Commissioner's Office
P.O. Box 64975
St. Paul, MN 55164-0975
(651) 201-5000
www.health.state.mn.us

Community Clinic Grant Program

Minnesota Department of Health

Report to the Minnesota Legislature 2012

July 1, 2012

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Health Policy Division/Office of Rural Health and Primary Care
Minnesota Department of Health
85 E 7th Place, Suite 220
P.O. Box 64882
St. Paul, MN 55164-0882

Phone: (651) 201-3838
Fax: (651) 201-3830
TDD: (651) 201-5797

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Community Clinic Grant Program

Executive Summary

Minnesota Statutes, Section 145.9268, directs the Commissioner of Health to report biennially to the Minnesota Legislature on the needs of community clinics and recommendations for adding or changing eligible activities under the Community Clinic Grant Program. This report includes grant award information for fiscal years 2002 to 2012.

The purpose of the Community Clinic Grant Program is to support the capacity of eligible community clinics to serve low-income populations by helping to reduce current or future uncompensated care burdens or helping to provide improved care delivery infrastructure.

Community clinics are an integral part of the health care safety net for the state of Minnesota. The definition for "community clinic" can vary; however, under this program, a community clinic is a nonprofit, tribal, Indian Health Service or publicly owned clinic that is established to provide health services to low-income or rural population groups. Eligible clinics are required to provide medical, preventive, dental or mental health primary care services and must utilize a sliding fee scale or other procedure to determine eligibility for charity care or to ensure that no person will be denied services because of inability to pay. These safety net clinics help to ensure access to health care for populations that are uninsured or underinsured.

Activities eligible for funding under the Community Clinic Program are broad, ranging from medical supplies to capital expenditures. The statute also provides for grant awards for "other projects determined by the Commissioner to improve the ability of applicants to provide care to the vulnerable populations they serve."

The need for grants to community clinics has continued to increase with the rising cost of health care. Safety net clinic applicants under the Community Clinic Grant Program report large uncompensated care costs resulting in operating losses. The current annual appropriation for this program is $561,000. Since the program began in 2002, the demand for funds has greatly exceeded the appropriated dollars.

With community clinics' uncompensated care burdens rising and this grant program's record of supporting projects serving underinsured patients, the Community Clinic Grant Program continues to respond to the needs of the health care safety net. There is no need to change the program's eligible activities. The current statute is adequately broad and allows for the type of projects needed to help safety net clinics provide health care services to uninsured and underinsured populations.

Legislative Authority

Minnesota Statutes, Section 145.9268 (appended), directs the Commissioner of Health to report biennially to the Minnesota Legislature on the needs of community clinics and recommendations for adding or changing eligible activities under the Community Clinic Grant Program. This report includes grant award information for fiscal years 2002 to 2012.

Program Introduction

The purpose of the Community Clinic Grant Program is to support the capacity of eligible community clinics to serve low-income populations by helping to reduce current or future uncompensated care burdens or helping to provide improved care delivery infrastructure. The Office of Rural Health and Primary Care first implemented the grant program as authorized by the Legislature in 2001. Statutes require a geographic representation of grant awards among all regions of the state, urban and rural.

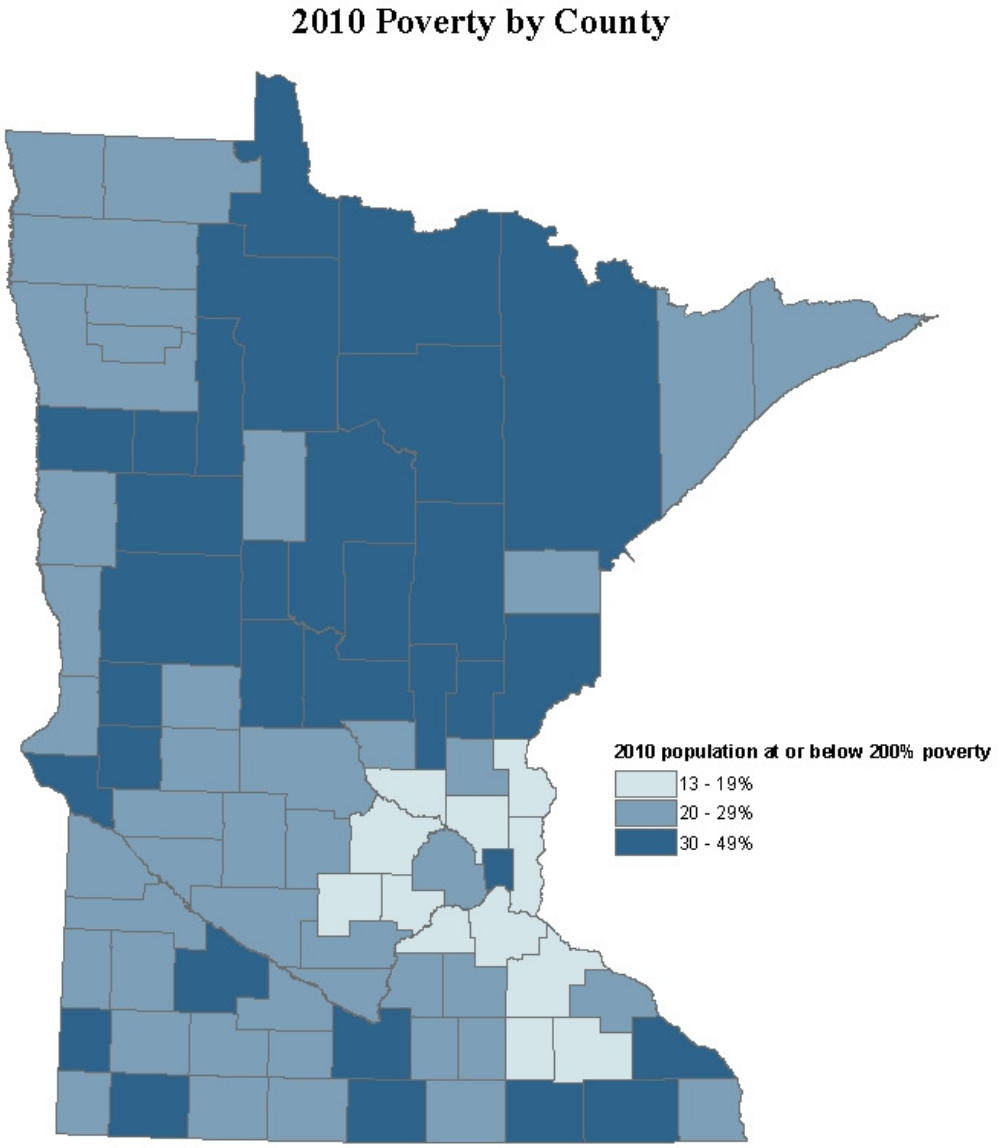
Community Clinics

Community clinics are an integral part of the health care safety net for the state of Minnesota. The definition for "community clinic" can vary; however, under this program, a community clinic is a nonprofit, tribal, Indian Health Service or publicly owned clinic that is established to provide health services to low-income or rural population groups. Eligible clinics are required to provide medical, preventive, dental or mental health primary care services and must utilize a sliding fee scale or other procedure to determine eligibility for charity care or to ensure that no person will be denied services because of inability to pay. These safety net clinics help to ensure access to health care for populations that are uninsured or underinsured.

Populations at Risk

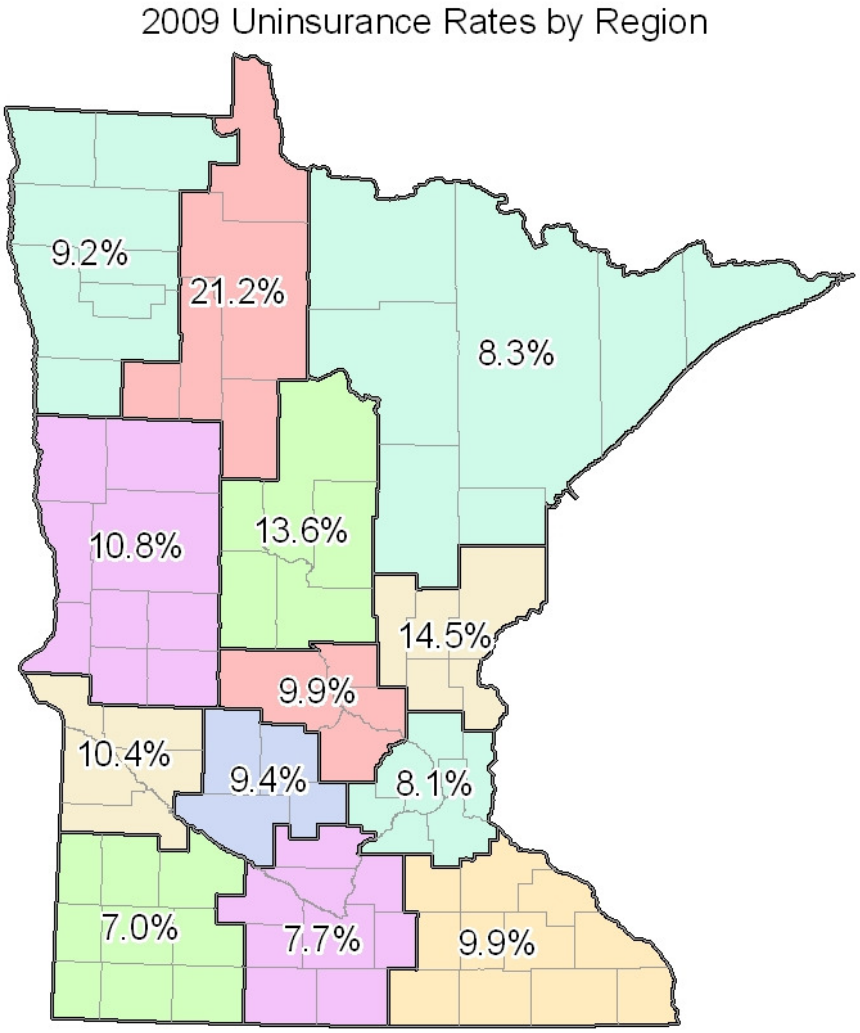
Two common indicators of health care access are poverty and un-insurance rate. Populations in poverty are often underinsured and, like the uninsured, lack a medical home. According to the most recent Census estimates available (5-year estimates American Community Survey 2010), about 25.5 percent of Minnesotans (1,306,622 people) are under 200 percent of the federal poverty level.

By county, the population under 200 percent of poverty varies from 13 percent to 49 percent, with over a third of Minnesota counties at 30 percent or higher. The following map shows poverty levels statewide by county (2010 American Community Survey).



Urban areas experience extreme concentrations of poverty. Within the city of Minneapolis, over half of the city's census tracts show that 30 to 87 percent of the population is below 200 percent of the federal poverty level. Within the city of St. Paul, almost three-quarters of the census tracts show that 30 to 90 percent of the population is below 200 percent of the federal poverty level (2010 American Community Survey 5-year estimates).

According to the 2011 Minnesota Health Access Survey (a collaborative survey by the Minnesota Department of Health and the University of Minnesota, School of Public Health), the overall rate of uninsurance in Minnesota is 9.1 percent. The 2009 Minnesota Health Access Survey (2011 data not available by region) showed regional variation in uninsurance rates from 8.1 percent to 21.2 percent, with many rural counties in regions over 9 percent, as shown in this map.



Not only do many rural populations experience higher rates of un-insurance, it is also important to note that many of the populations of color in Minnesota experience great disparities with regard to un-insurance. The uninsurance rate for Hispanic/Latino Minnesotans in 2011 was over three times the rate for White Minnesotans (26 percent compared with 7.6 percent). Additionally, un-insurance rate for Black Minnesotans (17.9 percent) was greater than twice the rate for White Minnesotans. St. Paul and Minneapolis have large concentrations of populations of color, with population of color in some census tracts as high as 91 percent. Community clinics are the major safety net for these rural and inner city populations experiencing poverty and uninsurance.

Eligible Grant Activities

Activities eligible for funding under the Community Clinic Program are broad, ranging from medical supplies to capital expenditures. Per the program statute, awards may be made to community clinics to plan, establish or operate services to improve the ongoing viability of Minnesota's clinic-based safety net providers.

Eligible grant activities include the following:

- Provide a direct offset to expenses incurred serving the clinic's target population.
- Establish, update or improve information, data collection or billing systems, including electronic health records systems.
- Procure, modernize, remodel or replace equipment used to deliver direct patient care at a clinic.
- Provide improvements for care delivery, such as increased translation and interpretation services.
- Build a new clinic or expand an existing facility.

The statute also provides for grant awards for "other projects determined by the Commissioner to improve the ability of applicants to provide care to the vulnerable populations they serve."

Types of Awards

Awards have been provided in each of the eligible categories. In the many cases involving direct services, the targeted populations have included not only uninsured and underinsured but also other disadvantaged populations experiencing barriers in accessing health care. These include farmers, migrant farm workers, American Indians, African and Asian refugees, immigrants, low-income children and pregnant women, rural/frontier populations, and people who are disabled, elderly, non-English speaking, Hispanic or homeless.

Recent awards have funded activities in the following categories:

- Direct health care services, including medical, dental, mental health, ob/gyn and pediatric.
- Equipment, including dental, medical and technological.
- Health information technology, including electronic health records.
- Outreach and education.
- Case management and chronic care models.
- Homeless medical services.
- Mobile clinic services.
- Offset of uncompensated care costs.
- Offset of uncompensated lab and testing services.
- Pharmaceuticals.
- Renovation of space, including medical clinics, dental clinics and mental health clinics.
- Translation/interpretation services.

Program Impact

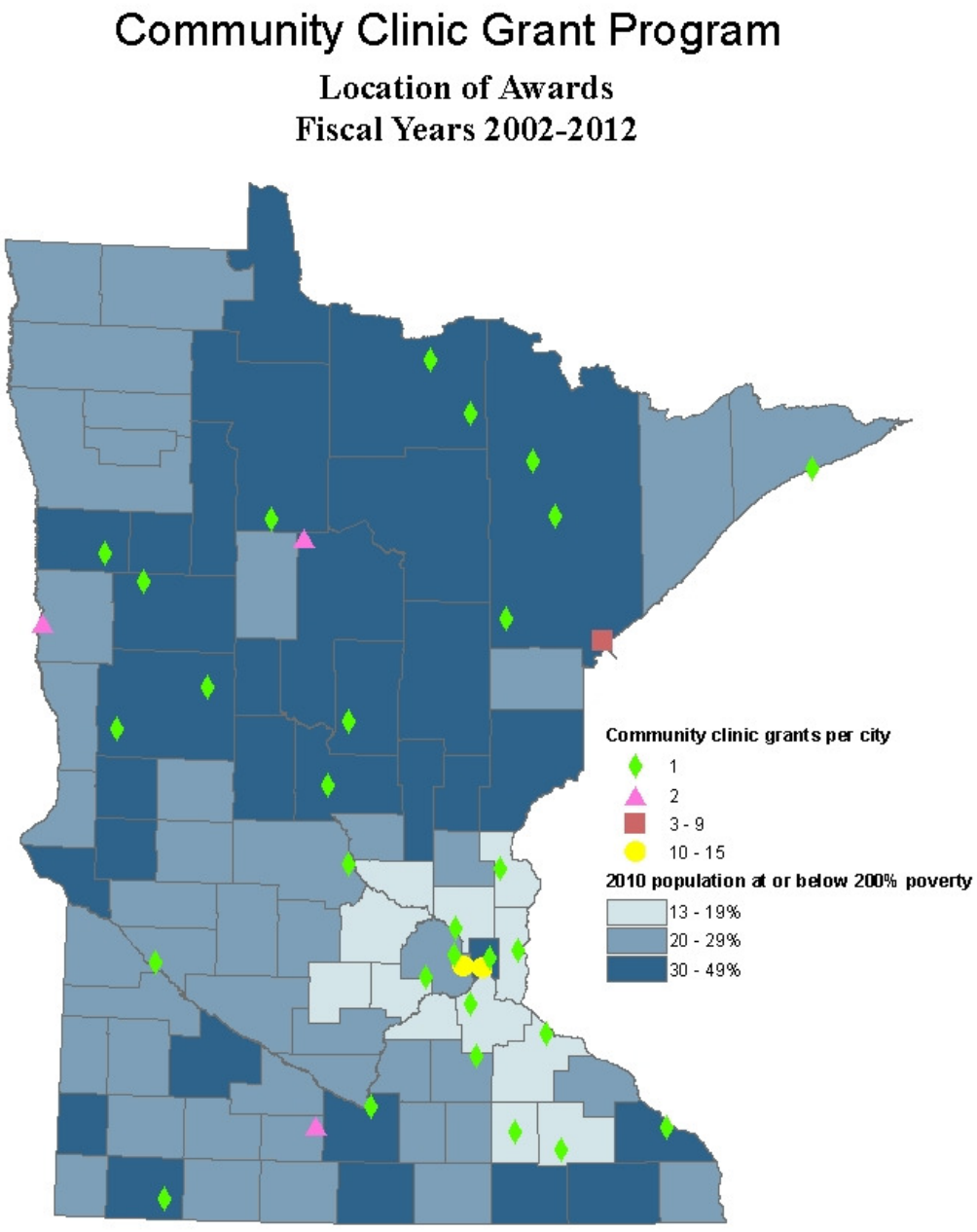
The recent benefits of this program to communities and underserved populations can be measured in many ways. Some examples include:

- Increased access to primary medical services for a growing uninsured and ethnically diverse pediatric population in Anoka County. Grant funds were used for clinical salaries to increase clinic hours and add 100 patient encounters.
- Increased access to dental services for uninsured children and diabetic adults in the Duluth area. Grant funds supported 50 preventive/restorative oral health visits to uninsured diabetic adults and 175 preventive/restorative oral health visits to uninsured children.
- Improved dental health outcomes for low-income and minority children and mothers in St. Paul and Maplewood. Grant funds supported clinical salaries to ensure that at least 40 percent of children participating in the project returned for an annual check-up, 50 percent improved dental caries risk, 120 pregnant mothers utilized preventive services, and 2,000 people received oral health information and dental care kits.
- Continued successful culturally competent outreach and service delivery to a chronically homeless uninsured and underinsured American Indian population in Minneapolis. Grant funds supported medical and non-medical services to an average of 22 homeless clients per day.
- Increased access to dental services to uninsured populations in Otter Tail County via a new dental clinic. Grant funds supported start-up costs, equipment and clinical salaries to establish a new dental clinic.
- Improved quality of care, care coordination and chronic disease management for uninsured and underinsured north Minneapolis patients through the implementation of electronic medical records. Grant funds supported staff training and equipment to complete implementation.
- Increased access to culturally competent mental health services to the American Indian population in Minneapolis. Grant funds supported clinical salaries to provide mental health services during 430 psychiatric hours.
- Improved health outcomes for diabetic American Indian populations in Koochiching and northern St. Louis counties. Grant funds supported the development of a diabetes case management system, which increased the percentage of patients with a controlled blood sugar (A1C < 7.0) and increased compliance with foot exams.
- Increased access to screening and treatment for sexually transmitted diseases in Pipestone, Winona and St. Louis counties for uninsured and underinsured youth. Grant funds supported salaries, lab costs, educational materials, equipment and office operations to provide screening and treatment to 920 youth.

Historical Allocation of Grants

Grants have been provided to a variety of organizations including Rural Health Clinics, Federally Qualified Health Centers, Community Mental Health Centers, hospitals, Indian Health Services, community networks, tribal clinics, public health clinics, rural medical clinics, dental clinics, family planning clinics, counseling and mental health clinics, teen clinics and faith-based clinics.

The following map shows the location of grantees across the state with the underlying poverty level by county (2010 American Community Survey, 2012 ORHPC Community Clinic data).



Grant Availability

The current annual appropriation for this program is $561,000. Since the program began in 2002, the demand for funds has greatly exceeded appropriated dollars. Consequently, program staff implemented a maximum award amount of $45,000, even though the statutory maximum award is $300,000. This allows for approximately 12-15 grant awards each year. For the current grant cycle, the Office of Rural Health and Primary Care received 42 applications with $1,848,167 requested in funding, more than three times the available appropriation. A historical summary of grant requests and awards is below:

Community Clinic Grants Summary				
Fiscal Year	**Total Requested**	**Total Awarded**	**Number of Requests**	**Number of Awards**
2002	$6,293,752	$3,039,300	27	22
2003	$2,569,613	$1,009,907	27	21
2004	$ 896,604	$ 317,000	20	9
2005	$ 967,700	$ 337,000	22	8
2006	$1,155,962	$567,000	37	13
2007	$1,599,004	$567,000	36	14
2008	$1,706,721	$567,000	40	14
2009	$1,745,794	$561,000	40	14
2010	$1,866,065	$561,000	42	13
2011	$1,884,772	$561,000	41	14
2012	$1,848,167	$561,000	42	15

The need for grants to community clinics has continued to increase with the rising cost of health care. Safety net clinic applicants under the Community Clinic Grant Program report large uncompensated care costs resulting in operating losses. Many applicants use financial reserves to maintain clinical operations for the uninsured and underinsured populations they serve. These safety net clinics increasingly rely on grant funding not only to maintain services to the uninsured and underinsured, but to continue to operate.

Recommendations

With community clinics' uncompensated care burdens rising and this grant program's record of supporting projects serving underinsured patients, the Community Clinic Grant Program continues to respond to the needs of the health care safety net. There is no need to change the program's eligible activities. The current statute is adequately broad and allows for the type of projects needed to help safety net clinics provide health care services to uninsured and underinsured populations. The mismatch of grant requests and available funding demonstrates the program could make effective use of additional funds should they become available.

Appendix

145.9268 COMMUNITY CLINIC GRANTS.

Subdivision 1. **Definition.** For purposes of this section, "eligible community clinic" means:
(1) a nonprofit clinic that is established to provide health services to low income or rural population groups; provides medical, preventive, dental, or mental health primary care services; and utilizes a sliding fee scale or other procedure to determine eligibility for charity care or to ensure that no person will be denied services because of inability to pay;
(2) a governmental entity or an Indian tribal government or Indian health service unit that provides services and utilizes a sliding fee scale or other procedure as described under clause (1);
(3) a consortium of clinics comprised of entities under clause (1) or (2); or
(4) a nonprofit, tribal, or governmental entity proposing the establishment of a clinic that will provide services and utilize a sliding fee scale or other procedure as described under clause (1).

Subd. 2. **Grants authorized.** The commissioner of health shall award grants to eligible community clinics to plan, establish, or operate services to improve the ongoing viability of Minnesota's clinic-based safety net providers. Grants shall be awarded to support the capacity of eligible community clinics to serve low-income populations, reduce current or future uncompensated care burdens, or provide for improved care delivery infrastructure. The commissioner shall award grants to community clinics in metropolitan and rural areas of the state, and shall ensure geographic representation in grant awards among all regions of the state.

Subd. 3. **Allocation of grants.** (a) To receive a grant under this section, an eligible community clinic must submit an application to the commissioner of health by the deadline established by the commissioner. A grant may be awarded upon the signing of a grant contract. Community clinics may apply for and the commissioner may award grants for one-year or two-year periods.
(b) An application must be on a form and contain information as specified by the commissioner but at a minimum must contain:
(1) a description of the purpose or project for which grant funds will be used;
(2) a description of the problem or problems the grant funds will be used to address;
(3) a description of achievable objectives, a workplan, and a timeline for implementation and completion of processes or projects enabled by the grant; and
(4) a process for documenting and evaluating results of the grant.
(c) The commissioner shall review each application to determine whether the application is complete and whether the applicant and the project are eligible for a grant. In evaluating applications according to paragraph (d), the commissioner shall establish criteria including, but not limited to: the eligibility of the project; the applicant's thoroughness and clarity in describing

the problem grant funds are intended to address; a description of the applicant's proposed project; a description of the population demographics and service area of the proposed project; the manner in which the applicant will demonstrate the effectiveness of any projects undertaken; and evidence of efficiencies and effectiveness gained through collaborative efforts. The commissioner may also take into account other relevant factors, including, but not limited to, the percentage for which uninsured patients represent the applicant's patient base and the degree to which grant funds will be used to support services increasing or maintaining access to health care services. During application review, the commissioner may request additional information about a proposed project, including information on project cost. Failure to provide the information requested disqualifies an applicant. The commissioner has discretion over the number of grants awarded.
(d) In determining which eligible community clinics will receive grants under this section, the commissioner shall give preference to those grant applications that show evidence of collaboration with other eligible community clinics, hospitals, health care providers, or community organizations.

Subd. 3a. **Awarding grants.** (a) The commissioner may award grants for activities to:
(1) provide a direct offset to expenses incurred for services provided to the clinic's target population;
(2) establish, update, or improve information, data collection, or billing systems, including electronic health records systems;
(3) procure, modernize, remodel, or replace equipment used in the delivery of direct patient care at a clinic;
(4) provide improvements for care delivery, such as increased translation and interpretation services;
(5) build a new clinic or expand an existing facility; or
(6) other projects determined by the commissioner to improve the ability of applicants to provide care to the vulnerable populations they serve.
(b) A grant awarded to an eligible community clinic may not exceed $300,000 per eligible community clinic. For an applicant applying as a consortium of clinics, a grant may not exceed $300,000 per clinic included in the consortium. The commissioner has discretion over the number of grants awarded.

Subd. 4. **Evaluation and report.** The commissioner of health shall evaluate the overall effectiveness of the grant program. The commissioner shall collect progress reports to evaluate the grant program from the eligible community clinics receiving grants. Every two years, as part of this evaluation, the commissioner shall report to the legislature on the needs of community clinics and provide any recommendations for adding or changing eligible activities.
History: *1Sp2001 c 9 art 1 s 47; 2002 c 379 art 1 s 113; 1Sp2005 c 4 art 6 s 39*

Commissioner's Office
85 East Seventh Place, Suite 400
P.O. Box 64882
St. Paul, MN 55164-0882

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