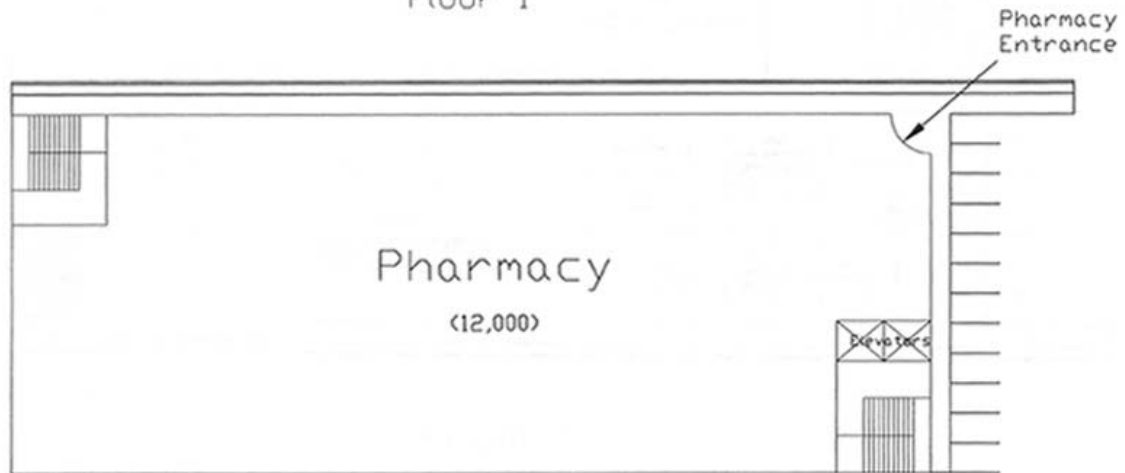
Corinthian Health Care Center - Concept Sketch 3
Floor 1



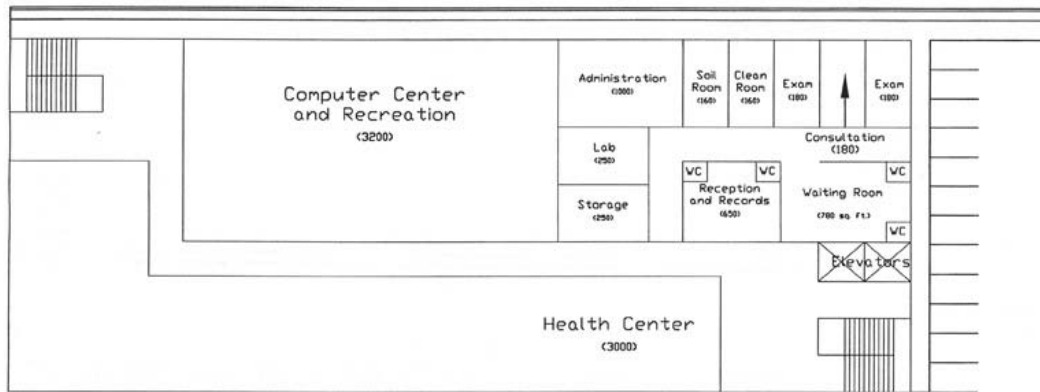
Corinthian Health Care Center - Concept Sketch 3
Floor 2



Corinthian Health Care Center - Concept Sketch 4
Floor 1



Corinthian Health Care Center - Concept Sketch 4
Floor 2



The series of renderings display an idealized version of what the health center might look like. The design is intended to create a feeling of openness, utilizing tall windows and skylights to maximize the amount of natural light entering the building. The design features abundant vegetation (proximity to which is proven to aid in the healing process) in the form of external arboretum and internal atrium. Flowing water is another possibility and would have been added to the rendering if not for technological limitations. The building is a modular design, with four 3,500 square foot modules that might accommodate a range of uses in any desired configuration. The main entrance is positioned off the parking area with a glass elevator and a pair of open stairways on either side of the building. Each module features windows overlooking the internal atrium and the outside environment. The windows for the health center might be tinted to ensure privacy.



Rental Income

A reasonable estimation of rental potential is important for determining whether the health center project is financially viable. At a minimum, the rent received from tenants should be able to pay for the annual operating costs and loan payments for the building. Corinthian also expects that the rent from tenants might be able to supplement revenue from the health center.

Estimating rent levels is an art rather than a science, especially when there is a lack of direct comparable buildings in the area or lack of commercial real estate sales activity in the area. We used information from five sources to evaluate the potential rental income rates for a building located at 19th Street and 16th Avenue in the West Side Park neighborhood. Two of these quotes came from real estate firms, two quotes were from Corinthian, and one quote came from UMDNJ.

Despite calling a number of real estate firms in the area, they were unable to provide quotes for the neighborhood due to either a lack of familiarity of potential rent levels for the area or a lack of recent sale activity in the area. Two firms provided potential rent levels although both were not definitive in their responses. North Metro believed retail activity like a pharmacy might pay \$7.5-\$9.5 per square foot while office space might only get \$4.5-\$6.5 per square foot. However, they also stated office rents might be higher if a higher percentage of the building is used for offices. A pure office building might be able to fetch as much as \$10-\$12 per square foot.

The real estate agent at Lucky Realty admitted to not being familiar with real estate activity at West Side Park but believed that rents would definitely be less than \$10 per square foot. He thought that \$7-\$8 per square foot constituted good indications of rent levels in the area.

Corinthian stated that Tri-City was willing to pay rent levels of \$9-\$12 per square foot. Recent discussions with Walgreens have indicated that the pharmacy was willing to spend up to \$15 per square foot. We also have a quote from UMDNJ that stated that within the UMDNJ campus, they pay between \$32-\$35 per square foot; however, their community centers, including the one located close to Lincoln Park and Broad Street, pay between \$10-\$15 per square foot.

Estimating rental rates with a lack of recent comparable rent levels is tricky. The indications from the real estate agents seem to be on the low side. The fact that the building will be new will help increase rent levels while the fact that it is not located on a major road (e.g., Springfield Avenue or South Orange Avenue) would lower the rent that can be charged on the building. We suggest that rent levels for the pharmacy and healthcare center will range from between \$10-\$15 per square foot. This is based on the belief that the most accurate quotes are probably the quotes based on negotiations by Corinthian and the real life quote from UMDNJ. It is also believed that the office space and other types of uses might fetch between \$8-\$12 per square foot. The lower estimates are based on real estate agents implying lower rates for office space in a building largely occupied by non-office uses.

Estimating rental income for this site will be very difficult because of a lack of comparable building sites and recent commercial building sales in the West Side Park area. Based on information received from real estate agents, Corinthian, and UMDNJ, it is believed that Corinthian should be able to collect between \$10-\$15 per square foot for retail and healthcare space. It is also believed that they might not be able to collect that same rent level for office space and government space. This space might only provide \$8-\$12 per square foot. However, due to the nature of the estimates, the group stresses that they cannot know what the rent levels might be until the space is marketed to tenants.

Parking

While many residents may walk or use public transportation to get to the health center, many will also drive and, therefore, there is a need to provide parking. Although a variety of rules of thumb for commercial and retail establishments set the appropriate number of parking spaces at anywhere from two to five parking spaces per 1,000 square feet, the zoning ordinance in Newark offers specifics that are used for this analysis. For a doctor's office there should be either five spaces per practicing physician, surgeon or dentist or a paved parking space area at least equal in area to the floor area of the medical building; whichever is larger. Retail and commercial establishments should have three parking spaces for the first 1,000 square feet and two parking spaces for each additional 1,000 square feet of net space. In the sample design layouts of the building, samples of parking at both the southern and northern end of the building along 19th Avenue are shown.

Factors to Consider When Choosing a Design

One important factor for a successful healthcare center is for the building to appear to have lots of activity and be seen as inviting to visitors. The healthcare center should be located close to areas with activity (e.g., the after-school care area) and dead space around the center should be kept to a minimum. If the healthcare center is located on the second floor, stress should be placed on making the entrance and stairwell leading toward the center inviting and open. The visitor should be able to hear the activity from the healthcare center when entering the building. This will be easier to accomplish if the healthcare center is located on the first floor.

The building also needs to achieve a connection with the population served by the health center. Signs located around the facility should be written in all languages prevalent in the West Side Park neighborhood. Artwork and pictures around the center should relate to the culture of the surrounding community.

Since many users will be bringing children and will invariably need to wait, a play area should be provided with plastic, easily washable toys to keep children busy. This area can be flexible enough to serve multiple purposes. For example, during health center hours it can serve as a play area while, at night it could serve as a community meeting area or as an area to hold classes (e.g., exercise classes). The waiting area should be large and some food should be provided, even if it is from a vending machine.

NEXT STEPS

Over the last few months, studio participants gathered information to provide Corinthian HDC and Tri-City Peoples Corporation with enough information to enable them to make informed decisions about building and running a community health center in West Side Park. Students consulted with community residents and community leaders to try to determine a vision for the health center. The demographics of the community and the health profile have been studied to find out if there is a need for a health center in this community. A wide variety of literature on healthcare and healthcare financing were reviewed, and healthcare professionals were interviewed to determine what is the best healthcare model that could be used for this center and the most efficient way of funding it.

From this research, it is clear that there is a strong need for a healthcare center in the West Side Park community. Although there are a number of healthcare facilities in the area, unfortunately they are not meeting the needs of the residents in this community. There are a number of issues that we feel are important to consider and it is hoped that Tri-City Peoples Corporation and Corinthian Housing Development Corporation consider these. Following are our recommended next steps:

Select a Health Care Model and Identify the Health Provider

The first step in designing a health center is determining what type of health center will be built. This includes the services offered, client base, hours of operation, type of provider, and physical design.

Select Services

Selecting services needs to be decided with extreme care and sensitivity to community needs. The community has expressed a strong need for dental and eye care, as these are two services that are currently lacking in the community and there is a strong need and desire to have these available at an affordable price. There are other services that are also needed that are specific to racial and ethnic groups such as lead screenings and asthma treatment for children, which should also be considered. Moreover, the majority of residents in West Side Park are African American, but there is also a Haitian population and a growing Latino population in the nearby communities that are potential users of the healthcare center. Their different ethnic and health needs need to be considered.

Hours

Community residents expressed a need for flexible hours where day workers can visit the health center in the evenings or on weekends.

Identify the Provider

In discussions with community residents, some expressed their preference for having doctors, as healthcare providers while others preferred the personal care that they can receive from nurse practitioners. The type of provider is a factor that will play an important role in the health center that will be designed.

We have described a few healthcare models, the Nurse Practitioner, the FQHC satellite, hospital partnership and stand-alone. The best model will fit the needs of the community and the goals of Tri-City Peoples Corporation and Corinthian Housing Development Corporation. To us, this means that the health model should provide comprehensive services either directly or in partnership with other institutions and providers and work closely with community organizations to do health promotion and outreach. It is critical that these needs be combined to ensure the financial feasibility of the center. We strongly encourage the community organizations to not attempt a stand-alone health center.

Develop a Community Outreach Strategy

Once the health center is designed and the partnership established, the third step is to work closely with the provider to formulate a community outreach strategy. This is important for encouraging community residents to access the health center. It is also important for the health institution to create a strong client base. Corinthian, Tri-City, and the health provider can work closely with other community leaders and organizations, religious institutions (there are more than 80 in West Side Park alone), schools, and advertisement through the local radio stations and newspapers.

Inviting People Into the Health Center

Physical design is important for community residents to feel attracted to use the facility and to make them feel comfortable once they are inside the center. Having paintings that are representative of the community is a way of tailoring the center to the communities it is serving. Hiring staff who are responsive and respectful of community residents should not be overlooked.

Identifying Tenants

The last step in designing this healthcare center will be to identify possible tenants to occupy the building. Tenants in the same building as the health center can help attract patients to receive care at the center as well as serve as a source of income to pay for the cost of the building. It is important that the tenants do not serve as a deterrent to potential patients.

We hope that the information provided in this report will enable Corinthian and Tri-City to take these next steps to establish a healthcare center in West Side Park that will meet the needs of the residents and be financially stable, so that it can prosper as a community resource.

- select a health care model and provider,
- develop a community outreach strategy,
- create an inviting health care center, and
- identify other tenants

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APPENDIX A: INTERVIEW INSTRUMENTS

Questions for community development corporation leaders

1. Would you please talk briefly about your involvement in the community. How do you participate and interact with community members?
2. What do you think are the most pressing health issues that this community is currently facing?
3. What resources does the community have to address those issues?
4. Are you familiar with where folks currently go for medical care? If yes, where?
5. Why don't people access the health services already available?
6. Aside from a health center, what other facility do you feel the community needs?
7. Are there others in the community that you feel we should speak to about the health issues in the community?

Questions for Focus Groups

1. What do you perceive as health issues in this community?
2. Who do you feel is in most need of health related attention? Who is being overlooked?
3. How do you feel about your current health?
4. Where do you get healthcare? How often?
5. Do you have any preference as to who provides medical care?
6. Are there any barriers that prevent you from getting medical care?
7. What special programs would you like to see provided in the community?

Points to mention if the residents do not bring up:

- Dental care/Eye care
- How they feel about docs, pharmacy in the area

Interview Questions for Corinthian HDC and Tri-City Peoples Corporation:

1. Can you describe what you envisioned would be your CDCs role in this project?
2. Do either CDCs have any preference as to whom they partner with for this program? (doctors for a specific hospital, nurse practitioners, etc.) (Mr. Russell's group?)
3. Can Ms. Favors, elaborate more on the services being provided by Tri-City? Any outreach education, if so how to they reach out to the community?
4. Has the community expressed any concerns over the current health center? Have they made any suggestions as to improving the quality of service?
5. What grants does Tri-City currently receive? Are they funding sources that we could consider retaining for the new center?
6. Ms. Cooper had mentioned several grants that CHD had received for this project some time ago and where trying to see if they were still available, has that been confirmed?

APPENDIX B: REIMBURSEMENT RESEARCH QUESTIONS

Policy Questions

What is “risk-based” contracting, specifically in the managed care arena?

Does New Jersey use any 1115 waivers? If so, what are they for?

We have read that Disproportionate Share Funds have been used by New Jersey to free up some funding for the uninsured, because NJ has used the disproportionate funds to cover charity care dollars. Is that still the case?

Eligibility

Where can we get information on NJ’s Medicaid and Medicare eligibility rules?

Does New Jersey have presumptive eligibility? In other words, if a patient shows up without insurance but would qualify for Medicaid or NJ FamilyCare etc, is there any way to enroll them on site and be reimbursed for that visit or are reimbursed retroactively? If NJ does have presumptive eligibility, is the provider still reimbursed if the person ends up ineligible for public insurance programs?

Administrative Questions

How does the Health Center register or gain access to the Medicaid/Medicare etc reimbursement system? Is it a license, and if so, how much? How far in advance of starting operations should the center think about doing this?

Is there anything else that has to be done in order to qualify to be a Medicaid provider other than obtaining a Medicaid provider billing number through the state Medicaid office? Medicare? How long does it take to get a number (physician PIN or Nurse Practitioner UPIN?)

What is covered under Medicaid managed care capitated rates? NJ Family Care? Medicare?

Realistically, what can we expect to find out in the way of fees and population?

When people say that Medicaid reimbursement levels are low, what range are they talking about? Fifty percent of the cost of care for Medicaid patients is not reimbursed, 20%?

How much funding do Health Centers have to leverage to offset the reimbursement shortfalls? How does your center make up for the shortfall?

What is the typical reimbursement level for private insurance?

Is it the case that there are a certain number of major HMOs that cover a large percentage of patients that the center should contract with (i.e. three largest etc?)

Does the center have to negotiate the HMO contracts, and if so, what are generally the main topics for negotiation?

Can a center negotiate with an HMO or other private organization, or only a physician or other provider?

If providers become part of an HMO, are they automatically agreeing to take that HMO's Medicaid patients, or is that a separate contract?

What happens if a Medicaid managed care patient assigned elsewhere comes to us? Is there any way to be reimbursed?

How does the Center handle patients without insurance who must be referred to a specialist etc?

How can we get access to enrollment packets?

Does the Health Center have access to any of the charitable relief funds?

Does Medicaid managed care exclude certain critical needs that we would definitely have to find alternate funding sources for?

What is your experience with pharmaceutical companies' drug assistance programs?

Funding for expensive AIDS meds?

Funding sources for treating substance abuse?

Billing

How do centers usually function on a day-to-day basis while waiting for reimbursement?

How do we get a schedule of capitation rates, Medicare reimbursements, etc.?

Do capitation rates cover costs?

What is a typical timeline for reimbursement: private insurance, Medicare, Medicaid, NJKidCare, Family Care?

How much does it cost to administer reimbursement? For 5000 patients a year, for 10,000? Would it ever be better just to not take insurance?

Do you need a skilled billing person to administer reimbursement?

Grants

How categorical are most healthcare grants? State funding? Private Foundations?

APPENDIX C: HEALTH POLICY DEFINITIONS

Health Policy/Reimbursement Definitions

Fee For Service or Indemnity Plan: Most people are familiar with this form of insurance in which you select a physician and a hospital and receive reimbursement after receiving services. These plans usually require a deductible, co-pay, or both. Fee-for-service reimbursement does not necessarily guarantee full reimbursement however.

Managed Care: Private insurance companies “manage” the healthcare of their clients by restricting what types of doctors the clients can see. Most managed care companies require clients to sign up with a *Primary Care Physician* (PCP). Patients often need a to get a referral from the PCP to see a specialist. The managed care company pays the PCP a *capitated rate* each month. Managed care organizations can either be health maintenance organizations, HMO (defined below), Preferred Provider Organizations (they pay in full for providers in their network but only a percentage of those outside of network and do not require referrals for specialists) and Point-of-Service organizations, (require referrals but may cover some out-of-network providers).

Health Maintenance Organization: The most common type of managed care organization, HMOs generally will not pay for any services a client receives outside their approved network of physicians, and clients may need permission before going to the emergency room. They require patients to name a Primary Care Physician and get a referral from them to see anyone else. However, clients often have little to no co-pay or deductible.

Capitated Rate: Each PCP is paid a fixed dollar amount per month to have the patient on their roster. No matter whether the patient never comes in, visits twice, or comes in 20 times a month, the doctor is paid the same amount. Doctors or centers negotiate capitated rates with each HMO.

Co-pay: Fee paid at time of healthcare service by patient. Ranges around \$5-\$25, but can be up to 20% of the cost of the healthcare service. Can seem nominal, but can be important to doctor’s office that is only receiving a small capitated rate payment for each patient each month.

Deductible: Amount a beneficiary or client has to pay in out-of-pocket healthcare expenses before the insurance company or program they are members of starts to cover the costs. For example, Medicare Part B, the section of Medicare that covers doctor’s visits and preventative care, has a \$100 deductible.

Premium: Amount a beneficiary or client has to pay each month or year to be part of a health insurance program. With employer-sponsored health insurance, the employer generally pays the majority of the premium. Again, Medicare Part B also has a \$20 a month premium.

Credentialing or Licensing: The process a doctor or center must go through in order to receive reimbursement from a health insurance company. Each HMO or company has its own credentialing requirements and application, and FQHCs and hospitals often devote one or more staff people to this process. Once a doctor is credentialed, she receives a number under which she can bill the insurance company.

Medicaid: Public health insurance for low-income people. Traditionally a fee-for-service plan, but recently moving into managed care.

Medicare: Health insurance program for which anyone over 65 is eligible, as long as they are eligible for Social Security (i.e., you have worked and paid your social security taxes). This is also available to disabled people under 65. Composed of three sections: Part A, hospital care, Part B, outpatient hospital services, physician services, mammograms and other cancer screenings, and medical equipment, and Part C, which is the managed care section of Medicare through which private health insurance companies provide both Parts A and B.

NJ FamilyCare: Health insurance program for children and families in New Jersey who are uninsured but whose income is too high to be eligible for Medicaid. Currently funded through federal Children's Health Insurance Program (CHIP) funding and tobacco settlement money. This is a completely managed care health insurance program, so recipients enroll with a private health insurance company.

APPENDIX D: HEALTHCARE POLICY PRIMER

Health Policy Primer Why? Just tell me if my health center can expect to break even. We've heard it repeated so many times—healthcare policy changes so fast—you have to be close to a genius to navigate the system. We've heard it so many times that unfortunately, we may have become desensitized to it. Healthcare providers will better serve their target population if they are able to explain the health insurance industry to their patients who, without fault, probably won't understand it. From a public policy perspective, community leaders who participate in shaping healthcare policy bring real and substantial change to the people whom they serve.

As the government works to remedy many concerns with the numbers of uninsured Americans and the rising costs of healthcare, healthcare policy is constantly changing in ways that directly affect community health centers. The Newark Community Health Center's East Orange site reported that they had a significant decrease in their patient population over the last several years, attributable to Medicaid and Medicare's move into managed care. The decrease was likely also related to the drop in Medicaid enrollment that has accompanied welfare reform. The ability of a community health center to maintain itself is and will be dependent on the understanding its leaders have of the rapidly changing field of health policy and how each reform impacts reimbursement.

Healthcare in the United States today is paid for by an increasingly complex and, some would argue, unworkable system of government insurance programs and private insurance companies. The situation can be most succinctly categorized as highly dynamic and complex. The realities of healthcare are almost absurd. No doctor is ever paid in full for a service she renders, but yet increasing numbers of working Americans are without health insurance because their employers can no longer afford to pay for it, or because they themselves cannot afford the premiums required (McDonough 2001, 10). Health costs constantly increase and much work is being done to find ways to contain them while providing health coverage for more people. In this maze of current health policy analysis, what are the most important issues for a community health center to think about? Critical areas to understand include the issues affecting the uninsured, the major types of health insurance, and the details on public insurance programs such as Medicaid, Medicare, and the Children's Health Insurance Program, or CHIP. This section of the report covers those topics and includes a small section on prescription drugs.

The Uninsured

The mission of community health centers is often focused on serving underserved populations, and one of the populations who face significant barriers to healthcare, particularly preventive healthcare, are those without health insurance. The Kaiser Family Foundation has a Commission on Medicaid and the Uninsured, which has done extensive research on the uninsured population. Despite an increase in employer-provided health insurance between 1994 and 1998 the number of uninsured continued to rise at rates similar to the increase in employer-provided insurance (Hoffman and Schlobohm 2000, 6). *The Uninsured in America: A Chart Book*, published by the Kaiser Commission, names three "major forces driving the growth in America's uninsured—the amount and

cost of job-based coverage, the number of families who live on low incomes, and the scope of state Medicaid programs”(Hoffman and Schlobohm 2000, 34).

Americans who are uninsured do not fit neatly into any particular. While the uninsured are largely low-income, in 1998 the majority had incomes above the federal poverty level, only 16 percent were in families where no one worked, while a surprising 19 percent were in families with two or more full-time workers (Hoffman and Schlobohm 2000, 10-12). Men were slightly more likely than women to be uninsured were, and “minorities are disproportionately over-represented in the uninsured population” (Hoffman and Schlobohm 2000, 19). Almost half of uninsured workers are employed by small firms with less than 25 employees, but at the same time over a quarter of uninsured workers are in firms with more than 500 employees.

States have widely varying uninsured rates. In New Jersey in 1997, 12 percent of the non-elderly population was uninsured, three percent, less than the national average. The table below highlights some of the characteristics of New Jersey’s uninsured population.

| Characteristics of the Uninsured New Jersey, 1997 | |
|--|-------|
| GENDER | |
| Male | 52.6% |
| Female | 47.4% |
| RACE/ETHNICITY | |
| White Non-Hispanic | 52.4% |
| Black Non-Hispanic | 15.8% |
| Hispanic | 24.6% |
| Other Non-Hispanic | 5.4% |
| INCOME | |
| Less than 100% | 31.7% |
| 100-200 % | 34.7% |
| 200-300% | 16.3% |
| 300% and above | 17.3% |

*Source: “Health Insurance: Access and Use: New Jersey.”
Urban Institute, July 2000.*

New Jersey covers a moderate percentage² of their 16 percent non-elderly uninsured population through state-only programs.

The lack of health insurance creates a complicated web of policy considerations. The uninsured have difficulty gaining access to healthcare, and due to the lack of preventative healthcare, “end up being hospitalized for controllable conditions that do not generally require hospital care”(McDonough 2001, 13). As a result, “the uninsured also have death

² Here "moderate" is defined as 2-10% (Spillman 2000).

rates 25% higher than the insured population” (McDonough 2001, 13). While it is more expensive to treat this population, if the uninsured received care, they would not be as expensive to treat, leading to a difficult policy situation. Community health centers, depending on their funding stream, can be a critical healthcare resource for the uninsured population and can play a role in providing some of the critical preventative care this population often needs.

Types of Insurance

Private Insurance

Private health insurance can be directly purchased by the consumer, but is generally bought by the employer in part or in whole. If the employer only buys part of the insurance, the employee has to pay a premium to have coverage. Private insurance runs in a number of different ways. The most basic is fee-for-service; the insurance company pays separately for each healthcare service the patient needs. Generally, one still needs to notify the insurance company before going to the emergency room, and the policy includes a deductible the patient has to pay before the insurance company begins to pay. Before managed care, Medicaid was a straight fee-for-service insurance program. Medicaid reimbursement that is not part of a managed care plan is now referred to as “straight Medicaid.”

The health insurance system is currently dominated by the concept of managed care, meaning that insurance companies “manage” who consumers go to for services. The most common form of managed care is the **Health Maintenance Organization (HMO)**. HMOs require members to choose a Primary Care Physician, or PCP, from the HMO approved network of doctors. This doctor is paid a capitated rate per month to have the patient on their roster. Regardless of the number of patient visits, the doctor is still paid the same amount per patient. Theoretically, capitation rates should encourage preventative medicine since the doctor does not want to see the patient repeatedly as she or he gets sicker. On the other hand, a common criticism of this system is that it provides incentives to provide less care (McDonough 2001, 22). Under an HMO, patients cannot see specialists without a referral from their PCP. Another type of insurance company is the **Preferred Provider Organization (PPO)**, which has a network of approved providers. However, in this case the consumer can see any doctor or specialist in the network without a referral from their PCP, though they are required to make a co-payment at the time of their visit. Doctors outside of the network must be paid in full at the time of the visit, though reimbursement may be available for up to 80% of that cost by the PPO. **Point-of-Service (POS)** organizations require a PCP and a referral to specialists, but may cover some services provided by doctors who are not in their approved network. HMOs, on the other hand, usually will not cover any expenses incurred with out-of-network providers, but often have low premiums and do not require co-payments.

It is extremely expensive to participate in any of these types of private insurance. In 1999, “average premiums for a family with group coverage [meaning a group health insurance policy through their employer] cost between \$5,000 and \$6,000 a year”

(Hoffman and Schlobohm 2000, 34). The average cost per worker has increased significantly over the last 20 years. In 1977, it cost \$1,584 on average to insure one worker, and the worker was responsible for 20% of that. In 1998, it cost \$4,092 on average to insure one worker, and the worker's portion was 27%³ (Hoffman and Schlobohm 2000, 37). The rise of managed care was celebrated as a means to cut healthcare costs by encouraging prevention—if doctors realize they are not going to get paid for their increased visits with a patient if a person gets very sick, they will work to insure patients stay healthy. It does not seem to be having this result, as costs continue to rise.

Medicare

Medicare is the health insurance program that provides coverage generally for adults over 65 and disabled of all ages, and is paid for by payroll taxes. It has three parts. Medicare Part A provides hospital coverage and is free. Medicare Part B provides physician services, outpatient hospital services, and cancer screenings (mammography, etc.) but requires a \$100 deductible and 20% coinsurance. Medicare Part C is the managed care portion of Medicare, which can be either Part A or Part B. Medicare usually does not provide enough coverage, particularly since it does not cover prescription drugs, and because it requires substantial co-payments for most services. People make up the difference with employer-sponsored benefits, Medigap policies, or Medicaid. Ten Medigap policies are nationally standardized and each provides different coverage packages. Consumers can purchase these plans from private companies.

Health centers can be eligible to accept Medicare Part B. Depending on whether a Medicare patient is in managed care or not, she or he may or may not have primary care restrictions. No one is required to enroll in managed care under Medicare, but insurance companies heavily recruit seniors. State governments also often encourage enrollment. However, many insurance companies with Medicare managed care contracts have not renewed their contracts, leaving many who enrolled in their program in the lurch. The lack of renewal is largely related to a lack of profitability, both because of reimbursement problems and the federal government's attempts to slow growth in healthcare payments to preserve the dwindling Hospital Insurance Trust Fund which is money used to support the Medicare Part A program which is slated to run out in 2025.

Medicaid Managed Care

Both Medicare and Medicaid have recently begun to convert their reimbursement system from the traditional fee-for-service system to managed care. The federal government hopes that this move will contain costs by improving economies of scale and improving preventative services for patients (Bovbjerg et. al. 1997, 4). States negotiate contracts with participating private managed care organizations, and pay them through capitation rates, or standard monthly payments, to provide primary care services to participants in Medicaid and Medicare. States have different methods of establishing capitation rates. In New Jersey, capitation rates vary across 21 state-defined regions and by the age of the HMO participant. The capitation or reimbursement rates also vary for each HMO, which

³ All figures are in 1998 dollars.

negotiates separately with the state Department of Health and Senior Services. Each HMO contracts separately with healthcare providers, doctors and centers, to determine the capitated rate the insurance company will pay each provider to see the Medicaid patient.

...health plans are paid a capitated amount per person per month and are responsible to pay providers for all services included in the capitated payment...A provider will need to be enrolled with a health plan to be eligible to receive payment for services to Medicaid beneficiaries in the health plan. It is the health plan that decides whether to contract with any provider, including a health department and the amount of payment it will make to the providers in its network. However, a Medicaid agency has discretion to require in its contract with participating health plans that certain providers be included in the network and how they are to be paid. A Medicaid program has the option to decide which services are included in the capitation payment and therefore must be billed to the plan instead of to Medicaid (HHS Dec. 2000)

From a business standpoint, the crux of the Medicaid Managed Care movement is to get the healthcare industry to function more efficiently and to stem the rapid rise in healthcare costs. Medicaid reimbursement rates did not parallel the rise in healthcare costs, thus the introduction of Medicaid Managed Care along with a host of changes to the healthcare industry as part of the 1997 Balanced Budget Amendment. Since reimbursement rates were far from adequate, for Medicaid recipients to receive affordable healthcare they had to seek out the lowest physician fees possible, which often resulted in inadequate care.

HMO participation in Medicaid Managed Care varies across the nation depending on the market and the particular state budgetary pressures (Holahan et al. 1999). As with any industry, if the organization faces diseconomies of scale they won't enter the market, which explains why states have set up programs or guidelines to get Medicaid beneficiaries into managed care. "Participation in Medicaid Managed Care may be due to the sense of mission that a health plan feels, the sense that they need to serve the poor, or they may not participate out of fear that serving the Medicaid population will tarnish their brand name" (Henry J. Kaiser Family Foundation 2000). If Managed Care Organizations feel that the capitation rates do not address the costs of managing Medicaid patients, the HMO will withdraw from the market. If too many HMOs withdraw from the market, Medicaid beneficiaries will find themselves in the same place they were before the program overhaul—hard pressed to find adequate, affordable, accessible care.

Almost all of the commercial Medicaid Managed Care plans have left the New York City market, asserting that the Medicaid population, already an expensive population to treat has found itself less healthy than it was before the reforms and the state has had to increase its capitation rates to reflect this (Henry J. Kaiser Family Foundation 2000). Managed Care companies also argue that administration costs related to Medicaid Managed Care are higher than regular managed care contracts although this may be symptomatic of the initial change over period during which time state agencies may struggle with adopting and implementing more flexible policies (Holahan et al 1999). To

complicate matters, capitation rates in New Jersey vary across 21 different regions and differ across sex and age categories creating 147 different rate cells (Holahan et al 1999).

In New Jersey, all those who sign up for Medicaid are expected to join an HMO. The state will place them in one if they fail to choose. According to Ms. Janet-White Hunt at the Plainfield FQHC, Medicaid patients have a right to discontinue their HMO membership and return to fee-for-service Medicaid, but many patients are unaware of this option. Eulette Reseau, at the East Orange site of the Newark Community Health Center, noted that TANF recipients who have Medicaid are required to have managed care, but that those on disability (SSI) are allowed to return to “straight” fee-for-service Medicaid. Throughout our research on health policy, it was clear that it is increasingly difficult to understand the requirements and characteristics of health insurance policies, public or private. Health consumers need to be better educated if they are to truly find the best health insurance program for themselves and their families.

New Jersey Family Care

In 1997, the federal government responded to mounting concerns about the uninsured population, particularly uninsured children, with the Children’s Health Insurance Program, or CHIP. States implemented CHIP on their own terms, but the goal was to provide health insurance for children who were ineligible for Medicaid under traditional income guidelines. States could expand Medicaid (i.e. use the federal dollars to expand the income requirements), create a completely separate and new program, or do both.

New Jersey created a new program called NJ KidCare, which they recently expanded to NJ FamilyCare. At first, the state only covered children, as the federal government had required. NJ FamilyCare extends insurance coverage to both the working parents of children that are eligible and some single adults. The expansion originally had a budget of \$100 annually from New Jersey’s tobacco settlement (“NJ KidCare to Become NJ FamilyCare”). Staff at the Plainfield FQHC shared with us their concern that the tobacco settlement is a finite amount of money that will run out sometime around 2002, leaving the state with a large shortfall if they want to continue the program. However, Gina Lucas with the Association for the Children of New Jersey, noted that it would be politically very difficult for New Jersey to stop providing health insurance for those it has expanded services to under NJ FamilyCare once the tobacco money runs out.

To be eligible for this program a family or individual must be uninsured for at least six months. Additional eligibility requirements depend on income and family size. The program will cover some people who earn up to 350% of the poverty line, if it is a large family. The income level determines eligibility and whether or not the member has to pay monthly premiums or co-payments when visiting a doctor. The FamilyCare Program is divided into Parts A through D, which all serve children, and the portion serving adults.

NJ FamilyCare is a managed care insurance program, and HMOs contract with the state to provide the program. HMOs apply to provide NJ Family Care in each county separately. In Essex County, NJ FamilyCare is currently provided by Aetna/US

Healthcare, Physician's Health Service, Americaid/Amerigroup, AmeriChoice, Horizon Mercy, and University Health Plan.

Prescription Drugs

One of the areas of health policy often discussed in the media and politics is the cost of prescription drugs which is of particular concern to older adults, who face higher pharmaceutical needs and often have no prescription plan. Medicaid covers prescriptions, though it does not pay for them in full and the regulations about the types of drugs Medicaid will pay for are as convoluted as any other part of the program (Bruen 2000, 4).

States are allowed to implement cost-sharing programs for prescriptions, meaning that Medicaid beneficiaries will pay a small fee, which in 1998 ranged from fifty cents to three dollars (Bruen 2000, 3). In a study about prescription drugs and Medicaid, for the Kaiser Commission on Medicaid and the Uninsured, Brian Bruen found that in the late nineties, Medicaid expenditures on prescription drugs rose dramatically, with expenditures per enrollee increasing by \$129 between 1995 and 1998 (Bruen 2000, 11). While this rise can be partially attributed to increasing costs of pharmaceuticals and the increasing elderly and disabled populations on Medicaid, it is a significant concern for states who bear these costs. Over the next several years, prescription drugs will be one area where health centers working to serve low-income communities will need to be creative in finding resources to support provision of prescriptions and active in protecting already existing resources such as Medicaid's coverage of prescriptions.

Options for providing prescription drugs include grants for that purpose and donations from pharmaceutical companies. Ms. White-Hunt at the Plainfield FQHC shared with us that they had previously received a grant to purchase prescription drugs for patients, but it had since run out. For uninsured patients who need prescription drugs the FQHC does have an on-site social worker who can help the patient find a program that might help to purchase prescriptions. Like the Elizabethport center and the East Orange branch of the Newark Community Health System, the Plainfield FQHC keeps common drugs from pharmaceutical representatives on hand to be given to patients for free, but Judy Pollacheck, from Elizabethport, warned that these are often drugs that are close to their expiration date, so the center needs to be on top of the dates when they dispense the medications. Ms. Pollacheck is also pursuing a relationship with the Rutgers University School of Pharmacy to get drugs provided at low costs for her center to dispense. We also spoke to Ellen Lambert, of the Healthcare Foundation of New Jersey, about pharmaceuticals. She mentioned the Safety Net program, which is a federal and state program offering low-cost or free drugs to hospitals or doctor's offices. While the program provides access to many types of drugs, it requires an "impossible" amount of paperwork, so is not the easiest way to access drugs for patients. She also recommended relationships with pharmaceutical representatives who provide free samples.

APPENDIX E: COMPARING HEALTHCARE MODELS

| Model Name | ST. JAMES HIGH SCHOOL HEALTH CLINIC | JEWISH RENAISSANCE FOUNDATION | E. ORANGE PRIMARY CARE CENTER (Newark Community Health Systems) |
|------------------------|---|--|---|
| Model Type | Hospital Based - Newark Beth Israel, School Based | Volunteer Docs, FQHC Look-Alike | FQHC |
| Services Offered | Primary and preventative care: most general types of services. No ancillary services. | Primary Care, Dental, Emergency Care, Pharmaceutical | Primary Care, Ob/Gyn Pediatric, Ear/Nose/Throat, Dental, Podiatry, Nutrition Counseling, Lab, Social Worker, Ophthalmology |
| Funding Sources | Hospital funding | Federal and State Grants, Donations, Free Charity Care | Federal and State Grants |
| Annual Operating Costs | n/a | \$450,000 | n/a |
| Benefits | Provides health care to the community backed by a local hospital. The hospital can provide the funding needed to keep this operation financially viable, as well as provide the expertise of hospital administration and practitioners. Doctors and NP's are hospital staff who visit the center as part of their normal work routine. | Cost effective; well connected to the community; free care available; variety of doctors available; office hours nights and weekends; tax exempt | Extremely cost effective, large variety of services available in one building, charity and low-cost care available; FQHC provides 80 percent reimbursement of allowable costs. In addition, FQHC reimburses Health Centers for certain preventive services not typically covered by Medicare. FQHC money is specifically for medically underserved area/population; automatically eligible for Medicaid/Medicare reimbursements |
| Drawbacks | Provides no charity care; little community involvement, hours and services decided by hospital administration; could lose backing of hospital if underutilized | As an FQHC Look-Alike, it does not yet qualify for Federal 330 monies or Federal malpractice insurance. | Affected by changes in healthcare policy |
| Notes | Pays low rent to the school in exchange for space. In return for low rent, this clinic provides services to the school free of charge. However, the main mission of the health center is to provide services to the community surrounding the school. The existence of the health center is part of Beth Israel's mission to serve the community. | See about 10,000 patients annually; targets medically underserved areas and populations | Center sees at least 13,000 patients annually; center will not deny care to anyone, multilingual doctors available, very good outreach to the community & preventive care incentives, large & well-designed building |

| Model Name | ELIZABETHPORT COMMUNITY HEALTH CENTER | TRI-CITY PEOPLES CORPORATION HEALTH CENTER | DENTAL MODEL |
|---------------------------|--|--|---|
| Model Type | Nurse Practitioner, University Affiliated | Stand-Alone Health Center | Dental |
| Services Offered | Primary Care, Holistic Well Care, Acute Care, Pediatric Care, Ob/Gyn, Health Education & Screening | Primary Care, Ob/Gyn, Screenings, STD Treatment, WIC Nutritional Counseling, Limited Senior Services, Immunizations | Emergency dental care or total care (depending on budget) |
| Funding Sources | 5 year grant (Health Resources and Services Administration, Bureau of Health Professions, Special Projects); University Funds; Hope IV Grant; County Services Block Grant; University Funds | CDBG; Health Department Grant | Possible donated dental services. |
| Annual Operating Costs | \$227,000 | n/a | \$80K+, dentist salary; \$30/hr, hygienist; \$12-14/hr, dental assistant; \$25K/yr, general anesthesia insurance; dentist's insurance, \$3K to \$25K/yr. Costs may be avoided by contracting with outside dentists. |
| Benefits | Nurses do home visits; city owns building and does maintenance; center has relationships with several specialty clinics in the area for patients who need to be referred; Nurse practitioners have a better reputation than doctors for giving lots of time for each patient visit | Good contact with the community; run by community groups | Will be able to offer direct dental service to patients. |
| Drawbacks | Patients sometimes are seen by student nurses; specialists sometimes do not want to take a referral from a nurse practitioner—they only want to deal with physicians. | Funding can be problematic, especially when/if grants run out; reliance on small grants makes needed expansion difficult; because large amounts of stand-alone funding are difficult to get, stand-alone health centers sometimes cannot offer comprehensive services | Start up costs of \$125K to \$250K to get office established. |
| Notes | Center sees about 4500 patients annually; center has a relationship with Rutgers Newark, which provides drugs at cost, keep the drugs on site at the center, and send payment (this ensures that the patients will not neglect to get their medicine). | Sees women and children only | Since start up costs are very high, it may be better to team up with another health center to offer dental services as a combined effort, or to contract with other dentists through a capitated stipend agreement. |

APPENDIX F: FUNDING SOURCES FOR COMMUNITY HEALTHCARE

Private Grants in Healthcare

There are a large number of sources for private foundation grants. The best way to keep track of them is to visit the Foundation Center's web site (www.foundationcenter.org) and subscribe to their listserv that sends out notices of grant announcements and RFPs.

ABB Corporate Giving Program

- Provides grants to organizations seeking to improve health and welfare, particularly community health organizations not already funded by United Way, and organizations serving the disadvantaged.

Contact ABB
501 Merrit 7
PO Box 5308
Norwalk, CT 06856-5308

Alcoa Foundation

- Applications accepted year round for areas of education, health and welfare, cultural, civic and community, and youth organizations.

Contact 425 6th Avenue
Pittsburgh, PA 15219
412-553-2348

Dr. Scholl Foundation

- Grants for AIDS services and research, healthcare and health services and family services. Grants range from \$10,000 to \$100,000 but cannot be used for public education, general or continuing support of deficit financing.

Contact Pamela Scholl, President
11 S. LaSalle St., Suite #2100
Chicago, IL 60603
312-782-5210

Healthy Tomorrows Partnership for Children Program (HTPCP)

- Grants up to \$50,000 for 5-year community based child health project

Contact Jane Bassewitz, HTPCP Manager
1-800-433-9016 ext 4750

Hearst Foundation

- Funding available for education, health, social service, and culture programs. Eligibility requirements are broad.

Contact 888 Seventh Avenue, 45th Floor
New York, NY 10106
212-586-5404

Johnson and Johnson Community Healthcare Programs

- Provides funding up to \$50,000 for organizations providing innovative care and access to medically underserved populations, and those promoting awareness of health risks to special needs populations, especially women and children.

Contact Tina M. Rasheed, Coordinator

Johnson & Johnson Community Healthcare Program

Morehouse School of Medicine

Dept. of Community Health & Preventive Medicine

720 Westview Drive, SW

Atlanta, GA 30310

TEL. (404) 752-1924

Robert Wood Johnson Foundation (General)

- Accepts unsolicited grant requests throughout the year but only funds about 12 percent of them. Also, watch for their national competitive grant deadlines throughout the year. Of interest to the foundation is whether they are the most appropriate source of funds for the purpose, and innovation is particularly highlighted.

Robert Wood Johnson Foundation's Faith in Action Program

- Funds are available for developing Interfaith Volunteer Caregiver coalitions serving people with chronic health conditions, bringing together religious communities, centers, and community organizations. Funding awards are specifically focused on programs designed to treat low-income populations.

SmithKline Beecham SHARE Grants

- In partnership with the University of Pennsylvania's Institute on Aging, grants are targeted toward organizations seeking to improve the health of the aging population who encounter access barriers related to income, race, culture, or ethnicity. Therefore, Grants are awarded to organizations that provide "culturally sensitive" healthcare, recognizing that health practices may be very different from the beliefs that the older population holds. Two-year grants of \$20,000 are available to new start up centers.

Starr Foundation

- Grants range from \$10,000 to \$250,000 to organizations in healthcare, public policy, human needs, culture, and higher education.

Contact Florence A. Davis, President

70 Pine St., 14th Floor

New York, NY 10270

Volunteers in Health Care (VIH)

- Mini-Grant Program: Subject specific, up to \$5,000. Topics change annually. This year's grants were available for:
- Developing an interpreter services program for healthcare providers serving a non-English speaking population

- Developing a Clinic Volunteer program for planning, staffing, and implementation of the program. One in five VIH centers do not use volunteer clinicians, in part because they don't know how to set it up.
- Developing a Chronic Disease Program: A survey of VIH clients revealed that 89 percent of centers see patients with diabetes, 83 percent see patients with cardiovascular disease and 31 percent see patients with some form of cancer.
- Computer Scholarship Program for up to \$2,000 for volunteer staffed centers

VIH developed RxAssist:

- rxassist.org
This web site has a search engine for healthcare providers that allow you to find Pharmaceutical companies with patient assistance programs, frequently distributing a limited number of drugs free. You can search by brand name or generic name.

Public Grants in Healthcare

Community Access Program (CAP)

- Originally called Community Health Care Access for Uninsured Workers Program. It began under the Clinton administration and it is supposed to continue for 5 years. The applicant can be a small non-profit but the application needs to show experience providing care to the uninsured and underinsured, so a co-applicant or pass through applicant is recommended.
- Grant size will average one million dollars
Contact HRSA NY Field Office
Manley Khaleel
Chief, Primary Care
212-264-2549

Healthcare for the Homeless (Health Center Grants for Homeless Populations)

- Grants to nonprofits and public entities for 1) primary healthcare, 2) 24-hour substance abuse treatment, 3) referral to appropriate medical facilities, 4) referral of mentally ill patients to appropriate facility, 5) outreach to homeless on primary care resources and substance abuse services 6) aid in establishing eligibility for assistance, and aid in obtaining services under entitlement programs.
- No matching requirements
- Submit application to HHS
- Grants range from \$62,000 to \$2,000,000
- Contact the HRSA NY Field Office

New Jersey State Grants⁴:
(Dept. of Health and Senior Services)⁵

HIV Counseling and Testing/Notification Assistance Program (01-41-AIDS)

- Grants to health centers and other care providers ranging between \$20,000 to \$450,000
- Funding renewed on an annual basis, but it was continued from last year.

Ryan White II grants for private non-profits and other care providers between \$10,000 to \$1,000,000 for a 12-month period beginning April 1, 2001. Grants are for developing ongoing treatment programs for HIV/AIDS families, particularly marginalized populations.

- In general, the state has a few grant programs for AIDS treatment that run on an annual basis with same funding range.

Ryan White Comprehensive AIDS Resources Emergency(CARE)

- This type of Ryan White grant is particularly important to community health centers, it serves as the payment of last resort in an effort to fill the gaps in HIV/AIDS care funding

Contact, Counseling and Testing Services Unit
 Division of AIDS Prevention and Control
 P.O. Box 363
 Trenton, NJ 08638-0363
 TELEPHONE: (609) 984-6125
 FAX: (609) 292-4244

Adolescent and School Age Health Services (01-6-CHS)

- Grants available for preventative dental health and oral health programs, nutritional education and physical fitness to prevent osteoporosis, substance abuse prevention, and youth violence prevention through community partnerships to reduce risk-taking behavior.
- Grants available to private non-profits and other healthcare providers.
 Contact: Office of the Director
 Maternal, Child, and Community Health Services
 50 East State Street,
 P.O. Box 364
 Trenton, NJ 08625-0364

⁴ The grants that are profiled here were selected because they were a concern or issue to the community and health care professionals.

⁵ There are grants that will only be available to a public entity or larger network or system of providers. Pass-throughs should definitely be considered.

TELEPHONE: (609) 292-9280
FAX: (609) 292-3580
Email: ds5@doh.state.nj.us

Family Planning (02-40-FP)

- Grants support family planning services for low income residents of NJ
- Eligibility is broad, must be a licensed ambulatory care facility
- Must be a Medicaid provider
- Funds are earmarked from Tobacco settlement

Contact the Office of Maternal and Child Health Services

Diabetes Control Services (02-49-SCH)

- Health centers and community-based organizations may apply for a \$95,000 grant to implement diabetes related activities at the local level.

Contact: Elizabeth Solan
New Jersey Dept of Health and Senior Services
P.O. Box 364
Trenton, NJ 08625
TELEPHONE: (609) 984-6137
FAX: (609) 292-9288
Email: esolan@doh.state.nj.us

Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

- Non-profit health agencies and community actions programs can apply for a grant to improve health and nutrition access and awareness among WIC participants

Contact: Deborah Jones, Director
NJ State WIC Services
P.O. Box 364
Trenton, NJ 08625
TELEPHONE: (609) 292-9560
FAX: (609) 292-3580
Email: djones@doh.state.nj.us

Child Health (02-39-CHS)

- Non-profit agencies may apply for this grant that focuses on preventative care, risk assessment, and case management for children at risk of developmental problems
- Prevention and remediation of lead poisoning for children under age six
- Promote awareness of child health problems by educating healthcare professionals.

Contact: Office of the Director
Maternal, Child and Community Health Services
50 East State Street, PO Box 364
Trenton, NJ 08625

Primary Prevention of Alcohol and Drug Abuse (02-7-ADA)

- Non-profit organizations and licensed healthcare facilities may apply for grants ranging from \$20,000 to \$460,000
- Grant awards will fund provision of primary preventative services to communities, families, and individuals who are at high risk of drug and alcohol abuse and misuse.

Contact: Richard T. McDonald
Division of Addiction Services
P.O. Box 362
Trenton, NJ 08625
TELEPHONE: (609) 292-4414
FAX: (609) 292-3816
Email: rmcdonald@doh.state.nj.us

Treatment Services to Women (02-4-ADA)

- Non-profit organizations may apply for a grant between \$50,000 and \$500,000 to provide outpatient addiction services, including transportation, to women, pregnant women, and women with dependent children.

Contact: Wanda Cintron
Division of Addiction Services
P.O. Box 362
Trenton, NJ 08625
TELEPHONE: (609) 292-7232
FAX: (609)-292-3816
Email: wcintron@doh.state.nj.us