Special Report

The Pfizer Foundation’s Community Health Ventures Program: Providing Models For Community Health Partnerships

Modest grants to community health centers can be effective.

by Caroline Roan and Carolyn W. Clark

ABSTRACT: In response to its concern for the future of community health centers (CHCs) and those who receive care in these centers, in 1997 the Pfizer Foundation created and funded Community Health Ventures (CHV), a four-year, $3.6 million grant-making program. It was designed to increase the capacity of centers to adjust to a changing health care environment. This descriptive special report discusses the outcomes of the program, including its impact on CHCs and their patients, and offers recommendations for funders on how to establish effective partnerships with CHCs.

Because of its concern for the future of community health centers (CHCs) and those who receive care in these centers, in 1997 the Pfizer Foundation created and funded Community Health Ventures (CHV), a four-year, $3.6 million grant-making program. The program was designed to increase centers’ capacity to adjust to a changing health care environment, including the growth of Medicaid managed care.

CHCs, which provide family-oriented primary and preventive care services to medically underserved populations, are a stable presence within the patchwork of organizations providing care to these communities. Fundamental changes in the way health care is delivered and financed are forcing centers to find new ways to fulfill their mission while contending with a shrinking revenue base. In addition, managed care is placing new requirements on community providers, including more complex record keeping and outcome measurements. These requirements are difficult for many CHCs to implement because they often lack the necessary data collection tools and technology.

Through CHV the Pfizer Foundation sought to provide support so that these providers could strengthen their capacity to deliver high-quality health care services and improve patients’ ability to manage their care.

The foundation designed CHV to allow centers to test new ways of providing care and measuring outcomes and to implement new technologies that would improve administration and potentially lower costs and improve care. Funded projects fell into two broad cate-

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categories: those designed to develop and test new models for patients’ self-management of chronic disease; and those designed to develop new solutions to CHC management issues, including the use of technology and the development of integrated delivery systems.

CHV built on the knowledge gained from existing programs, particularly Pfizer’s Sharing the Care program, a joint effort of Pfizer, the National Governors Association, and the National Association of Community Health Centers. Sharing the Care provides free Pfizer pharmaceuticals to low-income, uninsured patients at more than 380 CHCs nationwide.

This descriptive paper discusses the outcomes of the program, including its impact on CHCs and their patients, and offers recommendations for funders on how to establish effective partnerships with CHCs.

**Grant-Making Process**

The foundation hired Bass and Howes (now DDB Bass and Howes), a public policy consulting firm, to assist with management of the grant-making process. The original request for proposals (RFP) was mailed in 1997 to CHCs and state primary care associations. The application process had two phases. First, centers completed a letter of interest discussing their eligibility, capabilities, and project plan and objectives. Letters of interest were evaluated, and a select number of applicants were asked to submit full proposals.

Throughout both the letter-of-interest and full-proposal phases, technical assistance on the application process was made available by a Washington, D.C.-based nonprofit organization. The foundation did not want to eliminate a center simply because it was inexperienced in preparing proposals for private funders. The foundation designed this technical assistance to ensure that interested centers had the skills and knowledge necessary to complete the proposal process and meet the requirements of the RFP.

More than 350 letters of interest were received and reviewed. Eligible letters were read by a team of six, including Bass and Howes staff, foundation staff, and outside reviewers with extensive experience in the field. From the 350 letters, 64 applicants were asked to complete a full proposal. A total of twenty-five centers received funding.

**The Grantees**

Grantees represented nineteen states and the District of Columbia. They ranged from small clinics (some open only a few days a week) to centers having tens of thousands of patient encounters yearly and full pharmacies and specialty care. Most of the centers served large minority populations.

- **Chronic disease projects.** Ten centers initiated chronic disease management projects designed to educate patients about their illness and help them to manage it and to improve their health. In general, these projects provided intensive case management requiring large investments of staff time. Several of the projects included home visits; all included education about disease self-management. Most also included exercise components as well as diet and cooking instruction. Additionally, all of the chronic disease projects were designed to encourage clinical staff to work differently, often more in partnership with patient educators than they had done in the past. All chronic disease projects necessitated the development of new patient information forms and new clinical systems.

- **Projects to improve clinic management.** Five of the grantees worked to install technology to improve patient care and increase the centers’ capacity. All of the technology projects were designed to help the centers to better respond to the challenges of managed care and to improve quality of care.

Two projects developed integrated delivery systems. Another created a senior health clinic co-located with a nonprofit senior-citizen housing development, and two projects sought to better link homeless patients to managed care. The five remaining grantees designed a variety of other projects to respond to the changing health care environment, including streamlining referral systems and other management processes.

- **Funding amounts.** First-year grants
ranged from $10,000 to $50,000, with an average grant of $37,000. Centers were asked to reapply for additional funding each year. Twenty-three of the original centers received second-year grants averaging $59,000; third-year grants went to twenty centers and averaged $67,000. In the fourth year, eight of the original centers received grants, averaging $25,000, to replicate and disseminate their programs.

Impact Of The Program

Although no formal quantitative evaluation of the program was undertaken, both quantitative and qualitative evidence from grantees demonstrates that CHV had a major impact on grantees, their patients, and their communities. The CHV program improved health outcomes, increased center efficiency, and improved the health status of individual patients and the quality of care provided by the centers. Examples of this success include the following.

**Patients’ chronic diseases were better managed.** CHV chronic disease projects each used different evaluation tools and outcome measurements; however, qualitative evidence and quantitative data from the centers suggest that they were able to raise their standards of care and improve the health status of their patients.

Venice Family Clinic (Venice, California) developed and tested a pharmacist-directed intervention, the Rx clinic, to manage diabetes. The patients enrolled by their physicians in the Rx clinic had had diabetes longer and had more complications than patients not seen by the pharmacists. The pharmacists assessed compliance with medication regimens; adjusted medications; and counseled patients about diet, exercise, smoking, stress, and adherence to treatment. Patients enrolled in the clinic’s program were more likely to receive the American Diabetes Association’s recommended standards of care (for example, 90 percent of patients in the program received cholesterol testing, versus only 71 percent of those who were seen through customary physician visits). Compared with diabetic patients followed by physicians, the baseline HbA1c level (a test commonly used to measure blood glucose) among Rx clinic participants was significantly higher ($p < .001$) at the beginning of the intervention (8.8 percent versus 7.9 percent) but fell significantly more ($p < .03$) following one year of pharmacist intervention (–0.8 percent versus –0.5 percent).

**Technological advances improved patient care and center operations.** New technology for some CHV grantees included electronic medical record (EMR) systems, handheld computers for doctors seeing homeless patients on the street, and e-mail and Web sites to link the providers who worked with the homeless population. All of the technology projects were designed to help centers better respond to the challenges of managed care and improve quality of care, although the actual projects and individual goals varied widely.

Lamprey Health Care (Newmarket, New Hampshire) converted to an EMR system to improve quality of care and increase the efficiency and productivity of staff. Access to patient information is now instantaneous, allowing staff to provide patients with laboratory results, prescription refills, and other clinical information in a timely manner. Patients have indicated that they are satisfied with the changes. Although some external documents must still be filed, lab results and transcriptions flow in electronically. The need to pull paper charts for telephone calls has been eliminated; charts are pulled only for office visits. The clarity and accessibility of clinical documentation is an advantage for risk management. Medication entries are precise and up-to-date; checking for drug interactions is done for every new medication prescribed. In the third year of the program, Lamprey received additional Pfizer Foundation funding to use the technology to develop systems to notify clinicians when tests or appointments should be scheduled.

**Centers developed networks.** Two projects focused on developing consortia. These consortia were designed to improve patient care by capturing efficiencies and to strengthen the centers’ voices—both in conversations with policymakers about the
One of the consortia, the Coordinated Care Network (CCN) (Pittsburgh, Pennsylvania) is an integrated delivery system of thirteen organizations, including CHCs and other non-profit service providers. Together they provide some 187 medical and social service programs at 72 locations throughout Allegheny County and work as one unit in contracting with managed care companies and other service purchasers and suppliers. The CCN sought the Pfizer Foundation grant to improve health in underserved neighborhoods by contracting with three Medicaid health maintenance organizations to deliver intensive case management, computerized patient tracking, and health education programs. As a result of the collaboration and combined contracting, more patients received preventive services and regular visits with their primary care physician. The CCN model is beginning to demonstrate that a full range of medical and social services can be provided and financed by the savings generated by the efficiency of the network.

**CHV projects showed cost savings.** Because of CHV’s goal to ensure sustainability of CHCs, several centers sought to measure the cost implications of their projects. In the final year of the Venice Family Clinic project, the per patient cost for diabetes patients seen at the Rx clinic was $552 compared with $1,118 for such patients seen through customary physician visits because of multiple factors, including cost efficiencies from minimizing physician time. Transcription costs from Lamprey Health Care’s Raymond center have dropped from an average of $2,100 per month to $150 per month, because of use of the electronic medical record. Also, preliminary studies show that Medicaid patients using CCN services spent fewer days per month in the hospital than did other plan members (CCN patients averaged forty to fifty fewer days in the hospital, annually, per 1,000 patients).

**Lessons Learned**

Funders can glean a number of lessons from the Community Health Ventures program.

**Evaluation is critical.** As originally developed, CHV did not have a formal evaluation component. When the program had grown and anecdotal evidence of its success was clear, the Pfizer Foundation considered supporting a large-scale evaluation but decided that an evaluation begun while the program was already under way would not provide adequate data. Without this evaluation, the program’s success can only be measured from self-assessment by individual centers and from anecdotal evidence. Although the evidence of success is strong, a formal evaluation would have allowed for broader conclusions and rec-
ommendations and would have assisted in project replication.

- **Consistent outcome measures are important.** Although CHV required centers to design data collection systems, those undertaking similar programs were not asked to gather consistent data. For example, similar diabetes projects did not necessarily collect the same data. This lack of consistency makes it difficult to quantitatively compare projects or to measure the effect of the projects as a whole. Also, many centers struggled with the data collection requirements. The program did offer small technical assistance grants for data collection, but many programs needed more assistance than that.

- **Modest amounts of money spent on CHCs can go a long way.** CHV demonstrates to other funders that although they face a wide array of challenges, CHCs have the ability to respond creatively to the changing health care environment. Despite the relatively small size of these grants, the centers developed and implemented successful programs that were sustainable and replicable.

- **Allowing CHC staffs to network was critical.** Although the Pfizer Foundation had built some opportunities into the program to allow for centers to network, feedback from grantees quickly led the foundation to create additional opportunities. Blocks of time for networking were set aside at the 1999 grantee conference, and a newsletter was developed to share best practices among grantees. Phone conferences for grantees with similar programs were also set up, and the foundation sponsored other networking opportunities at conferences where grantees were presenting or were in attendance. Grantees valued these opportunities, and the networking led to a number of informal collaborations and opportunities for dissemination of project results.

- **Providing technical assistance was critical.** The foundation provided technical assistance in a number of areas including proposal development, fund raising, communication, and data collection. This technical assistance was provided through small additional grants, by experts at the grantee conference, or by phone. Grantees were very enthusiastic about this technical assistance and frequently noted that they had leveraged it in other work. For example, several centers noted that Pfizer funding and technical assistance made them better prepared to work with other private funders. In part as a result of the local funding and technical expertise provided, Chinatown Health Clinic (New York City) received almost half a million dollars from the Robert Wood Johnson Foundation's Local Initiative Funding Partners Program to continue its program focusing on mental health services. Grantees received additional funding from other foundations such as the Annie E. Casey Foundation and the New York Community Trust.

**Concluding Comments**

The Community Health Ventures program provided community health centers with a valuable opportunity to experiment with new approaches to patient care and center operations. While the broad program objectives and scope were defined at the outset, the Pfizer Foundation had no preconceived notions of specific project content and provided the CHCs with the flexibility to conceive, develop, and launch projects that built upon their respective strengths, expertise, and patient bases. The results yielded a range of innovative programs that offer suggestions for other CHCs and providers, funders, and the Pfizer Foundation itself. The foundation has sought to apply these lessons—such as the value of technical assistance, grantee networking, consistent outcome metrics, and evaluation—to new programs.

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