

INDIGENT CARE SUCCESS

The monthly advisor for professionals and executives who manage and fund healthcare for the medically uninsured and underserved.

Unsuspected Eligibilities Discovered:

Health System Nets \$38 Million by Improving Enrollment Process

Your apparently indigent patients may not be completely without resources or entitlements. In fact, many are eligible for more coverage than they — or you — realize. Find this money and ensure your financial survival. Here’s a step-by-step look at how one safety net provider screens its patients to uncover previously untapped sources of funding. They’ve been successful to the tune of \$38 million *new* dollars over the past three years.

Denver Health (DH) is the only major provider in its area caring for the indigent. DH serves 160,000 individuals — about one in four Denver residents. Few have private insurance, and 36% have no payer source at all — not even Medicaid. Of the patient base, about 23% indicate that Spanish is their preferred language. DH includes a network of clinics and Denver Health Medical Center, a 320-bed hospital.

To increase enrollment of eligible individuals into publicly sponsored programs such as Medicaid, the Child Health Plan Plus and the Colorado Indigent Care Program, DH reinvented its approach to enrollment. The comprehensive enrollment process involves a screening interview, help with the application and tracking of the application.

The redesign became self-sustaining quickly, explains **Elizabeth Whitley, RN, PhD**, project director, Denver Health Community Voices. DH recovered its initial investment in six months. The start-up money was provided by a W.K. Kellogg Foundation grant as part of its Community Voices: Healthcare for the Underserved program for safety net providers.

Thinking of implementing such a system? The payoff can be dramatic if you follow the tips from DH.

Assess the Situation

One of the first tasks was to assess the current process, and the employees were the key. DH looked at who was conducting enrollment and how they were doing it. It was, Whitley says, quite inefficient. Clients were waiting in the same lines for care and to sign up for Medicaid. Some of the staff signing up people often

seemed to make the process unpleasant, which discouraged enrollment. Moreover, there was no way to track enrollment. Obviously, a change was in order.

Make Enrollment a Dedicated Function

DH redesigned the process to include centralized application assistance and enrollment support. There are now 35 dedicated enrollment specialists, more than half of whom are bilingual, with at least one available at almost every DH site.

Hire the Right People

The enrollment employees, who take applications and conduct interviews with those signing up, have at least some college and receive customer service training. Even then, it took some additional tweaking. For instance, just last year, management identified a problem with recruiting and retaining. They were looking for what Whitley calls the most “hoping, caring and sharing employees.” That was nice, but it wasn’t what the job was about. The job called for someone who could conduct an organized interview and enter the data, so they adjusted the job requirements and changed the ads and job interviews accordingly.

On average, an enrollment specialist at DH should be able to complete seven applications a day, says Whitley. The time required to complete an application depends on

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the particular situation; for example, how much documentation the applicant brings and family size.

Strongly Encourage Screening

At DH, everyone must be screened for eligibility unless they have outside insurance or are self-pay. But no one is turned away if they don't qualify for assistance. Various programs have different requirements. To screen for everything, you need:

- Proof of address (some programs have state or local residency requirements);
- Social Security number (including those of children);
- Income verification: Paycheck stubs or a letter from the employer showing gross earnings for previous month (if self-employed, most recent business ledgers and expenses);
- Documentation on any other health coverage;
- Documentation of living expenses;
- Pregnancy verification, if applicable;
- Proof of payment for childcare, dependent elder care, child support, alimony, health insurance and medical expenses.
- Immigration documents, if applicable; and
- Approval/denial letter from Medicaid (if one was received).

Spread the Word

The enrollment process must start before the person walks through the door seeking medical attention, Whitley emphasizes. Five bilingual enrollment specialists work in the underserved communities through schools, churches, community events and other community organizations. Two of them are stationed at the Department of Human Services.

Brochures in English and Spanish are available throughout the community, detailing what documentation is required.

"If the outreach worker has done a good job, the person arrives on the scene for an enrollment with the [necessary] documentation," says Whitley. This is critical, since the number one reason for denial is lack of proper documentation.

Robert Esquivel, one of the enrollment specialists based at the South Street Clinic for the homeless, explains that applicants have three months to provide proper documentation. "Of course, we don't tell them that ... they'd never bring it." He tells them they have a month. Those who don't bring in the documentation are billed. "The minute they get the bill in the mail, they are knocking on my door," he says.

Note: Patients don't need to be screened to use only the South Street Clinic, but they must be if they are referred to the hospital for any service.

It took about a year to develop awareness. "At first, no one knew who I was. I didn't think I was ever going to get busy." Now? "There are tons of people coming in," Esquivel says. Not all come to be screened, but most are at least asking about the process.

In addition to the brochures, the clinic also distributed a postcard-size flyer in the community. The copy is in English and Spanish and states:

"Homeless but still protected. No matter where you live, you can be protected from living with the pain of a serious illness or injury. Stop by the South Street Clinic of the Colorado Coalition for the Homeless to meet with the Denver Health Enrollment Specialist and to see if you qualify for medical benefits and programs.

"Bring this postcard to the South Street Clinic to see if you qualify for medical benefits or programs. Ask for the Denver Health Enrollment Specialist." The address and phone number are included on the flyer.

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Indigent Care Success (ISSN and USPS numbers applied for) is published monthly by The Indigent Care Institute, a unit of PubWorld, Inc.
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Postmaster: Send address changes to *Indigent Care Success*, 851 Fifth Ave. N., Suite 102, Naples, FL 34102-5582
Customer service: (800) 645-1338 E-mail: service@indigentcare.org
Rates: USA: 1 yr. \$298; 2 yrs. \$561 (save \$35); 3 yrs. \$842 (save \$52)
Bulk prices available upon request.
Credit cards accepted: Visa, MasterCard, American Express, Discover

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Such outreach also allows enrollment before the patient needs care at the hospital or one of the Denver Health clinics.

Automate

Tracking applications through approval or denial is crucial, and automation makes that possible. Denver Health developed and implemented a comprehensive application tracking database, AppTrack, which allows it to track the progress of applications, monitor volume and provide quality control.

“The beauty of AppTrack is that once someone comes in to apply, they are in our system. We can see if all their documentation is complete and the status of the application,” says Whitley. In the past, individuals would start to sign up, not finish, and then sign up again another day.

“Traditionally, the biggest challenges with screening are identification of the patient to eliminate duplicate records and collecting the appropriate data to complete the application process,” explains **Craig Dahl** of Interlink Group, which worked with DH and subsequently launched HealthTrack, a commercial version of AppTrack.

An added benefit of automation is that it’s a management tool. It allows Whitley to track employee productivity, including the number of applications processed and approval rate. The system can stand alone, but ideally, it should be integrated, to avoid duplication of efforts. For instance, according to Dahl, collecting the billing data at the point of care allows it to be fed into the hospital’s automated billing system. Patients who can pay a portion of the cost can be billed.

HealthTrack is a Windows-based application that provides users with a central repository to enter, modify and track an application’s status within the process. It provides on-line inquiry capabilities on an application’s status throughout its entire process.

You can contact HealthTrack at www.healthtrack.com or (800) 529-1660.

Collaborate

Progress in the facilitated enrollment initiative is the result of collaborative relationships with state and county officials from several entities, including Medicaid, Human Services, Health Care Policy and Financing, Child Health Advocates, and the Division of Insurance. Representatives from each of the groups met monthly from 1999 through 2002.

“The only reason this is a success is because we brought all of our partners and collaborators to the table ... dreaming, scheming and problem solving together,” says Whitley.

Since everyone recognized that there was room for improvement, buy-in wasn’t a problem. The collaboration wasn’t only at the planning level, but at the front line. One example is Esquivel’s presence at the homeless clinic. Another is the fact that the Medicaid clerks, who process enrollment applications after the enrollment specialists finish, are located on-site.

Monitor Flow

It may take further fine-tuning to get the screening system to optimal efficiency. At first, enrollment specialists took appointments. But that wasn’t efficient. Walk-ins would want to enroll but every specialist was booked. And there’s the problem of a 50% no-show rate. So now, it’s generally a first-come, first served approach.

When appointments are made, the specialists double- and triple-book to allow for no-shows. When it gets particularly busy, they will do group enrollments. Other staffers will help pass out applications and check paperwork and make necessary copies before sending the individuals to an enrollment specialist. It takes time to get a sense of what’s “normal,” from the 50% no-shows to the seven completed enrollments per day.

Other questions to ask about the process:

- What causes the backlog?
- Which times are busiest?
- Which enrollment locations are the busiest?
- Are there patterns regarding which clients fail to bring adequate documentation?

“Analysis of the workflow process is critical to ensure the right steps are followed at the appropriate points in time,” says Dahl. It ensures that the screening process is completed. “This is where the real ROI [return on investment] resides — in ensuring the client is enrolled in a benefit program and the care provider is reimbursed for services rendered.”

Be Patient

DH has more than recouped its outlay, but the refinement process continues. Whitley and everyone else involved keep reviewing the process, from processing enrollments to money recouped to employee turnover. And the system needs to be adjusted as guidelines about public funding programs change. “Be very patient,” counsels Esquivel. “There are always going to be lots and lots of holes to fill in. The process takes years of implementing protocols and procedures.” ■

“Project Access” Brings Healthcare to Working Poor in Dallas

According to the Dallas County Medical Society (DCMS), there are about 500,000 citizens in the county, whose largest city is Dallas, who do not have health insurance of any kind. About half of that population is covered by services at Parkland Hospital, a public institution. The other half seeks care in the emergency departments of other hospitals or, says **Connie Webster**, Director of Community Service for DCMS, “intimidated by barriers to access, goes without healthcare services until their health is too far gone for care to be effective.”

In 2000, the Health Texas Provider Network (HTPN), another physician group, partnered with DCMS to locate a model that another organization had used successfully to solve the problem of providing healthcare services to an indigent population. Three years earlier, HTPN established a collaborative effort with the Central Dallas Ministries to provide primary care in the downtown area of Dallas.

Although that arrangement showed great success, it left many indigent without adequate access to specialty and institutional care. The new partnership intended to rectify that deficiency.

DCMS found its model in Buncombe County, N.C., where the county medical society established “Project Access” (PA) in 1994. A site visit by DCMS staff determined that this arrangement, adapted to the situation in Dallas County, was a perfect answer. There are 20 physician-led PA programs in the United States. The most recent one is in Santa Fe, N.M., but the Dallas County Project Access is still the largest, and the only one serving a major urban population.

Creating a Network of Providers

The first step in creating the DCMS PA was to develop a network of providers, provider organizations and funding sources. Physicians were recruited through DCMS and HTPN. Central Dallas Ministries provided access to faith-based and other medical clinics. The Dallas-Ft. Worth Hospital Council coordinated efforts with local hospitals. Finally, the Dallas Academy of Medicine, the charitable foundation of DCMS, managed funding.

PA applied for and in 2001 received a Center for Communities in Action grant from the Health Resources Services Administration of the federal Department of Health and Human Services. This grant allowed the project to begin

implementation of its program; the funding was renewed in 2002. Project Access in Dallas enrolled its first patient in April 2002. Funding for 2003 seems assured, according to Webster. The federal grants are being augmented by grants from local foundations and organizations and through charitable giving by individuals and organizations. Fundraising is an ongoing activity of the project.

Key to the success of PA, according to Webster, is its network of volunteer physicians. Each doctor who participates in the project agrees to a specified number of patient visits per month, with two being the minimum. Webster says that nearly 10% of the DCMS membership currently participates in the program and 2,200 patient visits were pledged for 2002. Physician participants cover the entire range of medical specialties. Webster expects expanded physician participation as PA becomes better known in the community.

Eligibility Requirements

The project is targeted to the working poor. Residents of Dallas County who meet all of the following conditions are eligible for the project:

- No health insurance coverage of any kind, including state and federal health programs.
- Annual income below 200% of the federal poverty guideline.
- Employed at least 20 hours per week or has been unemployed for less than six months.

Initial enrollment in the program is for a six-month period, but an extension may be granted if eligibility continues and continued treatment is necessary.

Enrollment may take place at medical clinics and other sites that participate in PA. Specially trained healthcare professions called community health workers (CHWs) conduct initial signup and monitor all clients. Each client in PA is provided with an ID card that indicates he or she is eligible for project services. Clients are notified two weeks in advance of expiration of their ID cards.

Community Health Workers

CHWs are critical to PA, according to Webster. In addition to ensuring eligibility and enrolling individuals in the project, they make all initial appointments and maintain records on all encounters with the project. Patients may make subsequent primary care appointments themselves.

All specialty appointments must be cleared by CHWs. Although PA patients are not billed for services, providers

file a standard CMS 1500 claim form with the project to monitor the amount of care provided under its direction. Information summarized in these reports is fed back to providers so they can understand the financial value of the services they have volunteered. The CHWs are responsible for determining the need for, and finding, social services required by PA clients.

Webster points to the relationship between healthcare status and other social conditions and says that the community health workers are instrumental in maintaining the overall well-being of their clients. The most frequent problem solved by CHWs, she says, is language barriers.

CHWs must have high school diplomas. All are subjected to a rigorous training program to ensure that they have the requisite skills to make referral decisions. They also assist patients in maintaining their own health and in navigating the project's healthcare network as independently as possible. A key part of their responsibility will be patient education.

Outcomes Measurement

The University of Texas Southwestern Medical Center in Dallas and the University of Texas at Arlington have undertaken ongoing studies of the outcomes of PA care. Elements of the measurement process include:

- A process evaluation designed to measure the progress and quality of PA activities.
- A program evaluation. Patients, staff and providers will be surveyed and interviewed, and indicators of patient health status and emergency department use will be developed.
- A determination of social outcomes related to the presence of PA.
- A rigorous evaluation of the CHW model.

More information on the Dallas County Project Access may be found at www.projectaccess.info. Information on the Buncombe County effort is available at www.projectaccessonline.org. American Project Access Network, founded in Asheville, N.C., to assist other communities adapt the model, may also be accessed at the Dallas County Web site. ■

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Cancer Clinic Develops Small-Scale Solution to Transportation Challenges

Transportation remains a significant barrier to healthcare for the poor, particularly in rural communities, where patients may live more than 100 miles from the nearest healthcare facility that has services for the uninsured. But some indigent-care facilities are finding solutions, including a small cancer clinic in a rural and often poverty-stricken region of South Carolina.

The McLeod Cancer Clinic is an outpatient facility serving 154 cancer patients, most of whom make regular visits. These patients have no third-party coverage (including Medicaid) and meet the South Carolina Department of Health and Environmental Control guidelines for financial assistance. They must be referred to the McLeod Cancer Clinic by a physician, and must have a biopsy-proven diagnosis of cancer.

The clinic is part of McLeod Health, based in Florence, S.C., a locally owned, not-for-profit health system that covers a 12-county, mostly rural, region in northeastern and coastal South Carolina called the "Pee Dee."

Identify the Problem

Linda Samuel, LMSW, oncology social worker at McLeod Cancer Clinic, began to keep track of the patients who couldn't make it into the clinic for their regular chemotherapy or radiation treatments. She discovered that transportation problems resulted in approximately 30 missed appointments per month.

Either the patients didn't have access to a car or couldn't afford gas. Clinic patients, on average, have to drive 40 miles (round-trip) for treatments; a few come from as far as 80 miles away. Samuel tells of one patient who completed five cycles of treatment but couldn't complete the sixth because she didn't have the money to pay someone to bring her to the clinic.

Samuel also identified a related problem: On occasion, a patient will need to go to the University of South Carolina in Charleston, two hours away, for more advanced treatments. Many of her patients lack the means to make such a trip. Samuel reports that arranging a trip to Charleston for one of her patients took several days and involved at least 16 hours of her time to find transportation and funding.

She came up with a solution. Last fall, she launched the Loving Initiative for Transportation (LIFT) program,

which provides transportation assistance for patients in her clinic. She requested and received a \$5,000 grant from the McLeod Foundation. She used the following computations to arrive at the figure:

- Average travel distance is 40 miles.
- 40 miles x 34 cents (the state mileage rate) = \$13.60
- 30 missed appointments per month x 13.60 = \$408.00
- \$408 x 12 months = \$4,896.00
- + \$101.00 (for one trip to Charleston) = \$4,997.00

The result is fewer missed appointments and better use of the clinic's resources.

Create a Plan

Samuel offers the following tips for creating a transportation program:

- **Quantify need.** You may have a sense of who needs transportation to your clinic, but you won't know what the demand is until you start tracking the numbers. Samuel documented how many patients missed treatment because of transportation problems. This let her know what sort of program to develop, and it armed her with the data she needed to receive the grant.

- **Start small.** The volume is low — and that's by design. The program is still in its infancy, and Samuel is seeking additional funding sources to expand it. But since she has to run it herself, it made sense to create a manageable program that had room for expansion.

- **Set limits.** The program is limited to patients in the cancer center. To participate in the transportation program, the clinic patient must have a written referral that includes income sources and the reason for the request. She doesn't depend solely on the referrals: "Most of the time, I know who needs help." When the program first started, some of the physicians thought it was open to all cancer patients in the McLeod system, and they started referring patients. She also received calls asking if she had transportation funds available. For the most part, she had to decline. "If I opened that up, the money would be gone the next day." Patient transportation is one program you don't want to spread the word on until you know you can meet the demand. She makes occasional exceptions for other cancer patients in the McLeod system, but it's on a case-by-case basis. "If I can help someone in a dire-need situation, maybe once, then I will."

- **Collaborate.** By consulting with local social service agencies, Samuel found a driver who volunteered to provide transportation for 34 cents per mile, the state's

mileage reimbursement rate. The driver, a retiree, provides similar services for Florence County Department of Social Services, so he already had an acceptable vehicle with all the necessary insurance coverage. (Not all attempts at finding transportation resources will have such serendipitous outcomes, but networking and collaboration greatly expands your possibilities.) Samuel is working with social service agencies in other counties to identify potential drivers who can serve as backups; she has already lined up a second driver who will work, when needed, under the same arrangement. Having this pool will allow the program to expand at a later date.

- **Combine strategies.** In addition to hiring a driver, Samuel distributes \$5 and \$10 vouchers to qualified patients to purchase gasoline at a local gas station. Each month, the station sends her the bill based on the number of vouchers received. (The station doesn't provide a discount.) The vouchers not only help those who have cars, they also make it easier for patients to ask for rides from friends and family, since they can reimburse the driver. "Sometimes, they can identify someone who will bring them to an appointment, but they may not have money to pay them," she explains. ■

Pharmacy Revamp Saves More Than \$5 Million Yearly

Drug costs aren't going down but you *can* keep them in check while still providing for your indigent patients. Parkland Health & Hospital System (PHHS), operated by the Dallas County Hospital District in Dallas, is the primary source of care for the county's medically underserved. It includes a 964-bed county teaching hospital/level-one trauma center, and a network of primary care and specialty clinics. Since initiating a pharmacy redesign in 1995, it has seen increases of approximately 5% to 7%, compared to national rates of 15% to 20%, and saved more than \$5 million annually.

Just as significant, the redesign allowed Parkland to continue providing ambulatory prescription services to indigent patients — 49% of its patients have no coverage, not even Medicaid. Many other public hospitals have had to abandon such programs, notes **Vicki Crane, MBA, RPh**, vice president, pharmaceutical and material services. Pharmaceutical services are provided at all sites through a single, closed and closely monitored network. The PHHS

Department of Pharmacy Services fills approximately 1.9 million ambulatory care prescriptions and dispenses approximately 2.1 million inpatient doses annually. In 2002, it had a \$60 million budget, which was spent on approximately 300,000 patients.

A crucial element of the redesign is an automatic drug exchange program. A prescription is automatically exchanged by the pharmacist from a nonformulary, noncontract drug to a formulary, contracted and cost-effective equivalent. This streamlines the process and minimizes variations in drug treatment. Not only is this approach more cost-effective, but it helps ensure that each patient receives appropriate treatment. Exceptions are made when the formulary medication doesn't work for a particular patient (about 1% of the time).

Science is First Consideration

To implement a cost-saving pharmaceutical program, you can't think about money. Not at first, anyway. It's all about evidence-based medicine. "We go through a very stringent process with our Pharmacy & Therapeutics (P&T) committee to make sure drugs are truly equivalent," Crane says.

The committee reviews:

- Efficacy;
- Safety and side-effect profile;
- Impact of drug on special patient populations

(elderly, immunocompromised, neonates, etc.);

- Compliance issue (e.g., a drug that needs to be taken four times a day vs. a one-a-day drug; pill size, etc.); and
- Cost.

"We don't get down to the cost consideration until all the therapeutic factors are deemed to be satisfactory," Crane says. Only after a drug is identified as equivalent does money come into the equation.

Tip: Those charged with identifying new additions to the formulary bring them to the P&T committee early in the pipeline, so the panel can consider them before the marketing blitz hits.

There are exceptions: Certain drugs needed for special situations, such as a rare disease or cases where a patient is unresponsive to the approved medication, are available on a restricted basis. Since these drugs are often considerably more expensive (and sometimes more toxic), they are placed under specific restrictions.

The therapeutic exchange programs saves Parkland at least \$5 million per year compared to what it would pay without the program, explains **Christopher A. Hatwig**,

MS, RPh, FASHP, director, ambulatory care pharmacy. "We know this because as Parkland's key negotiator with the drug manufacturers, we know what we pay for drugs at Parkland with our negotiated contracts versus what other public hospitals pay for the same drugs that do not perform therapeutic equivalency bids and negotiate pricing."

It works at the clinical level as well. Crane tells of one year when the FDA withdrew five drugs; the committee had previously rejected four because of the safety profiles. "It took the FDA a year to catch up with our process," she laughs. The fifth had made it to the formulary, but had been pulled once the side effects became clear.

Using Leverage

One key to PHHS's success is the knowledge of the pharmaceutical game and how to use it to secure medication for its indigent patients. "We fully understand the 340 B (PHS) legislation and know how to maximize its benefits for Parkland and our patient population. We have a full understanding of the pharmaceutical industry and their strategies," Hatwig explains. And, he adds, "We are very assertive in contract negotiations."

When the P&T committee bids out the process, it doesn't simply look at acquisition costs. Members factor in what else the pharmaceutical company has to offer, such as patient education materials, perhaps most significantly, the pharmaceutical company's patient assistance programs (PAPs). "That's money that goes right to the bottom line," notes Crane.

PAPs vary widely. But since it has the leverage of market share, PHHS can take full advantage of the best programs — and reward drug makers in the process. A generous PAP can sometimes trump acquisition cost and make or break a deal.

Win Buy-In Through Education

The evidence-based approach not only helps ensure quality control, it generates physician support, and physician buy-in is critical. In fact, in Texas, it's essential: State law requires getting physician permission before doing an automatic medication exchange.

That means winning over the physicians. No matter how good the process, unless the physicians understand it, it may look like nothing more than a cost-cutting, Crane warns.

Taking an evidence-based, scientific approach demonstrates that your objective isn't to cut corners. Some of the physicians were skeptical at first, but the process won them over. "Our physicians are scientists. We went

through a scientific process, and that alleviated their concerns somewhat,” Crane says. She’s also able to point out that that top level physicians have given their blessing. Once they hear the whole story, naysayers are generally convinced, she reports.

It’s an ongoing process. Crane makes a point of following up with the physicians regularly, seeking input on protocol development and possible new drugs on the horizon.

Empower the Pharmacist

Getting physician buy-in allows the pharmacy to bypass considerable red tape. “The program is very effective here because our pharmacists are granted authority by the medical staff to make the conversions at the time the prescription is being processed at the pharmacy with minimal phone calls to the medical staff,” Hatwig explains.

Most patients get their prescriptions filled or refilled every 30 days; therefore the pharmacy can complete a product conversion within about 60 days on average, explains Hatwig. “This is incredibly quick in comparison to managed care plans and provides us leverage in negotiating pricing with manufacturers.”

The pharmacists are key to the program, says Hatwig. Not only do they perform the conversions at the time the patients come in to pick up their prescriptions, but they handle all patient education regarding conversions.

Ensuring that patients understand the system is a particular challenge at a facility like Parkland, whose clientele may have low literacy or inadequate English, Crane notes. They need to understand that although (for instance) the color of the pill changed, the other issues remain.

“You have to come to where the patient is — you can’t expect the patient ... to know what renal dysfunction is,” says Crane. “You need to tell them that if they are not peeing, that’s a problem.”

Among the pharmacists’ educational tools are pictograms and patient counseling sheets written on the third-grade reading level in both Spanish and English. But those pale in significance compared to the direct interaction between the patient and pharmacist. Cultivating that trust is essential, and it helped make the implementation go more smoothly.

Maintaining patient trust is essential to the fiscal bottom line, Hatwig notes. “If the pharmacists did not do their jobs at the patient counter, we would not have the leverage we need at Parkland corporate to negotiate the lower prices. Drug companies will only respond with lower pricing with a customer that can effectively move market share.”

Communication is Key Ingredient

It all comes down to communication and education, Crane insists. “Include people in the decision process who will be impacted by the process.” If any shareholder along the way is left out, the system is likely to fail. That process goes beyond the doors of PHHS. When the automatic exchange was first proposed, community leaders and advocacy groups were concerned, and Parkland had to respond; Crane was tapped to make the case.

In layperson’s terms, she discussed evidence-based medicine and walked them through the process. She also reminded potential critics that in order to maintain the ambulatory prescription program for the indigent, everyone had to work together to make it work. And they understood.

Winning buy-in takes time and repeated explanations. Throughout, Crane has been “champing at the bit,” she says. But at each step she pulls in the reins and walks through the process. “If I can’t demonstrate it by evidence, perhaps I need to change my opinion.” ■

Eleven Tips for Crafting a Winning Grant Proposal

One of the most prominent granting sources in the U.S., the Local Initiative Funding Partners (LIFP) program of the Robert Wood Johnson Foundation in Princeton, N.J., offers suggestions about why grant proposals succeed or fail. Following their suggestions will help you write a winning proposal.

1. Follow Directions

“People don’t read ... that’s a frustration,” observes **Pauline M. Seitz**, director of the LIFP program. She’s been reviewing grant proposals from indigent care providers for more than 15 years.

Seitz sees submissions from clinics and public hospitals all the time — organizations with very worthy ideas — that simply don’t abide by the guidelines.

The ability — or inability — to follow directions can be very revealing. “It’s paying attention to detail. The ability to follow direction is a reflection of organizational capacity,” she says.

Even if the request doesn’t seem to make sense, follow it. “If a funder asks you for 10 copies, they have a reason,” says Seitz.

Sticking to the guidelines has paid off for **Nilda I. Soto, MD**, medical director of the Open Door Health Center in Homestead, Fla. Her successful proposals include a \$1.2 million grant from the Health Foundation of South Florida to start a free clinic. Based on her experiences and what she's seen from colleagues, poor understanding of the guidelines and failure to do one's homework are two of the biggest mistakes indigent care organizations make.

2. Start Early

One reason Soto has been successful is that she allows plenty of time to do her homework; waiting too long is another mistake she's made — and has seen other indigent care organizations make, too.

Her preparations start “as soon as the possibility of applying for the grant is even considered,” she says.

“Writing a grant involves a lot of homework — information gathering, identification of possible collaborators, brainstorming sessions (preferably by a team) — and then coming up with the proposal that not only has a good possibility of being chosen as a project to fund, but one that is manageable.”

Start early enough that you not only meet the deadline for submissions, but get yours in early. You don't want your proposal to be lost in the crowd of those who wait until the last minute.

Before starting to write a proposal, identify the important elements in the guidelines and highlight them. In addition to the basics (number of copies, format, deadline, etc.) look for such things as:

- Is collaboration required?
- Are there geographic limitations?
- Do you have to be a federally qualified health center?
- Is the grant limited to a particular health condition?
- Does your facility have to treat a certain number of indigent patients to qualify?

Then write the proposal accordingly. When you finish, compare the proposal to the guidelines, Seitz counsels. “If you can get someone not invested in the process to read the application guidelines and then read the proposal, they will be far more likely to pick up a variance [than is someone involved with the proposal].”

3. Don't Force It; Customize

Seitz often sees organizations that try to force their mission to fit the parameters of the LIFP guidelines. “Because the need is so great and because the resources are so scarce, there's a temptation to think ‘I'll throw my hat in the ring anyway.’”

It's usually a waste of precious time. Even if you get the grant, it's not a good situation: “A forced fit is not a happy experience for anyone,” she says. “When it does happen — and some projects manage to wiggle through — they find themselves making a commitment to do something that is out of mission for their organization.”

The opposite applies, too: Customize. A template approach won't work. “When you've seen one foundation, you've seen one foundation,” laughs Seitz. Rather than sending out multiple applications to every funder you can find, it may be more useful to do fewer more-focused applications. Target your efforts to those granters who have funded similar projects to yours. For instance, if you want money for a prenatal program, applying to a funder focused on chronic conditions will probably be a waste of time, even if you could find some tenuous connection.

You can find detailed examples and calls for proposals on the Web pages of various granters. Organizations that fund indigent healthcare projects often include current projects and requests for proposals on their Web sites. For example:

- Robert Wood Johnson Foundation: rwjf.org
- Local Initiative Funding Partners: lifp.org
- California HealthCare Foundation: www.chcf.org/grantinfo
- W.K. Kellogg Foundation: www.wkkf.org/Grants/ (look under the health section)

Checking out a granter's Web site not only helps you see if you are a good match; you'll often see examples of winning proposals that will help you craft yours.

Soto's most recent application — which won \$125,000 from the Robert Wood Johnson Foundation under its “Building Community Support for Diabetes Care” national initiative — was, she says, a “perfect match” for the request for proposals (RFP).

4. Quantify

It's essential to provide solid numbers to substantiate the request, Seitz says. Too often, there's simply not enough hard, quantifiable data. “They waffle around the numbers.”

She sees a lot of what she calls “free-floating percents.” For instance, a clinic may promise to “improve access to care in our community by 95%.” But with no idea how many people live in the community, “you don't know what that 95% means.”

“It's always important that anything that's a percent is connected to a number, and I'm continually surprised at how many proposals I read don't do that. Either they don't have the numbers or they aren't completely thinking through how they are going to measure impact,” she explains.

“If it’s just a percent, it’s meaningless,” says **Martin Rickler, PhD**, director of The Paladin Group in San Diego, which provides grant consulting and tutoring, with an emphasis on healthcare and alcohol/drug treatment (including programs for the indigent and underserved). He suggests that, ideally, you want to demonstrate a six-to-one benefit for the dollars sought.

LIFP reviewers are looking at the actual number of people being served and how that compares to the dollars requested. Seitz offers an example: “In our community we are going to vaccinate 800 out of 1,400 children.”

Likewise, successful proposals have clear, detailed budgets. “One of the things that makes for a strong proposal is when you can read the budget and the budget narrative as a stand-alone document.”

5. Make It Visually Accessible

Too many proposals are visually challenging to readers, and that makes it hard on reviewers, who are reading hundreds of proposals. Seitz and her colleagues read more than 300 each year and quite a few of them are visually challenging.

“It’s really difficult when you get to one where the executive summary is one paragraph in single space for the entire page out to the edge of the margins. You’re not able to extract what’s in there as readily as you can from a proposal that presents that one-page summary with some bullet points, in paragraphs, in a spacing format that’s visually friendly.”

The typeface should be readable — 12 point is good, unless instructed otherwise. Assume that reviewers will be reading your proposal in all sorts of places, such as planes and trains, and that at least one of them wears bifocals.

But form isn’t everything, and the copy doesn’t have to be flawless, she stresses. “If anything, we are suspicious of [proposals] that are too smooth.”

6. Be Clear

A well-written, clearly stated proposal will advance farther than one where the readers have to read it four or five times to understand what the request is, explains Seitz. A strong introductory paragraph explaining exactly what you want to accomplish for a particular indigent population can set the stage and give the reviewer a sense of the scope of your application.

“It’s really helpful, when you finish writing your application, to give it to someone who does not know anything about your field. Ask them to read it and, in two or three sentences, tell you their impression of what you are asking for. If they can’t read your application cold and

pick out the points of who you are, what you need, how much you’re asking for, when you would use it and what difference it would make in your community, you need to go back and rewrite until anyone could pick it up and understand your request,” Seitz says.

For examples of good, short descriptions of winning programs, visit www.lifp.org/html/local.initiative.funding.partners.current.projects.asp.

7. Don’t Over-emphasize the Needs Statement

Unlike many organizations seeking grant money, indigent care providers generally don’t have to bend over backwards to demonstrate need to most funders. With the LIFP, in fact, focusing too heavily on the problems could hurt your chances.

The need, Seitz says, is a given. The LIFP focuses on healthcare to the underserved; she knows your needs are critical, your intent sincere. She wants details on how you will meet this need. Her advice? Write a clear, concise needs statement and then move quickly to the solution.

“The ones that go forward are the ones where there clearly are solutions to the problems they are presenting and where they have information on how they can measure and assess what progress would mean in their community,” say Seitz.

8. Proofread

With the advent of word processing, she’s seeing fewer typos and misspellings. But errors still happen. She’s never seen a proposal rise or fall because of typos, but, “If you send anyone a letter or a request for funding or proposal that is full of mistakes, it’s a reflection on organizational capacity.”

Some of the proofing errors she’s seen:

- Another foundation referenced where LIFP should be.
- Place holders such as (XXX) where there should be numbers.
- The classic public/pubic mix-up: “We see that all the time.”
- A guarantee that project results would be widely “decimated” (instead of “disseminated”).

It’s just another reason to have a disinterested outsider — a neighbor or friend, for instance — read the application, she notes.

9. Reflect the Community You Serve

Successful proposals reflect collaboration. For many funders, including the LIFP, it’s important to develop

partnerships with other organizations that serve your indigent clients.

“Remember that togetherness increases strength. A collaborative project has better chances to succeed, says Soto. What made her \$1.2 million proposal stand out, she explains, was availability of groups willing to collaborate with the proposed program — and the trust that already existed among the partners. Likewise, her recent \$125,000 grant stressed community collaboration. That, too, requires homework.

“Familiarize yourself with ... the availability of potential resources, both human and material, community support, the necessary leadership and their potential collaboration willingness,” advises Soto.

The LIFP in particular looks for collaborative efforts and “the authentic community voice in what we are reading,” Seitz says.

The letters of support are an important part of capturing that voice. “It’s important that ... every support letter that goes into an application represents a true interest and not a blessing,” she adds.

She looks for letters that say such things as:

- We will be referring clients to this program, if funded.
- We will be providing space, volunteers or pro bono services.

The letters must have substance; those merely singing your clinic’s praises are meaningless. Even worse are the cookie-cutter letters. “We’ll get support letters that are all identical. They just cancel each other out,” Seitz says.

10. Be a Good Reporter

Successful proposals reflect good reporting. Reviewers think in terms of who, what, where, when and why, Seitz explains, and they want to know how the community will be different at the end of the grant. “Someone in another foundation recently was saying that all proposals eventually come down to who is going to do what for whom and who asked them to do it in the first place.”

Additionally, like any good reporter, include specific, local statistics. Too often, proposals contain lots of national data — information Seitz already knows anyway (often, it was compiled by her organization!). If local data isn’t available, explain how you plan to get it.

11. Be Able to Accomplish What You Promise

Take a hard look at your facility, and your resources. Can you demonstrate that you are capable of doing what

you say you want to do? Is the budget one that’s manageable? If you are asking for twice your annual budget, that’s going to be a huge red flag, notes Rickler. You need the resources to manage the grant money.

This applies to human resources, too. “The leader for this effort must be someone who has passion for and believes in the proposed project, and has the time and energy to do so,” says Soto. “In a sense, the leader is an advocate for the benefactors of the project.”

The Grant Writer Question

A final word of encouragement: None of our experts think it necessary to hire an outside grant writer. You *can* do it yourself. “If you hire a grant writer, they need to be able to understand the problem you are trying to address. And you can’t just dump the project on them; you need to work collaboratively throughout the process,” says Soto.

If the application looks like an outsider wrote it, it could cost you a grant. “When grant writers are used, it’s helpful to use them as coaches,” says Seitz. Like many funders, LIFP won’t let you build the cost of the grant writer into the grant. ■

READER QUESTION

Can You Hire Staff to Mirror Patients’ Diversity?

Question: Because our clinic is in an ethnically diverse urban area, we try to hire a staff that reflects the racial and ethnic makeup of the community. (We believe this increases the comfort level of our patients and sometimes helps us when we need a translator.) With all the talk about reverse discrimination in the news, however, I want to know if I can legally hire people based, in part, on their racial or ethnic background.

Answer: Probably not, according to **Douglas M. Towns, JD**, partner at Jones Day in Atlanta, an international law firm. “The short answer is that under federal law and most state laws, an employer [generally defined as an entity with 15 or more employees], including a clinic, cannot use racial or ethnic makeup as a basis for any employment decisions, including hiring decisions. That rule would even apply in situations such as this where the clinic may be in an ethnically diverse area.”

Turn the situation around and you see why. “On the reverse side, juries and the courts would be very

