Evaluation of the Grant Programs of the Pacific Hospital Preservation & Development Authority

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Elaine Albertson, MPHc

University of Washington
School of Public Health
Department of Health Services
Evaluation of the Grant Programs of the Pacific Hospital Preservation & Development Authority.

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Graduate Student:  
Elaine Albertson, MPHc  
Department of Health Services  
University of Washington School of Public Health

Site Advisor:  
Jeff Natter, MPH  
Executive Director  
Pacific Hospital Preservation & Development Authority  
1200 12th Ave. S, Quarters 2  
Seattle, WA 98144

Faculty Advisor:  
Clarence Spigner, DrPH  
Professor of Health Services  
University of Washington School of Public Health  
1959 NE Pacific Street  
Seattle, WA 98195
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Executive Summary

This report presents the results of an evaluation of two Pacific Hospital Preservation & Development Authority (PHPDA) grant programs. Section I provides an overview of the PHPDA. Sections II and III describe the methods used and results of the evaluations of the Major Grants and Nimble Fund grantmaking programs. Section IV lists references.

The Major Grants program was evaluated using a cost-benefit approach. Key results from this preliminary cost-benefit analysis included:

- All grants reviewed appear cost-effective based on best available information.
- Moderate estimates suggest that in total, the six grants selected for analysis result in a net benefit to the health system of approximately $1,998,466 per year, taking into account program costs and cost savings from prevention, or an average $333,078 per year per grant.
- Applying this average to all 21 active major grants, including 8 new and 13 currently under renewal, a moderate estimate suggests that the Major Grants program is currently producing approximately $6,994,631 in net savings per year for the health system through the prevention of adverse health conditions.
- These data are preliminary and based on simplified analyses that do not monetize important benefits such as long-term impacts, social and health equity, or workforce productivity. Future analysis should strive to access more detailed data on program effectiveness in preventing the targeted adverse health conditions.

The Nimble Fund program was evaluated using principles of sustained and emerging impacts evaluation. Key results included:

- Impact was most sustained for database, technology, and equipment projects.
- Impact was not as well-sustained for program development projects, such as evaluation and capacity-building. This was especially the case when the organization did not have a plan or adequate stakeholder buy-in for carrying forward the work that was developed.
- Some informants struggled to articulate how the project addressed a health disparity.
- Feedback on the grant process was overwhelmingly positive. Organizations valued the PHPDA as a partner, and appreciated any opportunities to gain insight into the PHPDA’s goals and approach to grantmaking.

Recommendations for consideration by the PHPDA are presented at the end of Sections II and III. These include:

- **Partner with interns and consultants to conduct additional analyses.** These may include examining traits of grant-funded projects that make them more or less cost-effective, conducting more detailed cost-benefit analyses that include individual-level patient cost and outcome data, and conducting a needs assessment comparing the demographics of those served to health disparities in King County.

- **Consider low-cost opportunities to develop and enhance the grants administration process.** For example, consider allowing new ways for grant-receiving organizations to provide anonymous feedback on their experience, providing additional educational materials to prospective applicants regarding health disparities, providing additional guidance to prospective applicants regarding the likelihood of receiving the full amount of funding requested, and asking Nimble Fund applicants for details on their plan for sustaining the impact of the work.
I. Overview of the PHPDA

The Pacific Hospital Preservation & Development Authority (PHPDA) is a quasi-governmental agency located on the historic Pacific Tower campus in Seattle’s Beacon Hill Neighborhood. The organization was chartered by the City of Seattle in 1981. The current mission of the PHPDA is to champion effective health care for the vulnerable and disadvantaged in our community, which the organization achieves through providing grants to agencies and organizations that serve these populations.

From 2013 to 2016, PHPDA grantmaking programs expanded significantly. The organization is currently operated by four staff members, and in 2016 it awarded over $3,000,000 in total funding to health and social service organizations for programs to reduce health disparities in King County.

More information is available at: http://www.phpda.org/.
II. Major Grants Evaluation

Background of the Major Grants Program

The PHPDA Major Grants program was established in 2014 as a funding stream for health and social service programs that advance the PHPDA’s mission and goals. Grant amounts range from $50,000 to $200,000 per year, and awards may be renewed for up to three years. More information about the Major Grants program is available on the PHPDA website at: http://www.phpda.org/funded-projects/overview/.

Evaluation Questions

This evaluation sought to address the following questions:

1. What is the potential range of health care cost savings from the prevention of targeted adverse health conditions resulting from the programs funded by Major Grants?

2. How do potential health care cost savings compare to the program’s budget and the amount invested by the PHPDA?

Methods

This evaluation applied principles from Haddix, Teutsch, & Corso’s (2003) guide to prevention-effectiveness evaluation and cost-benefit analysis. The following seven steps from the Haddix guide were followed to estimate the potential health care cost savings from each Major Grant selected for analysis, and compare these cost savings to the amount invested by the PHPDA.

1. Define the problem.
2. Identify the prevention interventions to be evaluated.
3. Identify the effects of the interventions.
4. Assign dollar values to the prevention interventions and their outcomes.
5. Determine and calculate the summary measure.
6. Evaluate the results with sensitivity analysis.
7. Prepare the results for presentation.

For the cost of adverse health outcomes targeted for prevention by each program, this analysis relied on a review of the academic literature, and on the Washington State Hospital Association Hospital Pricing System for data on the average cost of hospitalization for selected conditions in King County (http://www.wahospitalpricing.org/).

For program costs, this analysis used the total project expenses from the Attachment C budget files submitted to the PHPDA by each grant-receiving organization.
Results

The following pages present the results of preliminary cost-benefit analyses for six Major Grant programs selected for analysis (Table 1). Due to limitations on availability of patient-level and longitudinal health care cost and outcomes data from sites that have received Major Grants, this analysis presents a simplified cost-benefit analysis that uses the best information available to provide a conservative estimate of potential cost-effectiveness of each program selected for analysis. In addition, this simplified analysis does not take into consideration important factors such as quality of life, social and health equity, and workforce productivity that are important when weighing benefits and costs. Further data collection and analysis is recommended to confirm the potential cost savings from prevention arising from this work.

Table 1

*Major Grant programs selected for preliminary cost-benefit analysis.*

<table>
<thead>
<tr>
<th>Program</th>
<th>Organization</th>
<th>Year Funding Initiated</th>
<th>PDA Funds in Year 1</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth and Outreach Doula Programs</td>
<td>Open Arms</td>
<td>2016</td>
<td>$80,000</td>
</tr>
<tr>
<td>Emergency Shelter Primary Care Clinic</td>
<td>Downtown Emergency Service Center (DESC)</td>
<td>2016</td>
<td>$170,000</td>
</tr>
<tr>
<td>Integrated Behavioral Health Services for Des Moines Health and Housing Campus</td>
<td>Sea Mar Community Health Centers</td>
<td>2016</td>
<td>$180,830</td>
</tr>
<tr>
<td>Passage Point Health Coordination</td>
<td>YWCA</td>
<td>2016</td>
<td>$70,918</td>
</tr>
<tr>
<td>Weekend Hours to Improve Health Outcomes for Homeless and Low-Income American Indians and Alaska Natives</td>
<td>Chief Seattle Club</td>
<td>2016</td>
<td>$138,000</td>
</tr>
<tr>
<td>Wellness for Asian Pacific Americans Primary and Behavioral Integrated Care Project</td>
<td>Asian Counseling and Referral Service (ACRS)</td>
<td>2015</td>
<td>$100,000</td>
</tr>
</tbody>
</table>

For each program supported by a Major Grant, this document presents the background of the program, an estimate of program effectiveness, a cost-benefit analysis, and a table that shows the estimated net benefit for a range of assumptions regarding the effectiveness of the program in preventing targeted adverse health conditions.
Open Arms Perinatal Services: Birth and Outreach Doula Program

Estimated net savings to the health system: $213,436 per year (ranging from $17,218 to $707,273).

Background

The birth and outreach doula program operated by Open Arms provides culturally relevant doula services to assist with prenatal, birth, and postpartum health education and support. The program primarily works with low-income mothers in King County and the surrounding area, and specializes in supporting mothers who identify as American Indian or Alaska Native, Black or African American (including Somali), and Hispanic or Latino. More information is available at: [http://www.phpda.org/projects/addressing-disparities-in-birth-outcomes-for-king-county’s-most-vulnerable-c](http://www.phpda.org/projects/addressing-disparities-in-birth-outcomes-for-king-county’s-most-vulnerable-c).

This analysis uses preterm birth, caesarean births, and breastfeeding initiation as illustrative examples of adverse health conditions likely to be prevented by this program.

Effectiveness

The program likely prevented between 3 and 12 caesarean births over the 2016-2017 grant year. Over the course of the 2016-2017 grant year, the program supported 77 births (Pacific Hospital Preservation & Development Authority, 2017). Of the 26 births with records on file as of the time of this analysis, 5 were unplanned caesarean sections (19%). By comparison, the 2010-2014 average rates of caesarean births among low-risk women in King County were 22.4% for American Indian or Alaska Native mothers, 35.0% for Black or African American mothers, and 25.1% for Hispanic or Latino mothers (Public Health - Seattle & King County, 2017). A conservative estimate suggests that the program reduced the caesarean section rate from 22.4% (the lowest caesarean rate among the populations targeted) to 19%. Applying these rates to the 77 births supported, program data suggest a reduction in caesarean births from an expected 17.2 births, to 14.6, suggesting a prevention of at least 2.6 caesarean sections in the population reached. Given the high rate of 35.0% caesarean sections for Black or African American mothers, and the additional risk factors associated with having a low income during pregnancy, a less conservative estimate would be that the program reduced the caesarean rate from 35% to 19%, preventing up to 12.4 caesarean sections in the population reached.

The program likely encouraged between 3 and 9 women to initiate breastfeeding over the 2016-2017 grant year. All 26 mothers with data on file initiated breastfeeding at birth (100%). By comparison, the 2010-2014 average rates of breastfeeding initiation in newborns in King County were 88.9% for American Indian or Alaska Native mothers, 93.8% for Black or African American mothers, and 96.3% for Hispanic or Latino mothers. A conservative estimate would suggest that the program increased the breastfeeding initiation rate from 96.3% (the highest rate among the populations targeted) to 100%. Applying these rates to the 77 births supported, the data suggest an increase in breastfeeding initiation from approximately 74.2 to 77, or an increase of 2.8 mothers breastfeeding in the population reached. Given the low rate of 88.9% breastfeeding for the American Indian or Alaska Native mothers, and the barriers to breastfeeding associated with having a low income, a less conservative estimate would be that the program increased the breastfeeding initiation rate from 88.9% to 100%, resulting in an increase of up to 8.5 additional women breastfeeding.
The program likely prevented up to 8 preterm births over the 2016-2017 grant year. Due to the time lag in data collection, limited information was available at the time of this analysis to determine the extent to which the program was effective in increasing rates of full term birth. However, an evaluation prepared for Open Arms by the Center for Community Health and Evaluation in 2017 found that rates of preterm birth among Latina and Somali participants were lower than those of comparable subgroups in all King County (Center for Community Health and Evaluation, 2017), and research suggests that doula care is associated with prevention of preterm birth (Kozhimannil, Hardeman, Attanasio, Blauer-Peterson, & O’Brien, 2013). In King County, from 2010-2014 the prevalence of preterm birth was 15.2% for American Indian or Alaska Native mothers, 11.7% for Black or African American mothers, and 10.3% for Hispanic or Latino mothers (Public Health - Seattle & King County, 2017). Thus, using the most conservative preterm birth rate for the target populations, without intervention approximately 10.3% or 7.9 births would have been expected to be preterm. The doula program thus could have prevented up to 8 preterm births.

Preliminary Cost-Benefit Analysis

Benefits

The program likely produced cost savings to the health system between $31,785 and $127,140 from the prevention of caesarean births over the 2016-2017 grant year. As noted in the section above, among the 77 births supported during the grant year, the program likely prevented between 3 and 12 caesarean births. According to the Washington State Hospital Association, from October 2014 to September 2015 in King County the average cost of a vaginal delivery without complications was $13,281, while the average cost of a caesarean delivery without complications was $23,876 (Washington State Hospital Association, 2017). Cost savings from prevention of one caesarean delivery (without complications) is thus $10,595, or $31,785 for the prevention of 3 caesarean deliveries and $127,140 for the prevention of 12 caesarean deliveries. This cost assumption is conservative in that it does not consider the higher cost of births with complications.

The program likely produced cost savings to the health system between $10,326 and $30,978 from the promotion of breastfeeding over the 2016-2017 grant year. As noted in the section above, the program likely encouraged between 3 and 9 mothers to initiate breastfeeding, who otherwise would not have. Numerous studies have documented potential national health care cost savings from breastfeeding (Bartick & Reinhold, 2010; Rollins et al., 2016; Weimer, 2001). While fewer have presented per capita estimates of cost savings from breastfeeding, one such study found that over a 90-month follow-up period, breastfeeding led to savings of $3,442 to $6,060 per family to state health insurance and social service programs (Tuttle & Dewey, 1996). Using the low estimate of savings presented by Tuttle & Dewey (1996), which is even more conservative because it was calculated in 1996 dollars, cost savings to health and human services from encouraging 3 mothers to initiate breastfeeding can be estimated at $10,326 over the first years of life, and cost savings from encouraging 9 mothers to initiate breastfeeding can be estimated at $30,978.

The program likely produced cost savings to the health system up to $1,148,096 from the prevention of preterm births over the 2016-2017 grant year. According to the Washington State Hospital Association, from October 2014 to September 2015, the average cost of infant care for a full term, normal newborn was $4,168. The average cost for a premature infant with major problems was
$147,680, resulting in an additional cost to the health system of $143,512 per preterm infant with complications. Cost savings from prevention of 4 preterm births with complications can be estimated at $574,048, and cost savings from prevention of 8 preterm births with complications can be estimated at $1,148,096.

Costs

Total project expenses reported in the budget submitted to the PHPDA were $598,941 in the 2016-2017 grant year. The amount funded by the PHPDA was $80,000 (13% of total project expenses).

Cost-Benefit Comparison

A moderate estimate is that the program produced a net benefit of $213,436 to the health system over the 2016-2017 grant year, taking into account program costs and cost savings from prevention. Table 2 combines the estimates of cost savings and program costs to provide a conservative, moderate, and high estimate of net benefits to the health system and society from the prevention of adverse health outcomes by this program. This analysis is conservative in that it does not take into account the intangible benefits of receiving culturally relevant support around childbirth, and does not take into account the potential health care cost savings arising from non-clinical health promotion, education, and case management activities provided by the doulas.

Table 2

Estimated net benefit for different assumptions regarding the prevention of adverse health outcomes for the Birth and Outreach Doula Program.

<table>
<thead>
<tr>
<th>Estimate</th>
<th>Total Program Expenses</th>
<th>Cost Savings from Prevention</th>
<th>Net Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conservative</td>
<td>$598,941</td>
<td>$31,785 (3 caesarean births prevented) $10,326 (3 breastfeeding initiations) $574,048 (4 premature births with complications, or other outcomes of similar cost and severity, prevented)</td>
<td>$17,218</td>
</tr>
<tr>
<td>Moderate</td>
<td>$598,941</td>
<td>$74,165 (7 caesarean births prevented) $20,652 (6 breastfeeding initiations) $717,560 (5 premature births with complications, or other outcomes of similar cost and severity, prevented)</td>
<td>$213,436</td>
</tr>
<tr>
<td>High</td>
<td>$598,941</td>
<td>$127,140 (12 caesarean births prevented) $30,978 (9 breastfeeding initiations) $1,148,096 (8 premature births with complications, or other outcomes of similar cost and severity, prevented)</td>
<td>$707,273</td>
</tr>
</tbody>
</table>
Downtown Emergency Service Center: Emergency Shelter Primary Care Clinic

Estimated net savings to the health system: **$599,416 per year (ranging from $34,906 to $2,594,018)**.

**Background**

The Emergency Shelter Primary Care Clinic operated by the Downtown Emergency Service Center (DESC) offers primary care services to people experiencing homelessness. The PHPDA Major Grant supported the staffing of a primary care clinic at an emergency shelter, specifically, an Advanced Practice Registered Nurse (APRN) and Medical Assistant (MA) who work in collaboration with the existing Registered Nurse (RN) funded by the Healthcare for the Homeless Network (HCN). More information is available at: [http://www.phpda.org/projects/desc-emergency-shelter-primary-care-clinic](http://www.phpda.org/projects/desc-emergency-shelter-primary-care-clinic).

This analysis uses hospitalization for minor skin conditions as an illustrative example of an adverse health condition likely to be prevented by this program.

**Effectiveness**

The program likely prevented up to 156 hospitalizations for minor skin conditions or illness of similar magnitude and cost over the 2016-2017 grant year. Constraints on data availability limit estimates of program effectiveness in preventing targeted adverse health conditions. While clinic staff document health care encounters in a secure electronic health records database, DESC is still developing its data sharing agreement with its partner, Harborview Medical Center, and does not have access to detailed health care data at this time. However, program reports show that out of 549 visits during the 2016-2017 grant year, most (329, or 59.9%) were primarily related to short-term illness or injury (Pacific Hospital Preservation & Development Authority, 2017). Applying this rate to the 260 unique clients who were served over the grant year, prevalence of short-term illness or injury in the population can be assumed to be 59.9% or 155.7 individuals. Thus, disregarding chronic disease and psychiatric care encounters, and assuming all cases of short-term illness or injury could have resulted in hospitalization if left untreated, the clinic could have prevented up to 156 hospitalizations for minor injury or illness.

Due to the diversity of health conditions that could be treated in the category of short-term illness or injury, for illustrative purposes this preliminary analysis will use hospitalization for minor skin disorders without major complications or comorbidities (the skin treatment with the lowest average cost reported by the Washington State Hospital Association) as an example condition likely to be prevented.

**Preliminary Cost-Benefit Analysis**

**Benefits**

The program likely produced cost savings to the health system of up to $2,935,452 from the prevention of hospitalization for minor skin conditions, or short-term illness or injury of similar severity, over the 2016-2017 grant year. According to the Washington State Hospital Association, from October 2014 to September 2015 in King County the average cost of hospitalization for minor skin disorder without major complications or comorbidity was $18,817 (Washington State Hospital Association, 2017). Cost savings from prevention of 20 hospitalizations can be estimated at $376,340,
cost savings from prevention of 50 hospitalizations can be estimated at $940,850, and cost savings from prevention of 156 hospitalizations can be estimated at $2,935,452.

Costs

Total project expenses reported in the budget submitted to the PHPDA were $341,434 in the 2016-2017 grant year. The amount funded by the PHPDA was $170,000 (50% of total project expenses).

Cost-Benefit Comparison

A moderate estimate is that the program produced a net benefit of $599,416 to the health system over the 2016-2017 grant year, taking into account program costs and cost savings from prevention. Table 3 combines the estimates of cost savings and program costs to provide a conservative, moderate, and high estimate of net benefits to the health system and society from the prevention of adverse health outcomes by this program. This analysis is conservative in that it does not take into account potential cost savings from chronic disease and medication management services provided by the clinic.

Table 3

<table>
<thead>
<tr>
<th>Estimate</th>
<th>Total Program Expenses</th>
<th>Cost Savings from Prevention</th>
<th>Net Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conservative</td>
<td>$341,434</td>
<td>$376,340 (20 hospitalizations for minor skin conditions, or other outcomes of similar cost and severity, prevented)</td>
<td>$34,906</td>
</tr>
<tr>
<td>Moderate</td>
<td>$341,434</td>
<td>$940,850 (50 hospitalizations for minor skin conditions, or other outcomes of similar cost and severity, prevented)</td>
<td>$599,416</td>
</tr>
<tr>
<td>High</td>
<td>$341,434</td>
<td>$2,935,452 (156 hospitalizations for minor skin conditions, or other outcomes of similar cost and severity, prevented)</td>
<td>$2,594,018</td>
</tr>
</tbody>
</table>
Sea Mar: Integrated Behavioral Health Services for Des Moines Health and Housing Campus

Estimated net savings to the health system: $80,034 per year (ranging from $18,624 to $386,070).

**Background**

The integrated behavioral health services operated by Sea Mar Community Health Centers (Sea Mar) at the Des Moines Health and Housing Campus provide mental health services in the clinic at a 42-unit family-oriented affordable housing development. Many of the clinic’s patients live in the Des Moines housing development, and almost all have low household incomes. The PHPDA has funded staff hours for a behavioral health team to work in partnership with physical health providers at the clinic, consisting of one Integration Specialists and two Mental Health Therapists. The most common mental health conditions addressed by the behavioral health team are depression and anxiety. More information is available at: [http://www.phpda.org/projects/integrated-behavioral-health-services-for-des-moines-health-housing-campus](http://www.phpda.org/projects/integrated-behavioral-health-services-for-des-moines-health-housing-campus).

This analysis uses depression as an illustrative example of an adverse health conditions likely to be prevented by this program.

**Effectiveness**

The program likely prevented the progression of between 90 and 97 cases of depression over the 2016-2017 grant year. During the 2016-2017 grant year, 338 patients were seen by the Integration Specialist due to their Patient Health Questionnaire-9 (PHQ-9) score, a common clinical screening tool for depression, and 254 patients were referred to the program’s Mental Health Therapist for ongoing treatment (Pacific Hospital Preservation & Development Authority, 2017). It is widely accepted that psychological treatments including psychotherapy and antidepressant medication are effective in ameliorating symptoms of depression (American Psychological Association, 2012; Berg & Høie, 2010; Churchill et al., 2001, Hunsley, Elliott, & Therrien, 2013). A quantitative review of the literature by De Maat, Dekker, Schoevers, & De Jonghe (2006) estimated a pooled remission rate of 38% for patients receiving psychotherapy, and 35% for patients receiving pharmacotherapy for depression. Applying these remission rates to the 254 patients referred to the Mental Health Therapist for treatment, a conservative estimate is that the program prevented progression of depression for approximately 90 to 97 patients.

**Preliminary Cost-Benefit Analysis**

**Benefits**

The program likely produced cost savings to the health system between $212,940 and $580,836 from the prevention of hospitalization for depressive neuroses over the 2016-2017 grant year. Greenberg, Fournier, Sisitsky, Pike, & Kessler (2015) estimated that in 2010, an individual with major depressive disorder (MDD) cost $5,988 more to the health system than an individual without MDD, with $2,366 of the incremental cost due directly to MDD, and the remainder due to other depression costs ($584) and non-depression costs ($3,038). Cost savings from prevention of MDD, or mental-health related illness of comparable severity, for 90 patients at $2,366 each can be estimated at $212,940. Cost savings from
prevention of MDD and any incremental depression costs for 93 patients at $2,950 each can be estimated at $274,350. Cost savings from prevention of MDD and any incremental depression or non-depression costs for 97 patients at $5,988 each can be estimated at $580,836.

Costs

Total project expenses reported in the budget submitted to the PHPDA were $194,316 in the 2016-2017 grant year. The amount funded by the PHPDA was $180,830 (93% of total project expenses).

Cost-Benefit Comparison

A moderate estimate is that the program produced a net benefit of $80,034 to the health system over the 2016-2017 grant year, taking into account program costs and cost savings from prevention. Table 4 combines the estimates of cost savings and program costs to provide a conservative, moderate, and high estimate of net benefits to the health system and society from the prevention of adverse health outcomes by this program. This analysis is conservative in that it does not take into account the risk factors associated with having a low income, and does not consider hospitalization for related conditions such as psychoses or physical health conditions aggravated by a mental health condition.

Table 4

*Estimated net benefit for different assumptions regarding the prevention of adverse health outcomes for the Integrated Behavioral Health Services for Des Moines Health and Housing Campus.*

<table>
<thead>
<tr>
<th>Estimate</th>
<th>Total Program Expenses</th>
<th>Cost Savings from Prevention</th>
<th>Net Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conservative</td>
<td>$194,316</td>
<td>$212,940 (90 cases of major depressive disorder or other outcomes of similar cost and severity, prevented)</td>
<td>$18,624</td>
</tr>
<tr>
<td>Moderate</td>
<td>$194,316</td>
<td>$274,350 (93 cases of major depressive disorder or other outcomes of similar cost and severity, prevented)</td>
<td>$80,034</td>
</tr>
<tr>
<td>High</td>
<td>$194,316</td>
<td>$580,386 (97 cases of major depressive disorder or other outcomes of similar cost and severity, prevented)</td>
<td>$386,070</td>
</tr>
</tbody>
</table>
**YWCA: Passage Point Health Coordination**

*Estimated net savings to the health system: $191,814 per year (ranging from $39,993 to $286,776).*

**Background**

The health coordination program operated by the YWCA at the Passage Point campus provides health care navigation and coaching, nutrition, and stress reduction activities for formerly incarcerated women and men transitioning back into the community and at high risk of homelessness. These services are located at a 46-unit affordable housing development near Issaquah that provides wraparound services to meet the social, economic, and health needs of the target population. Approximately 44% of residents identify as African American, and 63% identify as people of color. An estimated 61% of residents have at least one chronic health condition (YWCA, 2017). Nearly all residents have zero to very low household incomes, and are working toward self-sufficiency and family reunification with their children. The PHPDA funded staffing in the form of a Health Coordinator responsible for the health promotion activities described above. More information is available at: http://www.phpda.org/projects/ywca-passage-point-health-coordination.

This analysis uses cardiovascular disease (CVD) and recidivism as illustrative examples of adverse health and social conditions likely to be prevented by this program.

**Effectiveness**

The program likely prevented the progression of up to 32 cases of cardiovascular disease (CVD) or illness of similar magnitude and cost over the 2016-2017 grant year. Literature suggests that prevention interventions including exercise, modification of diet and weight, and psychosocial support can be effective in mitigating adverse health outcomes of cardiovascular disease (CVD) and related chronic illness (Clark, Hartling, Vandermeer, & McAlister, 2005; Leon et al., 2005; Taylor et al., 2004). Over the course of the grant year, the program provided supportive services to 52 unique clients, 32 (61%) of which can be assumed to have at least one chronic health condition (Pacific Hospital Preservation & Development Authority, 2017). Thus, it can be assumed that the prevention activities could have prevented the progression of up to 32 cases of CVD or similar chronic illness.

The program likely prevented between 2 and 6 reincarcerations over the 2016-2017 grant year. Due to constraints that limit the program’s ability to follow up with former residents, data on recidivism is also not available at this time for the population served. However, research suggests that formerly incarcerated individuals without physical illness are 25% less likely to be reincarcerated within one year compared to those with physical illness (Mallik-Kane & Visher, 2008, p. 29). In addition, a study of 5,189 individuals released from King County jails found a 16% reduction in number of subsequent detentions associated with Medicaid enrollment upon release (Morrisset, Cuddeback, Cuellar, & Steadman, 2007). In 2009, the recidivism rate within three years of release for individuals exiting Washington State prisons was 27.8% (Washington State Department of Corrections, 2013). Applying these rates, a conservative 16% reduction in recidivism from 27.8% to 23.4% would result in the prevention of 2.3 reincarcerations per annual cohort of residents. However, given the depth of wraparound services provided, and the incentive to pursue family reunification, the high estimate of a 41% reduction in three-year recidivism (25% reduction from physical health improvement, and 16% reduction from insurance enrollment) is
also relevant. The program could have reduced recidivism from 27.8% to 16.4%, and prevented up to 6.0 reincarcerations per annual cohort of Passage Point residents.

**Preliminary Cost-Benefit Analysis**

**Benefits**

The program likely produced cost savings to the health system up to $606,496 from the prevention and management of cardiovascular disease (CVD), or chronic disease of similar cost and magnitude, over the 2016-2017 grant year. A five-year study of 12,278 patients estimated that average total direct medical costs for patients with CVD are $18,953 per year, including inpatient care, outpatient care, and pharmaceuticals (Nichols, Bell, Pedula, & O’Keeffe-Rosetti, 2010). Cost savings from prevention and management of CVD for 25 patients at $18,953 can be estimated at $473,825, for 30 patients can be estimated at $568,590, and for 32 patients can be estimated at $606,496.

The program likely produced cost savings to the human services system between $57,056 and $171,168 from the prevention of recidivism over the 2016-2017 grant year. As noted in the section above, the program likely prevented between 2 and 6 reincarcerations among the 52 individuals supported by the program. In 2016, the cost to incarcerate an individual in the Washington State Department of Corrections was $28,528 per year for a minimum-security institution, including the cost of state-provided health care (Washington State Department of Corrections, 2017). Cost savings to health and human services from preventing 2 residents from recidivating can be estimated at $57,056, and cost savings from preventing 6 residents from recidivating can be estimated at $171,168.

**Costs**

Total project expenses reported in the budget submitted to the PHPDA were $490,888 in the 2016-2017 grant year. The amount funded by the PHPDA was $70,918 (14% of total project expenses).

**Cost-Benefit Comparison**

A moderate estimate is that the program produced a net benefit of $191,814 to the health system over the 2016-2017 grant year, taking into account program costs and cost savings from prevention. Table 5 combines the estimates of cost savings and program costs to provide a conservative, moderate, and high estimate of net benefits to the health system and society from the prevention of adverse health and social outcomes by this program. This analysis is conservative in that it does not take into account potential cost savings from family reunification, or from management of mental health and substance use conditions.
Table 5

*Estimated net benefit for different assumptions regarding the prevention of adverse health outcomes for Passage Point Health Coordination.*

<table>
<thead>
<tr>
<th>Estimate</th>
<th>Total Program Expenses</th>
<th>Cost Savings from Prevention</th>
<th>Net Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conservative</td>
<td>$490,888</td>
<td>$473,825 (25 cases of cardiovascular disease or other outcomes of similar cost and severity, prevented) $57,056 (2 reincarcerations prevented)</td>
<td>$39,993</td>
</tr>
<tr>
<td>Moderate</td>
<td>$490,888</td>
<td>$568,590 (30 cases of cardiovascular disease or other outcomes of similar cost and severity, prevented) $114,112 (4 reincarcerations prevented)</td>
<td>$191,814</td>
</tr>
<tr>
<td>High</td>
<td>$490,888</td>
<td>$606,496 (32 cases of cardiovascular disease or other outcomes of similar cost and severity, prevented) $171,168 (6 reincarcerations prevented)</td>
<td>$286,776</td>
</tr>
</tbody>
</table>
Chief Seattle Club: Weekend Hours to Improve Health Outcomes for Homeless and Low-Income American Indians and Alaska Natives

Estimated net savings to the health system: $575,732 per year (ranging from $191,672 to $978,995).

Background

The services operated by Chief Seattle Club support individuals who identify as homeless and American Indian or Alaska Native to meet their basic health, nutrition, and cultural needs. At its location in downtown Seattle, Chief Seattle Club offers a variety of programs including culturally relevant health promotion and wellness activities, physical and mental health services, hot meals, and hygiene services including showers and toiletries. The PHPDA funded Chief Seattle Club to extend its hours to include Saturday and Sunday. More information is available at: http://www.phpda.org/projects/weekend-hours-to-improve-health-outcomes-for-homeless-low-income-american-i.

This analysis uses hospitalization for alcohol and drug abuse as an illustrative example of an adverse health condition likely to be prevented by this program.

Effectiveness

The program likely prevented up to 61 hospitalizations for alcohol and drug abuse, or illness of similar magnitude and cost, over the 2016-2017 grant year. While data is limited, anecdotally the Saturday and Sunday hours have been effective in reducing relapse from substance use and mental health conditions by eliminating the weekend service gap. From 2010-2014, 20% of American Indian or Alaska Native residents of King County reported binge drinking (Public Health - Seattle & King County, 2017). However, according to Chief Seattle Club’s 2016 Major Grant application, because Chief Seattle Club supports individuals at high risk of substance use disorder, the rate of mental health and substance abuse conditions in the population served is likely closer to 75%. Informal reports from program leadership in September 2017 estimated that the percent of members with alcohol and drug addictions may even be as high as 90%. Thus, this analysis is based on the moderate assumption that 75% of members would be at risk of hospitalization for alcohol and drug abuse, or a behavioral health condition of similar severity. Applying this rate to the estimated 606 unique clients served by the funded program over the 2016-2017 grant period, approximately 455 can be assumed to be at risk.

Literature on hospitalization rates for individuals with alcohol and substance use disorder is not robust. However, one study of 1,011 adult patients entering an outpatient chemical dependency recovery program found that 19% were hospitalized as inpatients during the 18 months prior to intake, compared to only 5.6% of matched controls from the general population (Parthasarathy, Weisner, Hu, & Moore, 2000). Applying these rates to the estimated 455 Chief Seattle Club program participants with substance use disorder, or other behavioral health condition of similar magnitude, up to 86 members of Chief Seattle Club would likely be hospitalized without any intervention. With intervention, the number of hospitalized individuals might be reduced to approximately 25. That is, intervention could prevent up to 61 hospitalizations among members with substance use disorder.
**Preliminary Cost-Benefit Analysis**

**Benefits**

The program likely produced cost savings to the health system up to $1,171,383 from the prevention of hospitalization for alcohol and drug abuse, or conditions of similar cost and magnitude, over the 2016-2017 grant year. According to the Washington State Hospital Association, from January 2016 to December 2016 in King County the average cost of hospitalization for minor alcohol and drug abuse, without rehabilitation therapy and without major complications or comorbidity (the most common form of hospitalization for alcohol and drug abuse reported), was $19,203 (Washington State Hospital Association, 2017). Cost savings from the prevention of 20 hospitalizations can be estimated at $384,060, cost savings from the prevention of 40 hospitalizations can be estimated at $768,120, and cost savings from the prevention of 61 hospitalizations can be estimated at $1,171,383.

**Costs**

Total project expenses reported in the budget submitted to the PHPDA were $192,388 in the 2016-2017 grant year. The amount funded by the PHPDA was $138,000 (72% of total project expenses).

**Cost-Benefit Comparison**

A moderate estimate is that the program produced a net benefit of $575,732 to the health system over the 2016-2017 grant year, taking into account program costs and cost savings from prevention. Table 6 combines the estimates of cost savings and program costs to provide a conservative, moderate, and high estimate of net benefits to the health system and society from the prevention of adverse health outcomes by this program. This analysis is conservative in that it does not consider costs other than inpatient stays, such as emergency department visits, and it does not take into account the potentially even higher prevalence of alcohol and drug abuse among the target population.
Table 6

*Estimated net benefit for different assumptions regarding the prevention of adverse health outcomes for the Weekend Hours to Improve Health Outcomes for Homeless and Low-Income American Indians and Alaska Natives.*

<table>
<thead>
<tr>
<th>Estimate</th>
<th>Total Program Expenses</th>
<th>Cost Savings from Prevention</th>
<th>Net Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conservative</td>
<td>$192,388</td>
<td>$384,060 (20 hospitalizations for alcohol and drug abuse, or other outcomes of similar cost and severity, prevented)</td>
<td>$191,672</td>
</tr>
<tr>
<td>Moderate</td>
<td>$192,388</td>
<td>$768,120 (40 hospitalizations for alcohol and drug abuse, or other outcomes of similar cost and severity, prevented)</td>
<td>$575,732</td>
</tr>
<tr>
<td>High</td>
<td>$192,388</td>
<td>$1,171,383 (61 hospitalizations for alcohol and drug abuse, or other outcomes of similar cost and severity, prevented)</td>
<td>$978,995</td>
</tr>
</tbody>
</table>
Asian Counseling and Referral Service: Wellness for Asian Pacific Americans Primary and Behavioral Integrated Care Project

Estimated net savings to the health system: $338,034 per year (ranging from $33,398 to $642,670).

Background

The Wellness for Asian Pacific Americans (WAPA) project operated by Asian Counseling and Referral Service (ACRS) integrates behavioral health and primary care services for Asian and Pacific Islander populations with high rates of severe and persistent mental illness. The PHPDA Major Grant supported the continuation of care integration work after the conclusion of the federal Primary and Behavioral Health Care Integration (PBHCI) grant awarded to ACRS by the Substance Abuse and Mental Health Services Administration (SAMHSA). Specifically, the PHPDA funded the continued co-location of primary care and wellness activities in an outpatient mental health setting. More information is available at: http://www.phpda.org/projects/wellness-for-asian-pacific-american-wapa-project-primary-and-behavioral-int.

This analysis uses cardiovascular disease as an illustrative example of an adverse health condition likely to be prevented by this program.

Effectiveness

The program likely prevented between 9 and 13 hospitalizations for cardiovascular disease over the 2015-2016 grant year. Integrated behavioral health and primary care has been found to be effective in improving physical health for patients with severe mental illness. While a national evaluation of the federal PBHCI care integration initiative found no clear relationship between PBHCI and behavioral health outcomes, integrated care was tied to improvements in diastolic blood pressure, total cholesterol, and plasma glucose for patients in the intervention group compared to controls (Scharf et al., 2013). The ACRS program demonstrated positive results in similar health metrics related to obesity, diabetes, and cardiovascular health.

In 2014 the prevalence of having had a heart attack among those who identify as Asian in King County was 3% (Public Health - Seattle & King County, 2017). In addition, the end of the first year of the Major Grant, of the 443 patients who had repeat measurements on file, 68.6% showed improvement in blood pressure or maintenance of healthy blood pressure, and 47.1% showed improvement in BMI or maintenance of healthy BMI (Pacific Hospital Preservation & Development Authority, 2017). These program data suggest that the initiative may have reduced the heart attack rate by 47.1%, from 3% to 1.6% prevalence, or potentially by 68.6%, from 3% to 0.9% prevalence. Applying these rates to the 620 unique clients served over the 2015-2016 grant year, these data suggest a reduction in the number of heart attacks, or adverse health outcomes of similar severity, from an expected 18.6 without intervention, to 9.9 or as low as 5.6 in the population reached. Thus, disregarding hospitalizations for other purposes, the clinic could have prevented between 9 and 13 bypass surgeries, or procedures of similar cost and magnitude resulting from chronic disease.
Preliminary Cost-Benefit Analysis

Benefits

The program likely produced cost savings to the health system between $1,370,862 and $1,980,134 from the prevention of surgery for cardiovascular disease, or hospitalizations for chronic disease-related conditions of similar severity, over the 2015-2016 grant year. According to the Washington State Hospital Association, from October 2014 to September 2015, the average cost of a bypass surgery without insertion of cardiac catheter and without angioplasty (the most common and lowest cost form of bypass surgery reported) was $152,318 (Washington State Hospital Association, 2017). Cost savings from the prevention of 9 bypass surgeries can be estimated at $1,370,862, and cost savings from the prevention of 13 bypass surgeries can be estimated at $1,980,134.

Costs

Total project expenses reported in the budget submitted to the PHPDA were $1,337,464 in the 2016-2017 grant year. The amount funded by the PHPDA was $100,000 (7% of total project expenses).

Cost-Benefit Comparison

A moderate estimate is that the program produced a net benefit of $338,034 to the health system over the 2016-2017 grant year, taking into account program costs and cost savings from prevention. Table 7 combines the estimates of cost savings and program costs to provide a conservative, moderate, and high estimate of net benefits to the health system and society from the prevention of adverse health outcomes by this program. This analysis is conservative in that it does not take into account the intangible benefits of receiving culturally relevant integrated care, or other health care costs avoided through prevention and management of chronic conditions such as diabetes, obesity, and mental illness.

Table 7

Estimated net benefit for different assumptions regarding the prevention of adverse health outcomes for Wellness for Asian Pacific Americans Primary and Behavioral Integrated Care Project.

<table>
<thead>
<tr>
<th>Estimate</th>
<th>Total Program Expenses</th>
<th>Cost Savings from Prevention</th>
<th>Net Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conservative</td>
<td>$1,337,464</td>
<td>$1,370,862 (9 bypass surgeries prevented)</td>
<td>$33,398</td>
</tr>
<tr>
<td>Moderate</td>
<td>$1,337,464</td>
<td>$1,675,498 (11 bypass surgeries prevented)</td>
<td>$338,034</td>
</tr>
<tr>
<td>High</td>
<td>$1,337,464</td>
<td>$1,980,134 (13 bypass surgeries prevented)</td>
<td>$642,670</td>
</tr>
</tbody>
</table>
Summary and Recommendations

Overall, the Major Grant-funded programs selected for analysis appear to be cost-effective in generating net savings for the health system. A moderate estimate of net financial benefit to the health system resulting from programs supported by the six selected Major Grants is $1,998,466 per year, or an average of $333,078 per grant. However, net savings may be up to $5,595,802 per year for the six grants analyzed, or an average of $932,634 per grant. Extrapolating these estimates to all 21 Major Grants active in 2017 (8 new grants, and 13 renewal grants), a moderate estimate is that the projects supported by the Major Grants program generate approximately $6,994,631 in net savings to the health system per year through prevention of targeted adverse health conditions.

Limitations of this analysis include constraints on the availability of program data for evaluating effectiveness, barriers to accessing health care data for individual patients, and that programs may impact quality of life without resulting in directly measurable cost savings. Because the six grant-funded projects selected for analysis provide integrated care and health promotion services, there may be additional significant savings to the health care system and society, on the order of years or decades, that are not captured in this preliminary cost-benefit analysis. More in-depth analysis would be required to generate a more specific and accurate estimate of cost effectiveness in the long-term for each program. In addition, this preliminary analysis does not consider the intangible benefits of the funded programs, such as the psychological benefit of being provided with culturally relevant health care, the benefits of integrated wraparound services, or the benefits of workforce productivity.

Based on the findings of this analysis, the primary recommendation is to explore future opportunities to partner with volunteers, interns, and consultants to conduct additional in-depth analyses of program costs, benefits, and impact on health disparities. Future research and evaluation projects may include:

- Examining traits of grant-funded projects that make them more or less cost-effective, for example, the nature of the project, the population served, the adverse health conditions targeted, or the number of people reached per year.
- Conducting a more detailed cost-benefit analysis that uses longitudinal individual-level patient cost and outcome data to estimate cost savings over time.
- Evaluating the impact of grant-funded programs on quality of life for patients, potentially using systematic qualitative data collection or survey research methodology.
- Conducting a needs assessment comparing the demographics of those served to the health disparities and trends in morbidity and mortality in King County.
III. Nimble Fund Evaluation

Background of the Nimble Fund Program

The PHPDA Nimble Fund program was established in 2014 as a funding stream for one-time public health and health care projects that advance the PHPDA’s mission and goals. Grant amounts range up to $30,000. More information about the Nimble Fund program is available on the PHPDA website at: http://www.phpda.org/nimble-fund-grants/overview/.

Evaluation Questions

This evaluation sought to address the following questions:

1. To what extent have organizations sustained the impact of the work funded by Nimble Fund grants?

2. What factors have facilitated and challenged the sustainment of the impact of Nimble Fund grants?

3. What are successes and opportunities for the PHPDA in the administration of the Nimble Fund grants?

Methods

This analysis applied principles of Sustained and Emerging Impacts Evaluation (SEIE) to assess the impact of the work funded by Nimble Fund grants at least one year after the closure of the grant. More information on SEIE is available at: http://www.betterevaluation.org/en/themes/SEIE.

Semi-structured key informant interviews were conducted by phone with representatives of ten organizations that received Nimble Fund grants in 2016 or earlier (Table 8). The interview guide consisted of seven questions with optional probes to elicit additional detail from each informant, and interviews took between 20 and 30 minutes each. Verbal consent to conduct and record each interview was acquired before the start of each interview.

Interviews were transcribed and coded for themes using QDA Miner Lite 2.0.2 software. Recordings were destroyed upon transcription, and transcripts were password protected for security.
Table 8

Description of Nimble Fund grants included in analysis (coded to protect organizational privacy).

<table>
<thead>
<tr>
<th>Grant-Receiving Organization Code</th>
<th>Type</th>
<th>Sub-Type</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>DATABASE1</td>
<td>Database Development</td>
<td>Electronic Health Records</td>
<td>2015</td>
</tr>
<tr>
<td>DATABASE2</td>
<td>Database Development</td>
<td>Resource Database</td>
<td>2015</td>
</tr>
<tr>
<td>DATABASE3</td>
<td>Database Development</td>
<td>Client Database</td>
<td>2015</td>
</tr>
<tr>
<td>DATABASE4</td>
<td>Database Development</td>
<td>Electronic Health Records</td>
<td>2015</td>
</tr>
<tr>
<td>PROGDEV1</td>
<td>Program Development</td>
<td>Capacity-Building</td>
<td>2015</td>
</tr>
<tr>
<td>PROGDEV2</td>
<td>Program Development</td>
<td>Program Planning</td>
<td>2016</td>
</tr>
<tr>
<td>PROGDEV3</td>
<td>Program Development</td>
<td>Evaluation</td>
<td>2016</td>
</tr>
<tr>
<td>PROGDEV4</td>
<td>Program Development</td>
<td>Coalition-Building</td>
<td>2016</td>
</tr>
<tr>
<td>EQUIPMENT1</td>
<td>Equipment and Hardware</td>
<td>Clinical Equipment</td>
<td>2015</td>
</tr>
<tr>
<td>EQUIPMENT2</td>
<td>Equipment and Hardware</td>
<td>Technology Hardware</td>
<td>2015</td>
</tr>
</tbody>
</table>

Results

Extent of Sustained and Emerging Impact

Impact of Database Development Projects

Database projects funded by the Nimble Fund grant program have been impactful in motivating organizations to develop more efficient workflows and improve decision-making. For example, one informant described that “we’ve been incorporating it into our quarterly continuous process improvement meeting. Reviewing the information was part of that discussion, and kind of looking and trying to develop some recommendations based on the discussion. And then figuring out how to best use the data to inform decisions that we’re making.” All representatives of organizations that used the Nimble Fund grant to create or improve a database reported that the database is still in daily use today. These projects have also assisted organizations in strategic planning, developing strategic partnerships, and refining future priorities based on newly available data as a result of the database.

However, one unintended impact of the database projects funded by the Nimble Fund grant is that these projects have created ongoing needs for database development and data management that the grant-receiving organizations did not always foresee. As one informant stated, “One thing we’ve learned about the database is it’s never actually done.” To sustain the impact of database development projects, it is important that organizations consider potential staffing needs and ongoing database expenses.
Impact of Program Development Projects

Projects designed to contribute to general program development, such as needs assessments, evaluations, and general capacity-building activities, were most impactful when the organization had a sustainability plan and adequate stakeholder buy-in for leveraging the information or capacity generated under the Nimble Fund grant. Program development and evaluation projects were most impactful when the organization was able to build on the work that was done under the Nimble Fund grant to further grow the organization. For example, one informant commented that “I think it has helped us streamline some of our processes so much that those are sort of... future fundraising targets that we can put in place to eventually try to make that into kind of a full-time staff position that is more permanent.”

Outward-facing program development projects that facilitated future fundraising, or increased the visibility and credibility of the program, were more likely to have a lasting impact than internally facing projects that aimed to generate new ideas without generating a boost in resources to carry out the new ideas after the closure of the grant. In addition, these projects were typically effective in introducing new ways of thinking into the grant-receiving organization. As one organization described, “I think it elevated a different conversation about [patients] smoking internally, and a different kind of perspective on the problem [of patients smoking].”

Impact of Equipment and Hardware Projects

The purchase of hardware, such as laptops, and equipment, such as clinical supplies, was useful in helping organizations stay up to date in the shifting landscape of health care. For example, one organization commented that “When [organization] applied for the grant, we applied because we had technology needs. The behavioral health field has been changing. It has been moving to an integrated model which requires better technology to better be able to serve our clients. It also requires mobile technology for us to be able to provide home-based, school-based, community-based services that we could not do with the technology that we had before.”

Another organization commented on how the Nimble Fund grant enabled their organization to improve access to clinical services for the target population. As they described, “when we started to negotiate the terms of the partnership with the [school district], they said you can only come into our district if you have a mobile unit because too many of our schools just don’t have space. And that made it even more important because [the district] has like fourteen elementary schools that we now serve with the mobile unit, and that would not be possible without it.”

Impact on Health Equity

When asked to describe the sustained impact of the project funded by the Nimble Fund grant on the populations served, respondents often conflated their discussion of the impact on the community with their discussion of the impact on their organization. The respondents tended to view impact as starting internally with organizational change, and there was a strong focus on the project more than the health disparities it addressed. Many respondents also focused on barriers to having an impact, rather than discussing the extent and manner in which the project had an impact on health disparities.
Informants varied in their definition of what health disparities are, and how such disparities were addressed by the project supported by the Nimble Fund grant. Some were able to describe disparities with clarity. For example, one informant stated that “the health disparity is that the rate of smoking among homeless people is at like 70%, where the normal American, I don’t like using that word, in America, generally, smoking is at about 14%. It’s a huge difference.” However, when asked about how the project addressed a health disparity, other informants simply described the population served or what activities the program implements, but did not discuss a gap in outcomes between the target population and a comparison population.

One way in which projects had a sustained impact on health equity was by making data about the target population and community needs more available. Database, research, and technology projects were most effective in this aim. As one organization described, “Say, we’ve seen a thousand people come through looking for housing assistance and we’ve been able to help like, zero of them. So, you know, it’s frustrating, but having that data available is really crucial in terms of being able to make the case for what’s needed.”

Other projects had an indirect impact on health equity by providing the organization with the capacity and credibility to grow and develop, with a goal of improving services for the target population. For example, projects that increased access to care for the target population, grew the organization’s volunteer base, or motivated internal improvements in efficiency were more likely to have had a sustained impact on the population targeted. As one informant stated, “it helped us to sort of get organized and figure out what are our priorities, what are our goals, what are our missions, what kinds of outcomes are we looking for, how are we going to measure those things, what do those things mean.”

**Facilitators to Sustained Impact**

Informants identified several internal and external facilitators that helped their organization sustain the impact of the work funded by the Nimble Fund grant.

Internal facilitators to sustainment within the organization’s structure included:
- Assistance of hired or volunteer consultants in developing the project.
- Leadership of staff champions in carrying forward the work during and after closure of the grant.
- Availability of financial resources to sustain the work funded by the grant.
- Implementation of a project that meets the demands of multiple funders, to facilitate future development of the work.
- Onboarding of volunteers with specific skills required to assist with the work.
- Organizational commitment to addressing health disparities in their program, including at least one program that is focused on health care or health promotion.
- Buy-in from the organization’s board and staff.

External facilitators to sustainment outside of the organization included:
- Creation of opportunities by the political environment.
- Partnership with organizations with shared goals.
- Buy-in from direct-service providers throughout the public health and social services system.
Barriers to Sustained Impact

Informants identified a number of internal and external barriers that posed challenges to organization’s sustainment of the impact of the work funded by the Nimble Fund grant.

Internal barriers to sustainment within the organization’s structure included:

- Lack of staff with expertise to assist with project development and ongoing implementation after closure of the grant.
- Limited staff time to sustain the work after the initial development of the project. One informant commented on a need to balance staff time for programming with staff time for fundraising, stating, “there’s the terrible catch twenty-two of if I had more time, I could focus on fundraising, but if I had more time I wouldn’t have a job, so I’d have to raise more money.”
- Inadequate funding to carry forward to the work. As one informant described, “the competition is so fierce for grant funds, and they are not sustaining funds. So it’s like yeah, I can get you a three-year grant for shelter nurses, but what are you going to do in year four.”
- Inertia and resistance to change among staff in the organization.
- Difficulties maintaining and developing technology, such as the organization’s website or database.
- Lack of commitment to health-related programming in the organization’s mission and vision.
- Confusion regarding the PHPDA’s goals and intentions for the Nimble Fund grant program.

External barriers to sustainment outside of the organization included:

- Bureaucracy and siloed services in the health and human services system in the United States.
- Manifestations of systems of oppression in health care and human services. As one informant described, “if you want to talk about external barriers, let’s zoom out to a thirty-thousand-foot level and talk about heteropatriarchy, and white supremacy, and all of the things that keep people from marginalized groups from actualizing their healthiest selves.”
- Limited availability of outside volunteers with skills necessary to support the project.

Feedback on the PHPDA Grant Administration Process

Feedback on the PHPDA’s approach to administering the Nimble Fund grants was overwhelmingly positive. Each informant expressed a positive attitude toward the PHPDA, and only a few provided suggestions for the PHPDA to consider regarding opportunities for improving grants administration.

Feedback on Application

All informants that commented on the application found it straightforward relative to other grants. One particularly appreciated the transparency in the application system, stating that “I really like at the end of your system how they gave us basically a full PDF of everything we had submitted including the file attachment summary is very helpful.”

One informant suggested that the application process could be improved by aligning budget forms with grant applications from other organizations in this field, stating that “Budgeting is always a little bit tricky because everyone has their own template of how they want it to look, and so you’re basically
having to write your budget all over again every time you get funding from somebody, to make it fit with their particular format and template.”

Feedback on Reporting

Generally, informants who commented on the reporting requirements of the grant found the reporting to be reasonable and straightforward. One informant commented that data on disparities can be difficult to access, stating that “we love outcomes, but sometimes we just don’t have the systems that we really need in place to be able to adequately and confidently measure those things. And so if that was included with the funding package that we were applying for, we would be very interested. I think that would be really helpful.” It may be beneficial to clarify the extent to which it is acceptable for Nimble Fund grant-recipients to rely on qualitative information in reports.

Feedback on Funding Eligibility

Many informants commented on the flexibility and range of projects funded by the Nimble Fund as a strength of the program. One shared that they had recommended the Nimble Fund grant program to a peer organization that very day “because they were sort of lamenting that it was hard to find funding for this particular thing that they were wanting to do. Well, there’s this opportunity with the Nimble Fund, which is truly very nimble, and it’s aptly named because it’s super flexible. It can maybe fund things that you may not have success in finding funding for other places.”

Feedback on Funding Amount

Overall, informants appreciated the size of the grants offered by the Nimble Fund program. For example, one informant described how “The Nimble Fund was a great way to find a grant that, you know, it’s hard to find grants that fit in a sort of middle-range of funding dollars. It’s easier to find grants that are like, one thousand to five thousand dollars, or grants that are like fifty to a hundred and fifty thousand dollars. I didn’t need that much, but I needed enough to get me through a year of hard and intense work, so the Nimble Fund was a great opportunity to find that middle amount of funding.”

One informant suggested that more transparency and guidance around how much to apply for could be helpful, commenting that “if we had had guidance that we should only apply for ten, that would have been different. And, just wasn’t sure if that was a policy...that they never fund the full amount, or something. It would have been easier. We could have maybe found other funding in advance, or right-sized the project, or made a different decision about submitting.”

Feedback on Relationship with the PHPDA

Several informants commented on how one important benefit of having received the Nimble Fund grant is that it allowed them to formalize and deepen their relationship with the PHPDA, which was viewed as a credible organization to be affiliated with. One informant went as far as to say, “I would say that our connection with PHPDA I think is significantly more important than the amount of money that we got from the Nimble Fund grant.” Maintaining strong relationships with funded agencies likely
also provides reciprocal benefits to the PHPDA by allowing the PHPDA to strengthen its programs and maintain high visibility in the community.

Informants typically felt that the goals of the organization aligned with the goals of the PHPDA, and that the PHPDA was a true partner in the work. Representatives of the organizations generally found the process to be transparent, and appreciated when the PHPDA demonstrated a strong understanding of the organization’s work and programming. For example, one commented that “They made me feel supported, they made me feel like I could totally ask questions, they made me feel like, they really felt like a partner in the work, rather than this external body that is writing a check.”

Summary and Recommendations

Overall, Nimble Fund grants have had a sustained impact beyond the closure of the grant period. Representatives of organizations that received grants for databases, technology, or equipment were more likely to describe a sustained impact on both their organizational operations and health equity than representatives of organizations that received grants for program planning, evaluation, and development. Some informants struggled to articulate how the project that was funded addressed a health disparity, although it is likely that many of the projects still did have a positive impact on health equity in King County despite the informants’ difficulties in describing this effect.

Feedback on the PHPDA’s approach to grants administration was overwhelmingly positive. Representatives of grant-receiving organizations valued the PHPDA as an important partner in their work, and generally found the grant application and reporting requirements to be straightforward and reasonable. Informants also expressed an interest in gaining as much transparency as possible during the grant application process, for example, learning more about what the PHPDA is looking for in terms of applications, and whether they should typically expect to receive full or partial funding.

Findings of this analysis generated recommendations in two areas: first, to explore future opportunities to partner with volunteers, interns, and consultants to conduct additional analyses, and second, to consider opportunities to adjust the Nimble Fund grants administration process.

Future research and evaluation projects may include:

- Creating an annual or otherwise regularly scheduled opportunity for former grant-receiving organizations to provide anonymous feedback to the PHPDA regarding their experience and the sustainment of the work.
- Collecting additional data to analyze the long-term effect of Nimble Fund investments on health equity and disparities in King County.
- Corroborating and expanding on the findings of this analysis by conducting additional Sustained and Emerging Impacts Evaluation for additional grants.

Opportunities to consider for future Nimble Fund grant cycles include:

- Providing additional educational materials to prospective applicants regarding health disparities.
- Providing additional guidance to prospective applicants regarding the likelihood of receiving the full amount of funding requested.
- Asking grant applicants for details regarding their plan for sustaining the impact of the project after the closure of the grant.
• Clarifying the extent to which it is acceptable for grant-receiving organizations to rely on qualitative data in reports. In addition, if organizations are interested in quantitative measurement, then connecting grant-receiving organizations with free and low-cost resources for data and evaluation, such as:
  – Communities Count: http://www.communitiescount.org/
  – Statistics Without Borders: http://community.amstat.org/statisticswithoutborders/home
  – Tech 4 Good: https://www.meetup.com/SeaTech4Good/
IV. References


