Moving CAP Forward:

LGBTQ Health Center Business Plan

2016-2020

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BUSINESS PLANNING AND STRATEGY FOR NONPROFITS

Executive Summary

For over thirty years, Cascade AIDS Project (CAP) has been a central force in the Portland region's response to HIV/AIDS. Rising from grassroots in the LGBTQ community, CAP has grown into a mature health and social service provider, with deep operational capacity, an array of public and private sector partnerships, and an established track record of improving health and welfare of at-risk populations in the region.

Community needs are changing, and CAP is evolving to meet these needs. While HIV remains a critical health concern in Oregon, improved treatment has made it a manageable chronic condition. At the same time, the LGBTQ community faces a range of serious health problems beyond HIV; recent studies document stark health disparities relative to the general population. Further, while some core government funding sources for CAP's current services are likely to change in coming years, the federal Affordable Care Act and the availability of other funding sources to AIDS Service Organizations create a unique opportunity for CAP to build on its success and expand its services.

Following a comprehensive planning process, CAP will launch a new initiative: a primary care medical practice to meet the needs of Portland's LGBTQ community. The LGBTQ Community Health Center will be the hub for an integrated set of health and wellness services aimed at improving the health status of LGBTQ people in the region and improving health outcomes. This initiative constitutes an expansion of CAP's mission beyond its traditional focus on HIV. However, CAP will remain committed to delivering a range of HIV support and prevention services to the Portland community.

The Health Center will be a non-judgmental, safe environment for LGBTQ people, with a medical staff trained in health issues affecting the community. Emphasis will be placed on eliminating stigma that can compromise care for LGBTQ people in conventional settings, as well as coordinating care across a qualified referral network and community-based health promotion efforts. These services will build on several of CAP's existing strengths as an organization, including cultural sensitivity with LGBTQ and underserved communities, a track record of addressing health disparities, coordination of a spectrum of client services, and deep partnerships in the public and healthcare sectors. CAP is ideally positioned to fill this essential role in the region's healthcare system.

CAP plans to serve a diverse market through the Health Center, including LGBTQ adults with employer-sponsored and private insurance plans, Medicare and Medicaid coverage. CAP aims to serve the full LGBTQ community. With a priority of inclusivity, the organization will conduct targeted outreach to communities of color and the transgender population.

The Health Center has a sustainable business model, including a range of continuing and new revenue sources. New sources will include third-party reimbursement of medical services and the federal 340B pharmacy program. The latter is available solely to AIDS Service Organizations (ASOs), such as CAP, and selected healthcare providers; it is designed to support a spectrum of services to underserved populations by making prescription medications available at low cost. Not only will CAP be able to provide integrated pharmacy services to patients under this program, it will help subsidize other needed services. CAP will continue to use government funding for ongoing social services and will invest in growing its fund raising efforts, a key source of unrestricted operating funds.

This business model has proven to be successful for other ASOs that have initiated healthcare practices.

In its transition to a healthcare provider serving a broad continuum of patients, CAP will build its organizational capacity and develop new areas of expertise. Key capacities will include: health administration; services to women and seniors across racial and ethnic identities; and new technology, including electronic health records, practice management, and contracting and billing systems. CAP has secured a new space for the Health Center, and will integrate administration of new and existing programs.

CAP will mobilize to implement this strategy between 2016 and 2020. Launching this initiative will require capacity-building funding of $1.0 million through this period to ensure a smooth transition and effective implementation

This plan frames a bold, carefully considered step for CAP. While this is a new direction, it is fully consistent with CAP's mission, history and expertise. This strategy can ensure the organization will remain strong and viable, while continuing to meet essential needs in the Portland community.

I. Background

Community-Based Response to an Epidemic

The HIV virus is believed to have first affected humans in the early 20th century. The unknown pathogen spread slowly at first, but its associated disease, AIDS, became an international epidemic by the late 1970s.[1] This immune system disorder had a high mortality rate and defied any existing treatment, presenting a major new public health challenge in the U.S. and throughout the world.

As government and healthcare providers struggled to respond, community-based nonprofit organizations emerged throughout North America, delivering valuable services to high-risk populations. These nonprofits would become known as AIDS Service Organizations, or ASOs. Cascade AIDS Project, founded in Portland in 1983, was among the first wave of local community-based responses to the epidemic. The organization's staff and an extensive volunteer network conducted outreach, prevention, education and testing services, as well as advocacy with local, state and federal government. Early on, CAP became a key player in the fight against HIV/AIDS and a critical partner of public health agencies and healthcare providers.

Organizational Development, Growth and Impact

As a system formalized for delivering services to people with HIV/AIDS, CAP and other ASOs matured as organizations. Government funding has supported a web of services for people living with HIV and prevention of new HIV infections. CAP strategically tapped into these funds and built internal systems for managing government contracts. The organization grew complementary funding sources, including significant state and federal contracts, foundation and corporate grants, and donations from individuals—primarily from Portland's LGBTQ community, which has consistently supported CAP through the decades.

Since 1990, CAP has systematically developed case management, service navigation and housing assistance programs for people and families affected by HIV, alongside expanded prevention, education and testing services to help limit the spread of the virus. The organization built core competencies in reaching and serving at-risk, traditionally underserved populations in low-barrier, non-judgmental, culturally affirming ways. These target populations include the LGBTQ community, communities of color, low-income groups with high infection rates, intravenous drug users and people experiencing homelessness. CAP also developed formal service delivery methods, an effective administrative capacity, information systems and a balanced business model.

With 60 employees and an annual operating budget of $6.7 million, CAP is the largest ASO in Oregon and Southwest Washington. The organization reaches over 15,000 people each year and continues to play a critical role in the region's health and human service system. CAP works closely with public health agencies, healthcare providers and a range of com-munity organizations to meet the needs of people living with HIV and those most at risk for HIV. CAP is also financially healthy, with fiscal surpluses in each of the past five years and cash reserves exceeding three months' operating expenses. CAP's Charity Navigator financial rating is 88, and its accountability and transparency rating is 100, indicative of strong organizational management and performance.[2]

In 2014, as a part of a strategic planning process, CAP broadened its mission, "to prevent HIV infections, support and empower people living with or affected by HIV, and eliminate HIV-related stigma and health disparities," and defined a broad goal of building health equity within the Portland region.

Drivers of Change

HIV remains a major public health problem, but the nature of the battle has changed substantially in the past decade. This directly affects ASOs, including CAP. The driving forces of change are social, market and economic trends, including:

- Improved treatments have made HIV/AIDS a manageable chronic illness.
- Though treatments have improved immensely, new HIV infection diagnoses have remained relatively constant since the late 1990s in Oregon.[3]
- The Affordable Care Act has reduced Oregon's uninsured population by over 340,000, meaning that many individuals affected by HIV can access treatment through the mainstream healthcare system.[4]
- Many ASOs are preparing for a likelihood that public funding of HIV support services will change and/or be reduced in the near-term, and the National Center for Innovation in HIV Care has called on ASOs to adapt to rapidly changing market conditions.[5]
- Other funding sources are available to ASOs that adapt their operations, such as reimbursable medical services and 340B pharmacies.[6]
- LGBTQ people, CAP's traditional service base, face a range of serious health threats.

To remain relevant and sustainable, organizations must evolve over time in response to changing conditions and needs. These forces have led CAP leadership to consider possible strategies to adapt.

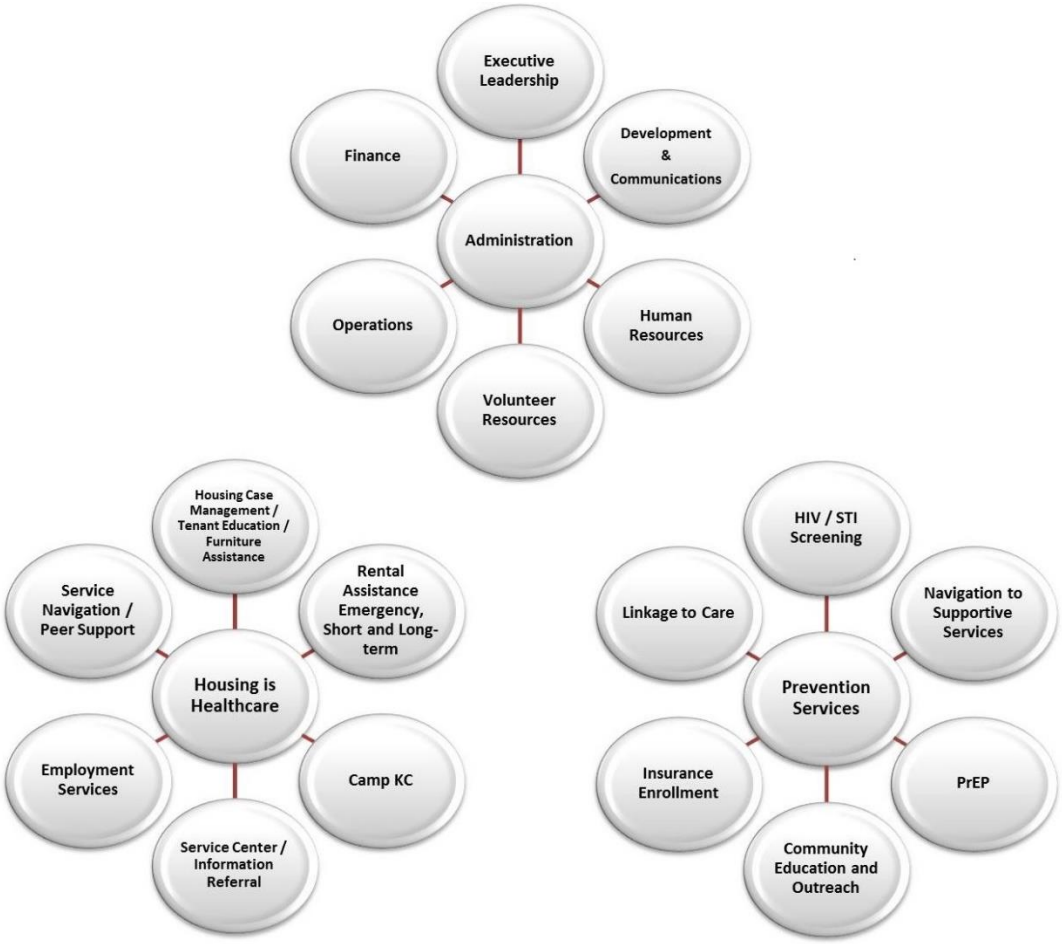
Planning Process

In 2013 CAP began a comprehensive planning process that has included:

- Development of a new strategic plan with input from major stakeholder groups (clients, community partners, donors, and staff)
- Research on approaches to organizational change in ASOs in the U.S.
- Survey of CAP staff
- Interviews of CAP management, program staff and stakeholders in the Portland community
- Survey of LGBTQ community members on health issues and needs
- Focus group of primary care medical providers serving Portland's LGBTQ community
- Review of health insurance market data
- Financial-operational modeling of a set of alternative organizational scenarios
- Financial analysis of primary healthcare practice startup parameters.

CAP applied several criteria in evaluating strategy alternatives, including impact on essential community needs and the quality of life in Greater Portland, efficiency of service delivery and CAP's financial sustainability. The process has culminated with identification of a strategy that will best address the needs of the community and the organization. This plan summarizes CAP's organizational strategy, outcomes and implementation steps.

Figure 1
Overview of Cascade AIDS Project Services



II. Market and Needs Assessment

In this section we present an overview of data on community needs and market factors related to CAP's organizational strategy to serve the Greater Portland region.

LGBTQ Health Disparities

Since its inception, CAP's primary service population has been the LGBTQ community, which has been disproportionately impacted by the AIDS epidemic. HIV/AIDS is now one of several serious health concerns for this population; the LGBTQ community faces a range of health disparities relative to the general population. Recent reports issued by an array of federal and state public health agencies, national health associations and independent researchers document extensive gaps. These health disparities adversely affect quality of life within the LGBTQ community, as well as workforce productivity (through increased morbidity) and healthcare system costs:

Quality of care: Research studies suggest that stigma and lack of provider training and awareness of LGBTQ health issues adversely affect care for many LGBTQ youth and adults.[7, 8, 9]

Access to care: LGBTQ adults are less likely to receive needed medical care, relative to heterosexual adults. For example, LGB adults were 71% more likely to delay or avoid medical care, and LGB women are 14% less likely to lack a defined primary care provider.[10]

Mental health and suicide risk: LGBTQ youth and adults are far more likely than their heterosexual counterparts to suffer from mental illnesses such as depression and anxiety. Nationally, and in Oregon, LGB adults report nearly twice the rate of mental distress and more than double the rate of suicide ideation relative to heterosexuals. Transgender adults have 25 times the rate of suicide ideation as non-LGBTQ adults. Oregon LGBTQ youth are five times as likely to attempt suicide as heterosexual youth.[11, 12, 13]

Violence: LGBTQ youth and adults are at substantially greater risk of domestic violence, bullying and criminal assault than heterosexuals. Gay and lesbian adults report more than triple the rate of intimate partner violence as heterosexuals. In Oregon, proportionally twice as many LGBTQ youth and adults are victims of domestic violence.[14]

Tobacco, alcohol and drug use: LGBTQ youth and adults use tobacco at a 40% higher rate than heterosexuals, among the highest usage of any U.S. subpopulation.[15] Further, LGB adults report high alcohol consumption, at rates between 35% and 60% greater than heterosexuals. [16]

Chronic diseases: Nationally, LGBTQ adults are at greater risk of a range of chronic conditions relative to heterosexual adults. A 20% greater proportion of Oregon LGBTQ adults report living with arthritis, diabetes, asthma or heart disease, and a 28% greater proportion of Oregon lesbians suffer from obesity.[17]

Cancers: LGB adults are 50% more likely to have been diagnosed with cancer, relative to heterosexuals. Lesbians have elevated risk of breast cancer versus heterosexual women. Gay men are at enhanced risk of prostate, testicular and colon cancers.[18]

HIV and sexually transmitted diseases: Gay and bisexual males account for nearly half of all Americans and 64% of Oregonians living with HIV and account for 63% of new cases, a figure that excludes men unaware they are infected. Black males have shown increasing infection rates in recent years, and black and Latino males account for disproportionate shares of new HIV infections in Oregon.[19, 20, 21, 22]

While these disparities affect the LGBTQ population as a whole, many are elevated for LGBTQ people in other high-risk categories, such as African-Americans and Hispanic/Latinos.

The American College of Physicians and the American Psychology Association, among other organizations, have recommended addressing health disparities through systemic improvements in care to LGBTQ people. These recommendations include: training of healthcare providers in LGBTQ health issues, improved provider sensitivity and communication (addressing stigma as a major contributing factor to obtaining quality care), and establishment of safe, non-judgmental healthcare environments for LGBTQ patients.[23] While research data is not yet available to confirm the impact of these measures, the experiences of ASOs and specialized LGBTQ healthcare organizations interviewed in this planning process align with the underlying approach that high-quality, culturally competent care expands LGBTQ people's use of healthcare, improves opportunities for treatment and preventive measures, and likely improves health outcomes, particularly for the highest risk patients.

Service Gaps in Greater Portland

In partnership with other community-based organizations, CAP administered a survey to members of Portland's LGBTQ community in 2015 on health and healthcare needs, access and utilization, with 584 responses.[24] The results reveal that:

- 29% of respondents have experienced difficulty finding a doctor who understands and is sensitive to LGBTQ health issues, and 28% have experienced discomfort expressing their LGBTQ identity to their physician.
- 80% believe LGBTQ individuals have distinct healthcare needs from the general population, with perceived differences aligning closely with research findings above.
- 72% believe the health and wellbeing of LGBTQ people could be improved through more healthcare staff with specialized knowledge about LGBTQ health issues.

The region's healthcare system is currently characterized by a patchwork of providers with varying levels of expertise in LGBTQ health issues, and no central, specialized source of care for LGBTQ people. A focus group of local medical providers revealed that some Portland-area LGBTQ adults receive high-quality care through providers they have identified, while substantial subsets of the population are either served by providers with limited knowledge or skill in LGBTQ health issues, or unserved by the system. Particular gaps may exist among lower-income, uninsured or underinsured people, as well as people of color. Participants concurred that many LGBTQ patients are, to varying degrees, uncomfortable communicating with their providers, and that providers often lack training or knowledge that helps translate general standards of care to LGBTQ patient care. Further, focus group participants noted the lack of a systematic approach to LGBTQ healthcare in the region; though the State has identified a clear public health need, specific care standards, training opportunities and provider networking and referral channels are largely absent.

Demand for Targeted Health Services

The CAP survey provided insight into the demand for a medical practice specifically serving Portland's LGBTQ population:

- While 87% of respondents currently have a primary care provider and 72% are at least somewhat satisfied with their provider, 74% of respondents are likely to consider using an LGBTQ-focused health center.
- Appealing features of such a practice would include high quality providers (73%), healthcare staff knowledgeable about LGBTQ health issues (70%), and a comfortable environment (63%).

Noting that communities of color were underrepresented in survey responses, presenting a need for additional outreach to these populations, the results show clear interest in, and desirable characteristics of, a dedicated LGBTQ medical practice.

The survey revealed that inclusion in employer insurance plans is the largest potential obstacle for respondents to change providers (71%). Portland's private health insurance market is diverse, with one major health maintenance organization (Kaiser), which comprised an estimated 27% of the Portland private insurance market in 2015, and various preferred provider (PPO) organizations (Regence, Providence, United Healthcare, Health Net, LifeWise, etc.), which comprised the remaining 73%.[25] A new medical practice can contract with a diverse range of PPO plans along with Medicare and Oregon Health Plan (Medicaid), while some Kaiser subscribers would have limited mobility. Relative ease of mobility by Oregon patients among care providers helps neutralize a major obstacle; with the exception of patients tied to restricted provider networks, an LGBTQ Health Center can be widely accessible to LGBTQ adults in the Portland market.

Finally, Portland has a large and growing LGBTQ market. The region currently has the second largest LGBTQ population concentration in the U.S., according to a recent Gallup survey.[26] The Oregon Office of Economic Analysis projects growth of the four-county region's population from 2.2 million in 2013 to 2.9 million by 2035, a net gain of 30%.[27] Portland's LGBTQ community is expected to grow proportionally. The region as a whole and the LGBTQ niche will experience increased demand for medical services in the years ahead.

These data suggest that a dedicated medical practice serving the LGBTQ community may have a clear niche over a long-term period.

III. Organizational Strategy

In the next major step in its organizational development, CAP will build on its core competencies in advocacy, education, prevention, housing and supportive service, continue to address the needs of people affected by HIV, and expand its mission to promote LGBTQ community health in the Greater Portland region.

The addition of services to the broader LGBTQ community is a natural outgrowth of CAP's expanded mission and capitalizes on CAP's core strength of providing culturally relevant care to LGBTQ individuals. Stakeholders interviewed during the planning process strongly support the concept of CAP as operator of a dedicated LGBTQ health center, based on CAP's roots in the LGBTQ community, track record as a culturally affirming provider of high quality social services, and administrative capacity. CAP is uniquely positioned to provide healthcare services to the LGBTQ community.

This section summarizes CAP's strategy for the next five years.

New LGBTQ Health Center

The core of CAP's mission expansion will be a general primary care medical practice, with the working name LGBTQ Community Health Center (the "Health Center").

CAP is uniquely positioned to pursue an LGBTQ Community Health Center for two reasons: First, the organization has extensive experience meeting social and health-related needs of people in the LGBTQ community. This work has provided invaluable insights into the health disparities faced by LGBTQ people as well as the lack of adequate, culturally-specific LGBTQ healthcare necessary to address population needs. Second, CAP has access to a critical funding source available only to ASOs and other qualified healthcare providers, the 340B pharmacy program. This source, combined with the recent expansion of insurance coverage under the ACA, contributes to a viable business model for the Health Center, and an opportunity for CAP to expand its role and address essential community needs.

The Health Center will offer a distinct value proposition to LGBTQ adults in the primary healthcare marketplace. Key principles of underlying Health Center operation will include:

- Nonjudgmental services that address specific LGBTQ health challenges in an emotionally safe environment that is rooted in understanding of and sensitivity to LGBTQ community culture
- A service delivery culture based on strong, long-term relationships with patients
- An integrated team approach to patient care, with linkage to other health and wellness services and complementary specialists
- Professionalism and competence in all levels of operations, from care delivery to administration and billing, scheduling and customer service
- Tracking and measurement of patient outcomes.

The Health Center will directly address core contributors to LGBTQ health disparities—stigma and specific knowledge. The theory of change behind the Health Center's services is that LGBTQ-centered care—with an inviting environment rooted in cultural sensitivity and a team of providers trained in LGBTQ health issues and responses—will result in improved patient outcomes. Without fear of being stigmatized, patients will be more likely to seek care and communicate openly with providers about their health, lifestyle factors and concerns.

Providers, in turn, will be educated and well-prepared to address patient needs, including risk factors patients may not self-identify. Through the Health Center's leadership, a web of complementary services will be developed to proactively address LGBTQ health needs.

The target market for the Health Center will be the full spectrum of Portland's LGBTQ community. All demographic segments of the LGBTQ community will be welcome, and CAP will continue its long-term commitment to reaching underserved subpopulations, including communities of color and transgender people, groups more deeply affected by several of the health disparities summarized above. CAP will also emphasize the development of women's health services.

Target market assumptions include:

- An estimated 50% of patients will be enrolled in employer-sponsored health plans.
- 35% of patients will be insured by the Oregon Health Plan (Medicaid).
- 15% of patients will be covered by Medicare.
- 38% of patients will be HIV-positive.
- Patients identifying as Hispanic/Latino, African-American, Native American and Asian/Pacific Islander will comprise at least one third of the base.[28]
- Patient gender identity will track the makeup of the LGBTQ community as a whole.

The Health Center will start with a core staff of a Medical Services Director and two care providers (a physician and a nurse practitioner) with specific backgrounds and experience in LGBTQ health. The practice will establish an external referral of specialists, for example infectious disease, OB/GYN and transgender health, as well as mental health and alternative medicine providers. This continuum, built on a foundation of CAP's existing long-term relationships with care providers to current and past CAP clients, will ensure coordinated care with partner providers that share expertise in meeting the needs of LGBTQ people.

The Health Center will include 340B pharmacy services, offering prescription medication to patients, and thereby streamlining services to patients who depend on prescription medications. This federal program for qualified ASOs and other HIV/AIDS care providers allows providers access to medications at reduced pricing.[29] CAP will operate pharmacy services through a contract with a dispensing pharmacy, under Health Resources and Services Administration guidelines.

CAP will also deliver new community health education services that directly address disparities impacting the LGBTQ community, to be developed based on community-identified needs and emerging research. In addition, CAP plans to use the Health Center as a platform for developing capacity for LGBTQ-focused healthcare services throughout the region, by presenting training for providers and convening a network of care providers.

Integration with Ongoing CAP Services

New community health education programming will be integrated with CAP's existing prevention and education services, which include testing for HIV and sexually transmitted infections. A core component of the Prevention & Education Department, Pivot, will be co-located with the Health Center. This will allow for continued access to low-barrier HIV/STI testing, referrals for gay and bisexual men into treatment or general medical services, and an easy introduction method of the Health Center to a large portion of the target demographic. This co-location will also facilitate low barrier referrals for pre-exposure

prophylaxis (PrEP) and other non-medical services. HIV and STI testing will continue to be offered in a variety of community locations within Portland and surrounding counties. Continuation of these services will meet clients where they physically are and serve as a potential referral mechanism for the Health Center.

CAP will continue delivery of its current set of social services, which include: case management and service navigation; housing counseling, placement and subsidy for low-income clients; and peer-to-peer support coordination. CAP will continue to allocate management and program resources to existing services to ensure clients will not see disruption or reduction due to CAP's mission expansion. HIV Support Services clients may or may not be Health Center patients, and this connection will not be a requirement for participation.

Continuing its historic role, CAP will advocate at the local, state and federal levels for policies and practices that support LGBTQ community health and help to close health disparities with the general population. CAP will participate in organizational networks at each level to help ensure effective outcomes. By nurturing relationships with public health agencies and policy makers, CAP will extend and deepen its historic role as a partner with government in the common cause of promoting the health and welfare of LGBTQ and HIV-positive people.

Organizational Structure

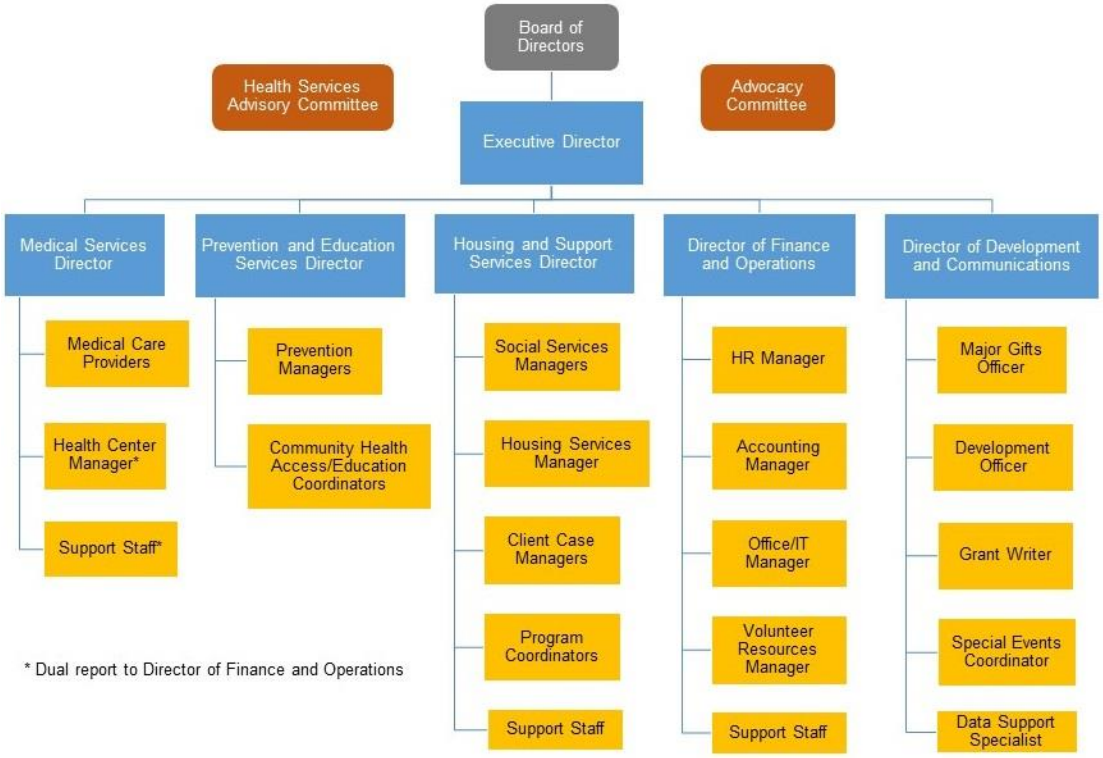
The revamped organization will have five departments: Medical Services; Prevention and Education; HIV Support Services; Finance and Operations; and Fund Development and Communications. Advocacy will be shared responsibility within the senior management team. The Volunteer Resources function will continue to be housed in Finance and Operations.

Two new volunteer committees will engage diverse health industry representatives and community members, and will report to the Executive Director—a Health Services Advisory Committee and an Advocacy Committee. The Executive Committee of the Board of Directors will oversee implementation of the organizational strategy.

The Health Services Advisory Committee will play a key role in implementing the Health Center, including medical and pharmacy services, as well as new health outreach programming. Members will include healthcare providers, administrators, insurers and public health agency representatives; the Committee's scope will include advising CAP leadership on establishment of the Health Center, staffing criteria, internal policies and procedures, programming content, key community relationships and outreach.

Figure 2 summarizes the organizational structure. Staff development will include hiring personnel for the new medical practice, including a Medical Services Director, which will initially be a part-time volunteer position, a Medical Office Manager, Health Center support staff and a Major Gifts Officer. CAP will consider alternatives such as a contractual relationship with a healthcare system or an existing medical practice for direct care provider roles prior to startup; criteria for a staffing model will include impact on quality and continuity of care, administrative simplicity and consistency with financial targets.

Figure 2
CAP Organizational Chart



Business Model

CAP's current business model relies heavily on federal, local and state government funding for its programming in Prevention and Education, and Housing and Support Services. Funding also includes foundation grants and a strong core of individual contributions, primarily from LGBTQ donors particularly concerned about HIV/AIDS.

Under this new strategy, CAP's business model will evolve to allow the organization to address a broader range of LGBTQ health needs. Revenues will diversify, with several new sources positioned to grow over time.

CAP will receive third party payments for medical services—a mix of private insurance, Medicare and Medicaid; these sources will grow in proportion to the patient base of the medical practice.

Pharmacy revenue under the 340B program is a key source of general operating funds; by design, surpluses generated through discounted drug pricing support the operation of services to at-risk communities, and will subsidize CAP's medical and social service operations. This federal program for qualified ASOs and other HIV/AIDS care providers allows select providers access to medications at reduced pricing.[20] It guarantees significant discounts in pricing of drugs, for the purposes of stretching limited funds to serve people in need and providing more comprehensive services. 340B revenue is a fundamental component of the business models of ASOs providing healthcare services. Specialized medical practices like the Health Center (as well as many nonprofit ventures that address community health and welfare needs) often

cannot break even based on market forces alone, due to limits in the potential scale of operations. Pricing of drugs under the 340B program generates an internal surplus that largely offsets deficits of Health Center operations and makes the practice economically feasible. CAP will thus be adopting a business model of ASOs that have initiated healthcare delivery.

In an organization delivering broader services to an increasing population base, fund raising, including foundation grants and individual contributions, will have greater growth potential. CAP will invest in development of a major individual giving program, engaging both traditional donors who have supported CAP through the HIV/AIDS epidemic and response, as well as diverse donors more broadly interested in the welfare of LGBTQ people. Fund raising has been and will continue to be a critical component of CAP's business model, providing unrestricted revenues for general operations and essential services that lack specific funding sources.

CAP's revised revenue structure will continue to support operations in the short-term, while building economies of scale and sustainability over the long-term.

Scenario analysis shows that this combination of revenue sources can anchor a robust business model, and in fact several ASOs around the U.S. are thriving with similar configurations.

Key revenue drivers in the revised business model will include:

- Volume and diversity of Health Center patients
- Payer mix of Health Center patients
- Volume of HIV Support Services clients
- Number and type of pharmacy prescriptions
- Major individual donor participation
- Diversity of public and private grant support.

The Financial Plan section, below, summarizes projections through initial transition years.

Operational Capacity

As an established social service provider with diverse funding sources, CAP has several core capabilities, including: a solid administrative and financial management infrastructure; skill in managing grants and contracts with a wide range of government agencies and private funding sources; program and constituent data management; skill in navigating the health, social service and housing systems to serve clients; and ability to engage at-risk populations, including major segments of the LGBTQ population. CAP also has strong relationships with local and state agencies, as well as peers in the nonprofit sector.

Implementation of this strategy will require building on these strengths to add capacity in several areas. An in-house medical practice and pharmacy will require new infrastructure, including an electronic health records (EHR) system, third-party contracting and billing systems, regulatory compliance and reporting mechanisms, and quality control protocols. CAP will draw on the body of knowledge developed by other ASOs that have made this conversion and seek technical assistance in building capacity in these areas. The Health Services Advisory Committee will provide guidance in this process. In addition, CAP will actively seek partnership with organization(s) that have existing, complementary capabilities in healthcare delivery. CAP will build internal healthcare administration capacity through training and hiring, diversifying skills within the management team. The organization will

also develop competence in general health and wellness issues, including women's health, through training and new hires.

Building new capacity will not only prepare CAP for success in delivering new services, it will also strengthen operations of ongoing HIV support, prevention and education services. The integration of EHR and third-party billing systems, for example, will enhance CAP's current social service operations, providing improved means of tracking client care and the ability to leverage third-party reimbursements for services such as case management and testing.

CAP has secured a 10-year lease on office space and ownership of a separate medical office space in Southeast Portland.

Strategic Partnerships

CAP will pursue formal partnerships with organizations that have synergistic goals, notably in the LGBTQ Health and Wellness Program. CAP will seek alliances that enhance services to CAP clients and patients, improve efficiency of service delivery, strengthen internal operating systems and support the organization's business model. Priorities will include partnerships addressing:

- Healthcare delivery systems
- Traditional and alternative medical specialties
- Mental health services
- Pharmacy operations
- Outreach to at-risk subpopulations, such as LGBTQ, seniors, people of color and non-native English speakers
- Health system goals of Community Care Organizations, other public health agencies and research institutions.

Marketing and Branding

As a key next step in the business development process, CAP will investigate and develop a marketing, branding, and communication strategy to reflect the expansion of mission and services. CAP anticipates issuing an RFP in 2016 to engage a marketing firm to offer analysis on how to preserve existing brand equity and appeal to the broader LGBTQ community, including communities of color, the transgender population, and women. As part of this process, CAP will develop a marketing strategy to effectively communicate the needs and benefits of the Health Center to both the donor community and our target market of consumers.

As part of the organization's evolution, CAP's service base and core constituencies will be broader. Messaging around new services and engagement of the LGBTQ community as a whole will be essential to long-term success. Revamping the organization identity and independently branding the Health Center and/or major programs will be among options to be considered through a systematic review.

CAP will design Health Center services with input from community members. CAP's marketing to prospective patients will focus on networking with other LGBTQ organizations, active presence in community events, publicity through local publications, communication with existing CAP clients and supporters, and peer-to-peer communication in the healthcare community. A detailed community outreach plan will articulate specific implementation methods and targets.

IV. Financial Plan and Funding Requirements

Financial Projections

Figure 3 summarizes financial and service projections over the next four years. CAP's staffing and budget will begin evolving at the start of fiscal year 2017, July 1, 2016, with a projected Health Center starting date of January 1, 2017.

Over the period of fiscal years 2017-2020, the organization's revenue base will transition. With uncertainty in government funding, we conservatively assume a gradually decline in these sources, which are partially replaced by fees for medical and pharmacy services, as well as increased fund raising.

Pharmacy revenues and fund raising subsidize medical and other health services, by design, in the program's early years. As the Health Center's patient volume grows over time, it will approach a break-even point, freeing more resources to address other LGBT community health needs. Pharmacy use is a key part of the Health Center's business model, with net income ranging from $93,000 in 2017 to $466,000 in 2020. We have used conservative estimates for prescription volume, and pharmacy services revenues may ultimately account for a greater share of Health Center income.

CAP's total operating budget is projected to rise from the current $6.8 million to $10.4 million in 2020, as the organization covers startup costs for the new initiative, as well as new expense items for Health Center and pharmacy operations, including cost of medications. Over this period, expenses of HIV Support and Prevention and Education Services decrease gradually, along with funding and service volume. Payroll will remain CAP's major expense category in these projections, at $3.1 million in 2020.

By 2020, the organization's operating cash reserve is projected to decrease slightly during initial transition years, and return to three months' operating expenses in 2020.[30]

Service Projections

CAP's traditional HIV services and staffing are projected to continue at reduced levels, as long as funding sustains, proportionate to changes in dedicated funding sources. Health services payroll will grow concurrently; the staff stabilizes at 40 FTE in 2020, a new base from which it can grow as the LGBT Health and Wellness program expands in future years.

Key service targets will be: annual primary care patient volume (conservatively projected to reach 1,000 by 2020); pharmacy volume (conservatively projected to reach 300 patients by 2020); the mix of patients (projections assume 38% HIV-positive patients, accounting for 50% of patient visits); and the mix of third-party payers for medical services (projections assume 50% private insurance, 15% Medicare and 35% Medicaid). These assumptions are based in part on community survey results, and in part on analysis of primary healthcare practice startup operations. This diverse medical patient mix balances several needs essential to maintaining a sustainable business model, not just for the Health Center, but for the entire organization: while low-income patients are central to CAP's mission, a strong component of privately-insured patients strengthens revenues, which frees up more general funds to support non-medical services. Similarly, while the Health Center will serve the general LGBT population, pharmacy utilization by HIV-positive patients will support general medical services and lessen potential strain on other services. These projections illustrate how drivers of the

business model can favorably impact CAP's capacity to meet a range of community needs while maintaining the organization's underlying financial health.

Funding Requirements

Capital requirements to implement this transition, in addition to ongoing operations funding, are $1.5 million over four years, including $1.0 million in operating capital (reflected in Figure 3), and an additional $500,000 in capital project funding, to renovate and fit out the Health Center space, and address capacity needs such as data system development. CAP will seek philanthropic investments to fund critical startup elements in the form of one-time and multi-year grants. Transitional startup components of the operating budget will include new positions, data systems, medical equipment and supplies, new program development, brand development work and related community outreach. These investments will help ensure that the new initiative is set up for success, and that CAP remains financially healthy through the startup period.

Risk Assessment

In developing this plan, we analyzed a range of scenarios for CAP, as an ASO in transition. While CAP is financially strong, maintaining the status quo brings long-term risk, due to the potential for reduced public funding of non-medical HIV services in the future, without an obvious replacement source. Other scenarios show high risk due to a lack of a clear business model and/or indirect impacts on community needs. This plan reflects the highest return scenario we examined, both for CAP and the community it serves, and brings a moderate level of risk.

Risks associated with this plan include the potential to fall short on Health Center and pharmacy service and revenue targets, and/or fund raising revenue targets. To mitigate these risks, we applied conservative early year projections for new services, relative to experiences of other organizations that have made similar transitions. In addition, we applied conservative projections of government funding for both new and traditional CAP services. In the event that several of these variables perform below projected targets, CAP will have a range of options available to mitigate any operating losses, including shifting the focus of the new initiative, cutting costs, and/or identifying alternate revenue sources.

The plan presented here frames a bold, yet carefully considered step in a new direction for the organization, with a clear value proposition, a set of services consistent with historic organizational competencies, a viable business model and a process for mitigating risk as CAP implements the initiative.

Figure 3
CAP Financial and Service Projections
2016-2020

Operating Revenue	Actual FY 2014	Actual FY 2015	Projected FY 2016	FY 2017	FY 2018	FY 2019	FY 2020
Government Grants/Contracts							
Federal-HHS	2,206,039	2,133,931	2,258,714	1,806,971	1,445,577	1,156,462	1,006,122
Federal-HUD	1,748,308	1,839,713	2,170,137	2,191,838	2,213,757	2,235,894	2,258,253
Federal-Other	-	-	-	-	-	-	-
State	472,165	465,625	225,000	231,750	243,338	255,504	268,280
Local	131,894	55,000	200,000	100,000	105,000	110,250	115,763
Subtotal	4,558,406	4,494,269	4,853,851	4,330,560	4,007,671	3,758,110	3,648,417
Fundraising							
Private Ops Grants/Sponsorships	657,449	660,603	772,125	795,289	819,147	884,679	955,454
Individual Contributions	835,028	834,929	922,875	980,655	1,078,720	1,165,018	1,258,219
Capacity-Building Grants	-	-	-	500,000	300,000	150,000	100,000
In-Kind Contributions	371,322	327,702	255,000	262,650	270,530	278,645	287,005
Subtotal	1,863,799	1,823,234	1,950,000	2,538,594	2,468,397	2,478,342	2,600,678
Third-Party Reimbursements							
Healthcare							
PPO	-	-	-	15,840	66,250	127,308	147,518
Medicaid	-	-	-	7,696	32,190	61,857	71,677
Medicare	-	-	-	4,455	18,633	35,805	41,489
Pharmacy							
PPO/Medicare	-	-	-	544,320	1,451,520	2,419,200	2,721,600
Medicaid	-	-	-	262,080	698,880	1,168,440	1,310,400
Subtotal	-	-	-	834,391	2,267,472	3,812,611	4,292,685
Other Fees for Service	-	-	20,000	20,600	31,518	48,223	73,780
Rental Income	-	-	-	-	-	-	-
Other Income	41,803	24,790	15,000	15,000	15,000	15,000	15,000
Total Revenues	$ 6,464,008	$ 6,342,293	$ 6,838,851	$ 7,739,145	$ 8,790,058	$ 10,112,286	$ 10,630,560
Operating Expense							
Staff	3,301,455	3,299,109	3,286,895	3,292,061	3,157,100	3,014,672	3,098,337
Professional Services	320,394	392,840	522,851	365,996	376,976	388,285	399,933
Office and Program Space	341,835	348,352	359,564	531,608	554,954	567,319	580,014
External Communications	61,572	66,213	58,520	74,906	80,898	83,325	85,825
Primary Care Directs	-	-	-	41,566	92,605	104,799	119,423
Pharmacy Directs	-	-	-	713,160	1,901,760	3,173,520	3,565,800
Infrastructure/Capacity Development	-	-	-	125,000	50,000	75,000	-
Other Operating	2,293,251	2,078,931	2,534,543	2,521,350	2,470,923	2,495,632	2,520,589
Total Expenses	$ 6,318,507	$ 6,185,445	$ 6,762,373	$ 7,665,646	$ 8,685,216	$ 9,902,553	$ 10,369,921
Net Revenue	$ 145,501	$ 156,848	$ 76,478	$ 73,498	$ 104,842	$ 209,733	$ 260,639
Operational Metrics							
Clients Served							
Case Management	2,620	2,600	2,400	2,040	1,734	1,474	1,253
Housing	812	825	800	800	800	800	800
Prevention/Education	12,696	12,000	11,000	9,000	8,000	8,500	10,000
Primary Care	-	-	-	129	476	889	1,000
Pharmacy	-	-	-	60	160	267	300
Community Services	231	200	200	200	200	200	200
FTE Staff	60	60	55	51	46	41	40
Clients/FTE Staff	273	260	263	241	250	294	335
% Unrestricted Revenue	26%	26%	26%	30%	37%	43%	47%
Operating Reserve (months)	2.3	3.1	2.3	2.5	2.7	2.7	3.0

V. Implementation and Evaluation

Senior management will oversee implementation of this plan, with key support roles played by the Board's Executive Committee and the Health Services Advisory Committee.

Figure 4 summarizes the timing of key implementation steps.

CAP will measure success with a set of programmatic, operational and financial metrics and will evaluate this transition on an ongoing basis. Community health outcome targets will be refined with input from the Health Services Advisory Committee. Key metrics will include:

Program Impact

- LGBTQ community health and wellness indicators
- Medical clinic patient health outcomes
- HIV support services client housing and employment status
- New HIV infection rates in Greater Portland

Operations

- Program client/patient volume (relative to plan targets)
- Pharmacy prescription volume/type
- Staff retention rate
- Staff satisfaction indicators
- Strategic partnership effectiveness

Financial Health

- Individual donor/average gift growth
- Health services program net surplus
- % Unrestricted revenue
- Operating surplus (% of expense budget)
- Operating reserve (months of operating expenses).

Cascade AIDS Project has been a critical part of Oregon's public health system for over three decades. In its next chapter, the organization will continue to play an essential role. In implementing this business plan, CAP will monitor progress and make course adjustments as necessary to ensure a strong and effective community response to emerging LGBTQ health needs in the region.

Figure 4
CAP Business Plan Implementation Timeline
2016-2020*

Category/Task		2017				2018				2019				2020			
	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Program Development																	
New space acquisition/fit-out																	
Health Center program development																	
Medical service protocol development																	
Insurance plan outreach/contracting																	
340B pharmacy application																	
Establish pharmacy operations																	
Establish specialist referral network																	
Health education program development																	
Open Health Center																	
Fund Raising																	
Startup capital fund development																	
Individual giving program development																	
Institutional giving program revision																	
Staffing/HR																	
Develop/revise job descriptions																	
Recruit/hire new positions:																	
Medical Director																	
Medical care providers																	
Health Center support staff																	
Medical Office Manager																	
Major Gifts Officer																	
Staff professional development plan																	
Advisory Committees																	
Establish Health Services Advisory Cmte																	
Establish Advocacy Committee																	
Committee work plans																	
Operations																	
Project management setup																	
Data system development:																	
Electronic health records																	
Third-party billing																	
Integrated program database																	
Upgrade CRM																	
Scorecard implementation																	
Partnership Development																	
Identify partner objectives/prospects																	
Strategic alliance outreach/development																	
Formalize partnership agreements																	
Branding/Communications																	
Marketing and communications plan																	
Health & Wellness community outreach																	
Branding review process																	
Brand update implmentation																	

* Date ranges refer to fiscal years ending June 30 of the stated year.

Appendix 1
CAP Leadership

Board of Directors

President
Robert Lusk, MD
Providence Health & Services

Vice President
Robert Goman
Nike

Secretary
Nancy Haigwood, PhD
OHSU

Treasurer
Jason Jurjevich, PhD
Portland State University

Former President
Warren Jimenez
Portland Parks and Recreation

Jim Armstrong
OnPoint Community Credit Union

Leo Bancroft
Nuance Communications

Kurt Beadell
Vibrant Table Catering & Events

Elise Brickner-Schulz
Miller Nash Graham & Dunn LLP

M. Lamar Bryant, Jr., MD
The Vancouver Clinic

Brian Buck
Portland Trail Blazers

Karol Collymore
State of Oregon

Paul Hempel
Community Volunteer

Edwin Kietzman
Fred Meyer Stores

Tawnie Nelson
Wells Fargo Bank

William Patton
Lane Powell PC

Judge Susan M. Svetkey
Multnomah County Circuit Court

Staff

Executive Director
Tyler TerMeer

Director of Finance & Operations
Mary Marshall

Director of Development & Communications
Peter Parisot

Director of Housing & Support Services
Angie Harbin

Director of Prevention & Education Services
Caitlin Wells

Notes

[1] http://www.avert.org/professionals/history-hiv-aids/overview

[2] http://www.charitynavigator.org/index.cfm?bay=search.summary&orgid=10556#.VpkK0XlIipo

[3] New HIV diagnoses fluctuated between 240 and 303 between 1997 and 2012; see: https://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/DiseaseSurveillanceData/HIVData/

[4] https://www.ohsu.edu/xd/research/centers-institutes/center-for-health-systems-effectiveness/upload/Health-Insurance-Coverage-in-Oregon-County-Results.pdf

[5] Enhancing the Sustainability of Ryan White-Funded AIDS Service Organizations and Community-Based Organizations, National Center for Innovation in HIV Care, 2016

[6] http://www.340bhealth.org/340b-resources/340b-program/overview/

[7] Kreheley, Jeffery, "How to Close the LGBT Health Disparities Gap," Center for American Progress, Dec. 21, 2009

[8] Daniel, H., and Butkus, R., "Lesbian, Gay, Bisexual, and Transgender Health Disparities," American College of Physicians, 2015

[9] *Top Health Issues for LGBT Populations*, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2012

[10] *National Health Statistics Reports*, Centers for Disease Control and Prevention, Number 77, July 15, 2014, and note 6

[11] https://public.health.oregon.gov/About/Documents/oregon-state-health-profile.pdf

[12] *Top Health Issues for LGBT Populations*, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2012

[13] *Improving the Health Care of Lesbian Gay, Bisexual and Transgender People: Understanding and Eliminating Health Disparities*, The Fenway Institute, 2010

[14] See notes 10 and 11.

[15] *Improving the Health Care of Lesbian Gay, Bisexual and Transgender People: Understanding and Eliminating Health Disparities*, The Fenway Institute, 2010, and CDC (note 9), and SAMHSA (note 11)

[16] See notes 6 and 14

[17] See note 10

[18] See notes 6, 11 and 12

[19] http://www.cdc.gov/hiv/statistics/overview/ataglance.html

[20] http://www.cdc.gov/hiv/group/msm/index.html

[21] https://public.health.oregon.gov/DiseasesConditions/CommunicableDisease/DiseaseSurveillanceData/HIVData

[22] Epidemiological profile of HIV/AIDS in Oregon, Oregon Health Authority, Public Health Division, 2013

[23] https://www.apa.org/about/gr/issues/lgbt/disparities-brief.pdf, and note 6

[24] CAP administered this survey by way of the email lists of several community partners: Basic Rights Oregon; The Q Center; the Black Chapter of PFLAG; and the Urban League. Respondents were most typically white (89%), male (62%), between ages 30-60 (69%), HIV-negative (74%), with employer-sponsored health plans (62%). Due to duplication between lists, we cannot determine a precise response rate.

[25] http://www.oregon.gov/DCBS/Insurance/insurers/other/Pages/quarterly-enrollment-reports.aspx

[26] http://www.gallup.com/poll/182051/san-francisco-metro-area-ranks-highest-lgbt-percentage.aspx

[27] http://www.oregon.gov/DAS/oea/Pages/demographic.aspx#Long_Term_County_Forecast

[28] The Portland metropolitan area's racial minority population is approximately 28%: http://priceonomics.com/how-diverse-is-your-city/

[29] http://www.hrsa.gov/opa/

[30] The expense of pharmacy medications is excluded from this calculation.