MINI GRANTS DO MAKE A DIFFERENCE

In 2004, the Mini Grant Initiative was established to support tax-exempt community health centers and other tax-exempt organizations that advance the mission of the Foundation. Since the inception of the program, an average of six community health centers a year receive $3,000 to $3,500 to enhance their clinical and service work. The range of services covered under mini-grants includes access and outreach to increase utilization rates and bridge disparate health care; quality of services through technology support; and, operational capacity building to sustain health centers.

The Foundation's focus on community health centers is based on emerging data highlighting the importance of community health centers as mechanisms to address health disparities. Community health centers, particularly federally qualified health centers (FQHC) and look-alike FQHCs, are receiving a lot of attention from the new administration under President Barack Obama. The Federal Health Center Growth Initiative was designed to increase the number of community health centers by 60 percent between 2002 and 2006.[1] A recent study conducted by The Center for Studying Health Systems Change, Johns Hopkins Public Health School, and the Bureau of Primary Health Care at the U.S. Health Resources and Services Administration concluded that FQHCs do a remarkable job of reducing health disparities in visit-based prevention delivery by racial, ethnic, as well as insurance status.[2] Although researchers concluded that continued growth of FQHCs would "likely help reduce health disparities and improve care for the underserved," they posed some concerns related to the impact on the mission of community health centers as capacities in technology and service provision expand. As community health centers are supported to expand their scope of services through increases in Medicaid and children's health care plans, as well as the new administration's Omnibus funds, how do they continue to maintain high quality in access and coordination of services for the growing number of uninsured and underserved?

Philanthropists have long used mini grants as opportunities to assist non-profit programs in the seeding of new initiatives with the expectation that these initiatives become sustainable through other efforts after a period of time. Mini grants have also been effective in supporting costs associated with funded initiatives that are either under-funded, not allowable through the awarded funds, or insufficiently funded through allowable indirect costs of the grant award.[3] The Mini Grant Initiative through the CHNCT Foundation supports community health centers' efforts in outreach and education through brochures, videos, translations services; training of staff to improve the system of care for uninsured and underserved populations; and, capital and equipment support in organizational capacity building services such as computers, vans, laptops, medical equipment.

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[1] AS O'Malley, CB Forrest, RM Politzer, JT Wulu, & L Shi. (2005). "Health Center Trends, 1994 – 2001: What do they portend for the federal growth initiative?" *Health Affairs*: 24, Number 2: 465-472.
[2] Ibid.
[3] Notes from 2005 Conference of Community Foundations. Washington, D.C.

We conducted preliminary assessments to determine if mini grants have the capacity to fill important gaps. Because it is unclear whether future federal funds to community health centers will contain additional support for expanded organizational capacity building, we are eager to use this and future more rigorous evaluations to shape policies and regulations in health care reform.

Interviews of grantees reveal that these small grants fill an important gap between allowable spending in federal and state awards and important needs in education, outreach, and organizational services. As in the research of trends in health care centers, this report does not provide an analysis of the effect of mini grants on the health and welfare of patients.[4] Instead, it offers some evidence that these mini grants allow community health centers to improve their outreach, access, and coordination of services in a manner that their present funding does not.

All respondents to the survey have received support from the Mini Grant Initiative for four to five years. The array of services in each of three target areas is:

Educational

- Five programs where brochures, postcards, and magnetized business cards in English, Spanish, Bosnian, and other languages are used by outreach workers to define and market the services of the community health center and to increase access to emerging populations. Although no efforts have been made to determine the impact of the brochures on access to the center, the estimated contact of potential new patients who as a result of outreach efforts incorporating these brochures is considered to be in the thousands.

- One site used funds to create a language interpreter system using telephone links with headsets among patient, health care provider, and interpreter service. That service has been in operation for five years and is now part of the operations budget of the health center. Over the five years, "thousands" of families have been helped through this method. While this site would prefer onsite interpreters, patients and health care providers have indicated better communication and higher levels of cultural competence.

Program Resources [capital and equipment]

- A number of health centers bought video equipment over the course of five years. At least eleven video players to play physical exercise program targeting hypertension, obesity, diet and nutrition, and exercise and other education programs.

- At least one program used the funds for exercise equipment: Three Thera-band rolls at 150 feet; five balance balls, 5 step exercise sets.

[4] AS O'Malley, CB Forrest, RM Politzer, JT Wulu, & L Shi. (2005). "Health Center Trends, 1994 – 2001: What do they portend for the federal growth initiative?" *Health Affairs*: 24, Number 2: 465-472.

- A number of programs bought videos for exercise, nutrition education, and other health related educational programs played at specific sites for exercise and either in classes or waiting rooms for educational programs, including those in Spanish and other languages.

- At least one center has expanded with hearing programs for young children and has replaced its broken Audiometer for hearing screening with a new one.

- Five Laptops have been purchased over time to improve the delivery of services and coordinate patient care and education sessions for patients.

Training

- A number of centers have used funds to conduct training. Five staff training sessions for coordination of services have used outside consultants.

- Centers have also used funds for four staff cultural competence training series using outside consultants.

- At least two centers used funds to seek outside consultants to support staff team work training sessions.

Other

- One center used funds to support an annual child development field trip with families that included outings to create a higher level of family interaction for more than 200 individuals over five years. Brochures, posters, invitations to families, bus rental, admission fees to activities and food were also supported through the mini grant.

- One center created a fathers' support program with a facilitator and 39-session curricula of education and support.

- At least one center sought support for the ongoing concern of good prenatal care. Prenatal support groups were curriculum-based and lasted for eleven weeks affecting more than 50 women.

Community health centers indicated that their outreach, clinical and educational services are all pre-determined by their state and federal funds. While most community health centers are entitled to indirect costs from federal allocations, these costs are critical to the maintenance and operation of the health centers—including capital, equipment, staff, etc.—and usually not available for the kinds of projects listed above. The populations served by community health centers habitually used hospital emergency rooms for family care. The movement of these patients in the last decade from emergency room to community health center services has unfolded, in part, because of the culturally sensitive

outreach and education efforts provided by these centers.[5] More importantly, the growth in utilization of community health centers by historically hard-to-serve populations is a strong indication that outreach efforts are working. Therefore, the focus of these mini grants appears to have an auxiliary effect on utilization rates—whether as added services to what is already done or to the support of initiatives to meet patient needs. Additionally, the growing visibility of community health centers and the changes they are making in utilization rates among populations who usually fall through the gap in early, prevention-oriented services supports studies that community health centers have the capacity to close the gap in health disparity.[6]

Historically, most foundations support new initiatives or ongoing, evidence-based programs. Some philanthropists have been strong proponents of highly effective community-driven health initiatives. Community Foundations and Family Funds invest as diligently in a wide array of community initiatives in health. Yet, it was not until the early 1980s that debate flourished on how economically weakened organizations could afford to create the structural capacity to implement these initiatives. If the staff is being laid off and the building is crumbling, how can good services and programs prevail? For the organizations facing economic hardships, the availability of funds to support organizational capacity building was virtually non-existent.

Foundations developed technical assistance initiatives designed to strengthen organizational capacity to implement effective programs. With this initiative came dollars for improving buildings, training staff, adding technological innovations, marketing and outreach. The Mini Grant Initiative of the Community Health Network of Connecticut Foundation can begin to build and improve on its efforts to bolster a community health center's organizational capacity to increase access and utilization to its diverse population; improve its coordination of services; and, expand the scope of the quality of its services—clinical and programmatic. The findings of this first five years of implementation for the Mini Grant Initiative provides some hopeful insight regarding the organizational impact of small funds for organizational capacity building that improves access and perhaps ultimately can bridge the gap in disparate health care.

FOR A FULL REPORT OF THIS EVALUATION CONTACT TRESSA SPEARS JACKSON, EXECUTIVE DIRECTOR, AT 203.949.4101

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[5] AS O'Malley, CB Forrest, RM Politzer, JT Wulu, & L Shi. (2005). "Health Center Trends, 1994 – 2001: What do they portend for the federal growth initiative?" *Health Affairs*: 24, Number 2: 465-472.

[6] AS O'Malley, CB Forrest, RM Politzer, JT Wulu, & L Shi. (2005). "Health Center Trends, 1994 – 2001: What do they portend for the federal growth initiative?" *Health Affairs*: 24, Number 2: 465-472.