

GRANTWATCH REPORT

Partnering To Advance Public Health: A Foundation Supports Public Programs

The New York Community Trust tells how it funded New York City programs to prevent colon cancer and sexually transmitted diseases.

by **Len McNally** and **Rachael N. Pine**

ABSTRACT: The New York Community Trust (NYCT), as part of its grant-making strategy, seeks to strengthen health services for the poorest residents of New York City. The NYCT worked closely with the Fund for Public Health in New York, a nonprofit agency affiliated with the New York City Department of Health and Mental Hygiene, to test new approaches to health screening for vulnerable populations. Grants jump-started innovative programs, leveraging public-sector support and program expansion beyond the scope of the grant-funded projects. [*Health Affairs* 28, no. 2 (2009): 578–583; 10.1377/hlthaff.28.2.578]

SINCE 1924 the New York Community Trust (NYCT) has had a mission to make New York City a vital and secure place to live. Improving the health of New Yorkers and strengthening the city's health care system have been two of the NYCT's principal grant-making strategies.

Periodically, to refine and refocus its grant making, the NYCT reviews reports issued by public health agencies describing New Yorkers' health status. In its 2004 review, the NYCT found that more than half of the city's eight million residents are minorities, about one-third of residents are foreign-born, and nearly one-quarter do not speak English proficiently. Also, many minority families live in poverty, and one-quarter have no health insurance; this results in families' not getting the health care they need. Heart disease and cancer account for almost two-thirds of all deaths in the city, and there are alarming rates of obesity, sexually transmitted diseases (STDs), and

HIV/AIDS among the city's youth. The NYCT also found that resources in the city are heavily focused on expensive institutional care, with too little spent on primary and preventive care.

In response, the NYCT's board approved a strategy with three objectives for its roughly \$10 million annual health grant program: (1) to promote access to basic services, especially in minority and immigrant communities; (2) to strengthen health service providers, especially those serving the city's poorest residents; and (3) to promote healthy lifestyles. The NYCT strives to achieve these objectives through support of direct health services, preventive care, policy analysis, and advocacy.

Jump-Starting Public Programs

To achieve the objectives of its health program, the NYCT reached out to local organizations to serve as partners. Many were exemplary nonprofits, but it also identified two public agencies that closely shared its objec-

Len McNally (lm@nyct-cfi.org) is a program director at the New York Community Trust, one of the oldest and largest community foundations in the United States. It is located in New York City. Rachael N. Pine is the former executive director of the Fund for Public Health in New York, also in New York City.

tives: the city's Department of Health and Mental Hygiene (DOHMH) and its Health and Hospitals Corporation (HHC). Believing that supporting public entities had the potential to reap high returns, the NYCT began to work with these city agencies to assess programs that could meet its health objectives. Subsequently, it awarded grants to the Fund for Public Health in New York (FPHNY), a nonprofit organization working in close partnership with the DOHMH to seek and administer private grants supporting innovative programs that advance public health. The grants supported two programs to be directed and carried out by the DOHMH: the Colon Cancer Prevention Program (a collaboration with HHC aimed at increasing colonoscopies in public hospitals) and the Screening and Treatment Program for Sexually Transmitted Diseases (a collaboration with New York City's Department of Education [DOE] aimed at educating, testing, and treating adolescents in public schools). Because this paper's focus is on a grant-making strategy, we include only a short summary of the data from program evaluations.¹

Adding 'Navigators' To Increase Colon Cancer Screening Rates

Each year, more than 1,400 New Yorkers die from colorectal cancer.² This results in an age-adjusted mortality rate of 19.6 per 100,000 people.³ Many, if not most, of these deaths are preventable through screening at recommended intervals. According to the New York State Cancer Registry, in 2005 fewer than 40 percent of diagnosed colorectal cancers in New York City were detected at an early stage.⁴ Yet this city has historically had one of the highest ratios of gastroenterologists to patients and adequate local screening capacity.⁵

Aiming to increase use of colonoscopies and reduce disparities in colon cancer death rates between the city's richest and poorest communities, the NYCT awarded five grants totaling \$1.65 million for a colon cancer prevention program developed by the DOHMH. The program uses hospital-based patient "navigators" to conduct community outreach,

support patients preparing for screening, and work with hospital staff and community providers to reduce barriers to screening.

Over a three-year period, funds from the NYCT supported the launch of the navigator program in three public hospitals. The DOHMH worked with staff at each hospital to train and support the navigators, track results, and inform hospital administrators of early findings showing an increase in colonoscopies. With the NYCT's funding, the DOHMH also did an evaluation, examined benefits to health and to hospital efficiencies, and performed a cost-benefit analysis.

The evaluation showed an increase in the number of colonoscopies performed per year at the three hospitals following the launch of the navigator program, although the rate of increase leveled off and even decreased slightly in subsequent years as community need was increasingly met. In total, the three hospitals performed close to 15,000 colonoscopies during the period in which their navigator programs were grant-funded (2003–2006). The average number of colonoscopies in the three hospitals increased by 68 percent after one year of the colonoscopy navigator program, as compared with the average for the preprogram baseline year.⁶

The evaluation revealed a decrease in broken appointments at two of the three hospitals over varying periods of time and, thus, a reduction of nonbillable operating room time because of fewer cancellations of scheduled colonoscopies at those hospitals. Combined with an increasing number of colonoscopies, a reduction in broken appointments can be expected to result in an increase in hospital revenue.⁷ The evaluation also documented an increase in screening colonoscopies performed at all three hospitals—again, over varying periods of time.⁸

These early results were presented by the DOHMH and hospital staffs at annual City-wide Colon Cancer Control Coalition (C5) Summit meetings and other conferences to share the success of the model with gastroenterologists. News of the program spread, helping build demand.

In a second phase of the program, five additional public hospitals were added, although only three received grant support from the NYCT. To set the stage for sustainability, all five second-phase hospitals were told that funding would be for one year only, after which each hospital would be expected to assume program costs. In addition, by the time the program entered its second phase, all three phase-one hospitals no longer had grant support from the NYCT but continued the program by assuming all costs on their own.

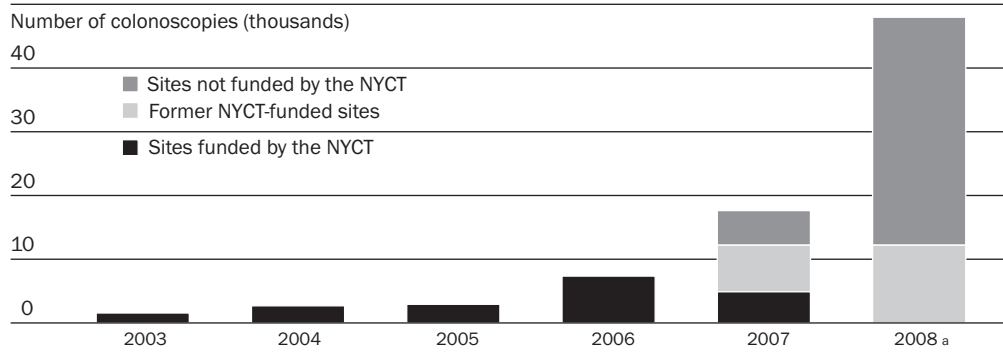
Also during this second phase, to facilitate start-up at three of the new program sites, funds from the NYCT supported development of forms, curricula, and protocols that make the colonoscopy navigator program easy to use and replicate at additional hospitals. Grant funds also helped strengthen and maintain program performance and supported ongoing technical assistance workshops, online discussion forums, and regular meetings, to foster sharing of best practices, mutual support, and cross-learning among New York City's growing navigator community.

In 2008, other public and private hospitals approached the DOHMH asking to participate. Eight hospitals were added during this third phase, and none of these programs were launched with funds from the NYCT. Instead, they all received public funding for one year, with the expectation that they would assume the costs of the program in subsequent years.

Exhibit 1 shows the total number of actual and, for 2008, projected colonoscopies per year, at all hospitals participating in the colonoscopy navigator program. It illustrates the steady increase in colonoscopies performed, reflecting both program sustainability and expansion from one to sixteen sites. It also highlights the shift from grant to public funding over time.

In sum, five years of grant funding from the NYCT for the colonoscopy navigator program produced well-documented public health results and substantial program expansion by the public sector. The program also may have contributed to boosting the overall number of New Yorkers who obtain a colonoscopy. In 2003 only 41.7 percent of New Yorkers age fifty

EXHIBIT 1
Number Of Colonoscopies In All Navigator Program Sites, By Funding Source, New York City, 2003–2008



SOURCE: 2003–2007 colonoscopy data are from M.S. Krauskopf, “Hospital Based Screening Navigation: Launching the NYC Navigator Network” (PowerPoint presentation at 2008 New York Citywide Colon Cancer Control Coalition [C5] Summit, 8 June 2008). Breakdown of colonoscopy data by funding source, colonoscopy data for 2007 and 2008, and projected colonoscopies for 2008 were provided for use in this paper by the New York City Department of Health and Mental Hygiene Colon Cancer Prevention Program.

NOTES: Increased total colonoscopies, 2003–2008, reflect the addition of new program sites and available data from all program sites combined for each year: 2003–2005 (one site); 2006 (three sites); 2007 (eight sites); and 2008 (sixteen sites). Number of colonoscopies at New York Community Trust (NYCT)–funded sites appears lower in 2007 when compared with 2006. This is attributable to the transition of initial three grant-funded sites into the non-grant-funded category. In 2007, NYCT funding was provided only to three new sites, all of which were in earlier phases of program implementation.

^aProjected.

and older reported having had one within the past ten years.⁹ By 2007, 61.7 percent of New Yorkers age fifty and older reported having had one within the past ten years, an increase of 424,000 New Yorkers.¹⁰ Racial and ethnic disparities for this procedure have nearly disappeared. Whereas whites were more likely than either blacks or Hispanics to have had a colonoscopy in 2003, screening rates were nearly equal for all three groups in 2007.¹¹

School-Based Screening And Treatment For STDs

STDs, such as chlamydia and gonorrhea, can lead to serious medical problems, including infertility and increased risk of certain cancers. These two bacterial infections are common in adolescents but are easily cured with antibiotics. Yet wide-scale screening and treatment programs for teens are rare. Because both infections are often asymptomatic, the absence of systematic screening can result in infections' being left untreated, increasing the chances of medical sequelae and the spread of infection to others.¹²

Chlamydia is the most common bacterial STD, both nationally and in New York City. As early as 1994, the total cost of care for untreated chlamydia infections and their complications was estimated to exceed \$2 billion annually, a figure that is likely considerably higher today.¹³ In 2004, 34,190 chlamydia cases were reported in New York City, a number that rose to more than 50,000 in 2007.¹⁴ In 2007 nearly half of all New York City cases were among women under age twenty-five.¹⁵ The Centers for Disease Control and Prevention (CDC) recommends annual screening for all sexually active females age twenty-five and under.¹⁶ Yet in New York City, as of 2004, fewer than 50 percent of teens were being screened for this infection.¹⁷

Ideally, screening and treatment would be obtained from a primary care physician. However, in the case of STDs, adolescents may feel uncomfortable raising the issue or fear parental involvement. Thus, screening often does not take place in this context. School-based screening and treatment programs offer an

ideal alternative; they afford the possibility of reaching large numbers of adolescents. The availability of new, noninvasive, urine-based tests has made testing easier in the school setting. However, such programs have been difficult to launch—in the past they have generated mixed reactions and even opposition from some parents and school administrators.

An eighteen-month grant of \$85,000 from the NYCT, awarded through the FPHNY, allowed the DOHMH to pilot a school-based STD education, screening, and treatment program in five New York City public high schools. Understanding that “buy-in” from school administrators and acceptability to parents would be critical, the DOHMH worked with the DOE to meet with parents, teachers, and administrators. They negotiated a passive-consent process allowing parents to opt their children out of the program, and administrators were consulted regarding on-site logistics.

The outcome was a documented public health benefit with little resistance from parents and school administrators. During the one-year pilot program, 1,798 students were educated about the risks of untreated STDs, 1,006 (59.3 percent of those educated) were tested, 55 (5.2 percent of those tested) were diagnosed with chlamydia or gonorrhea, and all but two (96.4 percent) of those who tested positive received treatment.¹⁸ Although the grant-funded pilot was small, its outcomes were promising, and the pilot documented the feasibility and acceptability of school-based screening and treatment of certain STDs.

Based on results from the pilot, the DOHMH received a commitment of “new needs” funding of nearly \$1 million per year from the city to support continuation and expansion of school-based STD education, screening, and treatment. The program expanded over the following two-year period, reaching forty-four locations in 2006–07 and ninety-one locations in 2007–08. The number of students tested increased from 1,066 in the grant-funded pilot year to a total of 16,523 students for the two-year period ending in June 2008. Also, the number of students treated in-

creased from 53 in the pilot year to 1,033 in the following two-year period. Plans for the 2008–09 school year included expansion to ninety-five sites, with the ultimate goal of testing 12,000–15,000 high school students each school year.¹⁹

There is also evidence of an 18 percent increase in visits to community-based DOHMH STD clinics by people ages 14–19 from year 1 of the program (2006–07 school year) to year 2 (2007–08 school year).²⁰ This suggests that the program has helped link teens to free, confidential, and ongoing reproductive and sexual health care services.

Defining And Understanding Success

The success of a private grant-making strategy that supports a publicly funded health program depends on whether there is evidence that the private funding (1) had a positive public health outcome; (2) leveraged public dollars to expand or sustain the program; (3) helped either generate demand for services or document their acceptability and feasibility; or (4) established a base for scaling up or replication of programs.

The need to prove positive public health outcomes is evident. But to assess the success of a grant supporting a public program, transition of the grant-funded program to one carried forward or expanded at public expense is an important sign. When the public sector picks up ongoing costs, this is evidence that the grant-initiated program has influenced the allocation of public resources and potentially improved or expanded a government service.²¹

Both programs described above meet these criteria. The grant-funded pilot programs demonstrated the public health benefits of a new or innovative model and also leveraged public money for expansion. They improved access to preventive care and documented acceptability, feasibility, or cost-effectiveness of the approach tested. Both programs also developed a “turnkey” model and materials needed to facilitate and support replication at new sites. The following are key characteristics of the programs that we believe contributed to

their success.

■ **An identifiable contribution.** The NYCT’s grants did not fund ongoing or mandatory government activities at the DOHMH or its collaborating public agencies. Instead, the grants helped the DOHMH develop, test, and fuel expansion of new or better ways of providing care. They supported innovation and evaluation of results and jump-started programs where political controversy and other barriers had prevented the public sector from intervening effectively.

■ **Potential for impact and scale.** Each program was carried out by the DOHMH at sites—public hospitals and high schools—run by public agencies serving vast numbers of New Yorkers, and, thus, delivering a ready-made avenue for program expansion. Also, both programs evaluated their effectiveness, a factor critical to justifying and securing government support for large-scale expansion.

■ **A plan for sustainability.** Grantmakers generally seek to identify an end point, a deliverable, or a plan for sustainability that ensures a lasting contribution from short-term private support. Both programs succeeded in creating a base for long-term sustainability or expansion. Factors contributing to this outcome included support of agency leadership; creation of an identifiable product with widespread usefulness; program evaluation resulting in useful new data; dissemination of results to build support among stakeholders; documentation of financial return and cost savings; and development of materials rendering the programs easily replicable.

MANY PRIVATE FOUNDATIONS are reluctant to make grants to government agencies. They fear that private funds will be dwarfed by large government budgets, bureaucratic requirements will hamper program implementation and evaluation, and political considerations will impede program sustainability. This paper provides evidence that positive results can be achieved, especially for high-need urban populations, by partnering with strong government health agencies. The FPHNY offered a

high level of commitment to grant-funded programs and the accountability and efficiencies needed to achieve foundation objectives. This three-way partnership between the NYCT, the FPHNY, and the DOHMH can serve as a model, paving the way for replication in other localities.

.....
The authors thank Ephraim Shapiro of the New York City Department of Health and Mental Hygiene (DOHMH) Colon Cancer Prevention Program for his extensive assistance helping to analyze, present, and respond to queries on program data, and Marian S. Krauskopf, program director, and Suzannah R. Blumenthal, also of the program. They also thank Sophie Nurani, director of the DOHMH's School-Based STD Education, Testing, and Treatment Program; Jessica Han and Susan Blank of the DOHMH; Sara Gardner and Pamela Nathenson of the Fund for Public Health in New York; and Resham A. Patel, an intern with the New York Community Trust.

NOTES

1. Full program data can be obtained by calling Pamela Nathenson, director of program and resource development, Fund for Public Health in New York, 212-227-0687.
2. These data were obtained from New York City Department of Health and Mental Hygiene, "New York City Vital Statistics Query," available through query at <https://a816-health3ssl.nyc.gov/VS/index.html>.
3. DOHMH, Bureau of Vital Statistics, *Summary of Vital Statistics 2006: The City of New York*, <http://www.nyc.gov/html/doh/downloads/pdf/vs/2006sum.pdf> (accessed 22 December 2008).
4. New York State Cancer Registry, "Percent of Invasive Cancers Diagnosed at an Early Stage by Gender, Race, and Year of Diagnosis, 1976–2005," January 2008, <http://www.health.state.ny.us/statistics/cancer/registry/docs/table3.pdf> (accessed 30 October 2008).
5. J.C. Leng et al., "The Volume and Capacity of Colonoscopy Procedures Performed at New York City Hospitals in 2002," *Preventing Chronic Diseases* 2, no. 1 (2005): A09.
6. M.S. Krauskopf, "Hospital-Based Screening Navigation: Launching the NYC Navigator Network," PowerPoint presentation at 2008 New York Citywide Colon Cancer Control Coalition (C5) Summit, 8 June 2008, <http://www.nyc.gov/html/doh/downloads/ppt/cancer/NYC-navigator-network.pps> (accessed 30 October 2008). The percentage increase was calculated by the DOHMH Colon Cancer Prevention Program and provided to the authors.
7. Ibid.
8. Ibid.
9. "Community Health Survey 2003," available through query at <https://a816-health3ssl.nyc.gov/CHS/index2003.html>.
10. "Community Health Survey 2007," available through query at <https://a816-health3ssl.nyc.gov/CHS/index2007.html>.
11. See Notes 9 and 10.
12. Centers for Disease Control and Prevention, National Center for HIV, STD, and TB Prevention, Division of STD Prevention, "Chlamydia—CDC Fact Sheet," <http://www.cdc.gov/std/chlamydia/STDFact-Chlamydia.htm> (accessed 23 December 2008); and "Gonorrhea—CDC Fact Sheet," <http://www.cdc.gov/std/gonorrhea/stdfact-gonorrhea.htm> (accessed 21 January 2009).
13. T.R. Eng and W.T. Butler, eds., *The Hidden Epidemic: Confronting Sexually Transmitted Diseases* (Washington: National Academies Press, 1997).
14. DOHMH, Bureau of Sexually Transmitted Disease Control, *Quarterly Report*, vol. 3, no. 1 (New York: DOHMH, June 2005); and DOHMH, BSTDC, *Quarterly Report*, vol. 6, no. 1 (New York: DOHMH, March 2008).
15. DOHMH, BSTDC, *Quarterly Report* (March 2008).
16. CDC, "Chlamydia—CDC Fact Sheet."
17. M. Rogers et al., "Estimates of Chlamydia Screening Coverage among NYC High School-Aged Females" (Poster presentation, CDC National STD Prevention Conference, Philadelphia, Pennsylvania, 8–11 March 2004).
18. M. Rogers and S. Nurani, "School-Based STD Screening Programs: Reaching a Vulnerable Population," *Infertility Prevention Program* (Summer 2006).
19. Ibid.; and S. Nurani et al., "Addressing an Unmet Need: Using Schools to Screen Adolescents for Sexually Transmitted Diseases (2007–2008)" (Poster presentation at American School Health Association Conference, Tampa, Florida, 12–15 November, 2008). Pilot and subsequent year data provided and updated by the DOHMH.
20. Nurani et al., "Addressing an Unmet Need."
21. Of course, public-sector resources may wax and wane. However, success as measured by the other factors mentioned here ensures that a program that is downsized or cut in a time of fiscal constraint can readily be restarted when resources are found.