



Hospitals & Philanthropy

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Foundations are a natural partner for the Stakeholder Health community. In fact, they have a few distinct advantages over hospitals when it comes to our line of work.



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TABLE OF CONTENTS

2. Q &A DOUG EASTERLING: HEALTH SYSTEMS AND FOUNDATIONS

9. HOSPITALS AND HEALTH CONVERSION FOUNDATIONS

12. FOSTERING PARTNERSHIPS BETWEEN HOSPITALS AND FOUNDATION

16. THE BUSINESS OF GRANTMAKING

All articles (except the Q & A) are by Doug Easterling, Allen Smart and Laura McDuffee and are adapted from the upcoming book *Stakeholder Health: Insights From New Systems of Health*, edited by Teresa Cutts and James Cochrane.

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Q & A with Doug Easterling: Health Systems and Foundations

Doug Easterling, Ph.D., is a Professor in the Department of Social Sciences and Health Policy at Wake Forest School of Medicine, and served as department chair from 2005-2015. He has served as an evaluator, strategic advisor, learning coach and facilitator for more than 20 national, state, and local foundations. From 1992-1999 he served as the Director

of Research and Evaluation at The Colorado Trust, where he oversaw the foundation's evaluation of a series of community-based initiatives. He is currently conducting a study for the Robert Wood Johnson Foundation which explores how health conversion foundations have innovated and adapted their strategies to address the social determinants of health.



Interview by Tom Peterson

Stakeholder: What are foundations looking for when they choose their grants?

Easterling: You might think that foundations are just looking for the strongest applications. In fact, foundations always have a particular lens they apply when making grants. First off, they have defined areas of interest that limit what will fund. For example, more foundation dollars are now going toward health-related programming than any other area.

Once a foundation receives a batch of applications in its funding area, let's say health, what does it look for? Foundations each have their own perspective and intelligence on the community and its health needs, what's out there, and what works. So even the most responsive grant makers – the ones that wait for proposals to come to them – have a lot of perspective that comes from funding many different groups. This al-

lows them to say, "Well, this portfolio of projects is the most potentially powerful thing we could do to improve health."

This is different from a bank that makes loans, where all they want is a balanced portfolio in terms of funding risk. Foundations are somewhat interested in the risk exposure but they are more interested in putting put together a coherent strategy of different projects that when combined will make a difference.

Stakeholder: So how do foundations create a community health strategy?

Easterling: The term strategy has become a hot topic in philanthropy, with plenty of confusion and difference in opinion in what constitutes a strategy. Many foundations think they have a strategy when all they have is a kind of compilation of grants. Strategy presumes that you actually are after a particular set of outcomes that is based on an informed assessment of what the community needs, what the resources are, what's been done to-date, who else is doing stuff in this space, etc. Then the strategy involves then either funding the organizations that do the work that's needed or else stimulating that work.

If a foundation has a strategy that means it's being proactive in improving health. It means being out there – part of community partnerships, working with institutions, with health care systems, with public health, with elected officials, with senior services. Strategic foundations are part of the conversations where the rest of the community is talking about their

own strategies for improving health. And then the foundation finds its own role as part of the overall strategy.

Stakeholder: You said that the most funded issue is health, which may surprise some people.

Easterling: That stems from the fact that we now have over 300 health conversion foundations, created since the late 1970s. They came from the sale of a nonprofit hospital, health care system or insurance plan, ranging from small county hospitals to statewide Blue Cross Blue Shield plans. Their sale or conversion creates a new foundation. Some of these are \$20-\$30 million foundations. At the other end of the spectrum, the California Endowment, the Colorado Health Foundation and the Health Foundation of Greater Kansas City each have more than \$2 billion in assets.

So you're talking about huge resources, new resources coming into communities where there is no long history of having funded a favorite set of organizations. It's new money, free money to go to the highest needs.

Stakeholder: Do their bylaws require them to do health and, more specifically, health in a certain geographic area?

Easterling: Typically, in creating a conversion foundation you essentially maintain, not the actual non-profit organization, but the assets doing the same mission. The new foundation created out of the sale of a hospital or something has to have a mission at least somewhat consistent with the organiza-

tion that was sold. It has to be about improving or maintaining population health. In some states the Attorney General gets deeply involved to make sure that happens, even to the point of overseeing the appointment of the board. In others it's just a kind of check-off step.

Stakeholder: Since this is only a few decades old, how these foundations see themselves and operate is probably still evolving. Are they still in flux or is it settled down?

Easterling: There have been waves. The first wave formed in the 1980s and 1990s have generally stabilized and found their niche. But then successive waves come in, and they all go through a learning process. The field as a whole is still dynamic and going through a lot of change.

Meanwhile, you've got this chaotic health care environment. New work needs to be done. Many conversion foundations have been actively trying to figure out what they need to do with the passage of the Affordable Care Act. And what they do depends on whether they are in a state that either did or did not expand Medicaid coverage. Likewise, the major shifts we're seeing with electronic medical records, accountable care



organizations and the restructuring of public health departments all present major challenges and dilemmas that are essentially opportunities for foundations to add value.

Stakeholder: Besides this newer group – you have some older foundations that have focused on community health for many years. What are some trends in how they are engaging?

Easterling: One trend you see in all foundations over time is moving from being responsive and reactive to designing their own initiatives. They are taking the prerogative to move at least some of their grantmaking decisions and strategizing in-house. That could mean simply deciding on a process for convening local actors. It doesn't mean you tell the community what needs funding, but you may introduce a process that allows for a strategy to emerge.

In addition, many foundations have moved into the advocacy space.

Stakeholder: For example?

Easterling: Even before the Affordable Care Act was passed, there was a lot of work in Colorado, which I know best, to build public will around universal health care. Then once things began to shake out, Colorado was ripe for Medicaid ex-



pansion because people recognized the need for increased access to health care and bought into it. In states where a foundation wasn't taking that lead, that space was vacant. We lost an opportunity by not having foundations play a leadership role in the advocacy realm.

Stakeholder: Do these foundations see health systems as potential partners?

Easterling: They see them as partners, but they also see them as nuisance grantees. Meaning that a lot of these health-care systems have their own fundraising needs around facilities, setting up new units, doing research. Especially academic health centers have viewed health foundations as the “golden cow” where they go for pet projects. They sometimes propose huge multi-million dollar projects that directly compete for the money that could be going to community health promotion work or to grants.

Most foundations recognize that they've got limited resources – their greatest value is working in ways that improve the operations of organizations that provide health support services to the community. Introducing ideas, promoting innovation, things like that. It doesn't take a lot of money to make good stuff happen on that scale. But if you sink \$5 million into one isolated project at a hospital, you may have lost half of your funding capacity.

That said, foundations do recognize health care institutions as partners. In some ways, both institutions have improving population health as their ultimate goal. There are many ways

beyond the grantee-grant maker relationship for foundations to work collaboratively and collectively with health care institutions to improve community health.

Stakeholder: Where you have seen the philanthropic sector work well with health systems to improve health?

Easterling: It happens in different ways. Sometimes it's having a long enough working relationship with the hospital that the hospital knows what the foundation is looking for. They come up with programs that support the foundation's strategy around overall community health improvement. You see that with the Health Care Foundation of Greater Kansas City. They've been working with local hospitals for years to improve quality of care and to coordinate electronic medical records between different providers. And they have brought hospitals into multi-sectoral conversations that explore how the region can address issues such as behavioral health and childhood obesity.

Stakeholder: Shifting gears, what is “evocative grantmaking” and why does it matter?

Easterling: Think of what needs to happen to improve community health. Stakeholder Health shows the importance of promoting innovation, both within individual health care systems and across the board among community-based organizations. All of us have to be smart, thinking more holistically about all the different assets in a community and how they can come together. So if that's the way forward for improving



community health, what can foundations do to promote smart innovation? I would say ongoing innovation because whatever ideas people come up with at the beginning are just first approximations to whatever is ultimately going to work.

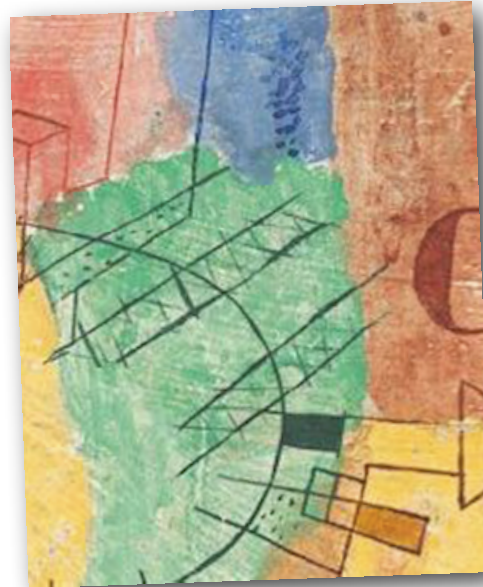
Foundations have money, which gives them influence to change behavior. How do they use that influence? Traditional grantmaking is overly bound by the specifications that are spelled out in the grant proposal: the work plan, the blueprint. Some foundations will take that proposal as written in stone, believing that this is what the organization has to do over the next year or two or three. This approach obviously undermines innovation and creativity.

Evocative grantmaking, at least as I'm framing it, is an approach where the foundation recognizes its ability to promote innovation and uses that to reinforce the learning process, and in some ways, underemphasizes accountability to tightly held metrics. That requires a different way of interacting with grantees, one that's more open-ended, back and forth, interactive. So the foundation is inquisitive about what's happening and maybe provides some advice and probing questions, can identify particular forms of assistance or coaching or expertise that could help the grantee and brings them in at key points in

time. It does peer networking across multiple grantees. It uses a successive or sequential approach to grantmaking where a short grant gets the project going, and you expect the organization to come back and apply for a second one that's going to be the next iteration. The foundation sticks with the same organization through multiple iterations.

Stakeholder: Is there an example of this that you've been involved with?

Easterling: At Colorado Trust with the Violence Prevention Initiative, we funded 26 organizations across the state, all trying to be more effective at preventing some sort of violence, whether its child abuse, elder abuse, youth violence, gun violence. Some were start-ups, some were grassroots, and some had come up with their own programs. Our grantmaking approach was to take them through a multi-year process where they could benefit from the expertise of the University of Colorado to develop their programs to the next level. We framed this as a kind of learning laboratory. When they got the grant they told us what they were doing, but we didn't even ask them for a proposal to tell us what they would be doing in a year. We said, "We know you're going to be learning, so we'll figure out as we go forward what your program should look like."



Stakeholder: How did that work out?

Easterling: In the end, it was received really well. In the beginning, the grantees were incredulous that we would actually provide that kind of flexibility.

Stakeholder: And did organizations adjust during the process to things that would work better?

Easterling: Yes, or at least they recognized that what they had in mind was not even half-baked. It was not going to reach the population. So this idea of abandoning an initial idea quickly, to me, was one of the greatest successes of the whole thing.

Stakeholder: What else should we know about health conversion foundations?

Easterling: Um... how foundations can be obnoxious.

Stakeholder: I would have never thought of that question. So, if you were to design the worst-case scenario in this area, what would it look like?

Easterling: The worst actually starts out sounding like the best – that a foundation takes time to figure out its strategy as opposed to just going out and just doing a shotgun approach. But instead of doing this kind of deep-dive into the community, working with partners and doing this interactive, participatory grantmaking, they hole-up and bring in a bunch of experts, especially out of state experts, and based on their own internal analysis, they decide how community health needs to

be improved. Then, based on that assumption, they design an initiative that prescribes what the funding will support, what kinds of organizations they want to participate. They take that RFP onto the street and get proposals back because everybody wants to play the game. Nobody is going to tell them that this is stupid so they submit a proposal.

But the whole initiative plays out without any chance for learning, without any intelligence growing up from the grassroots. It reinforces the foundation as this elitist leader, which is exactly the same complaint that communities level against health care systems – that they are back in their ivory towers and don't understand how health is really created and what the needs of the community are. Foundations can be just as guilty of that.

Stakeholder: Why is it important that foundations align with others? What do they bring that the government or hospital systems can't bring?

Easterling: That's a great question, and the other side is what is it they can't contribute? So what they can contribute is that, first and foremost, they've got resources to invest in innovative stuff. Unlike government agencies, you don't have pre-defined funding streams from legislation limiting your selection, so you've got that discretionary funding available.

More important, because they're funding different types of organizations trying to improve health from different angles, health foundations have that larger community perspective that sees multiple bodies of work and how they relate to one

another. So if they do critical thinking and learning inside their organization, they'll begin to develop their own internal map of how the work is currently being conducted and how it might be conducted. They've got that 30,000- or 50,000-foot vantage point of seeing, not only the different players but also how they connect or could connect to one another.

Also, their mission is about the common good. So unlike any of these other funded grantees – nonprofits that are focused on a particular segment of the population – foundations focus on the whole community. Unlike a hospital, especially a for-profit hospital, it's not about revenue streams, it's not about bringing patients into their own institution. It's just about impact. They can bring this consciousness to keep people focused on the right bottom line.

And here's what foundations can't contribute: they don't actually do any real on-the-ground work. They orchestrate the funding, but they're essentially setting the table. They're making things happen. They're incentivizing behavior. They're encouraging stuff and providing educational frameworks, but they need other people to be the actors.

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Hospitals & Health Conversion Foundations

By Doug Easterling, Allen Smart and Laura McDuffee

Before probing how hospitals can work productively with foundations—at the most general level, organizations that disburse money for activities that the Internal Revenue Service regards as “charitable,”—here are some basics on how foundations are structured and how they work.

One typically thinks of philanthropy as high-profile national foundations with billions of dollars in assets, such as the Bill and Melinda Gates, Ford, the Rockefeller, Robert Wood Johnson, and William K. Kellogg Foundations. However foundations come in all shapes and sizes. Some are highly visible (for example, those that sponsor National Public Radio) while others can be found only by searching a philanthropic database. Some foundations make grants throughout the world while others focus on a particular state or community. A typical grant in some foundations is well over \$100,000 while in oth-



ers it is under \$10,000. Some have a large staff with specialized expertise while others have a barebones administrative structure. Some have highly defined funding interests while others are more open and responsive to ideas that come from outside.

Foundations also vary in their organizational structure and legal status. “Grantmaking foundations” disburse charitable funds to nonprofit organizations and government entities, while “operating foundations” carry out charitable work themselves. Among grantmaking foundations, some draw from an endowment (often established through a bequest or an estate), while others raise the money they give away. From the standpoint of the Internal Revenue Service, the former are “private foundations” while the latter are “public charities.” Federal tax law requires that private foundations spend at

least 5 percent of their assets each year on charitable expenses (which includes not only grants made to nonprofits but also the foundation's own administrative costs). Public charities are not subject to the same requirement but in practice most of these foundations give away at least 5 percent of their assets each year. However, since fundraising foundations rely more on ongoing donations than on endowments, this statistic is less meaningful.

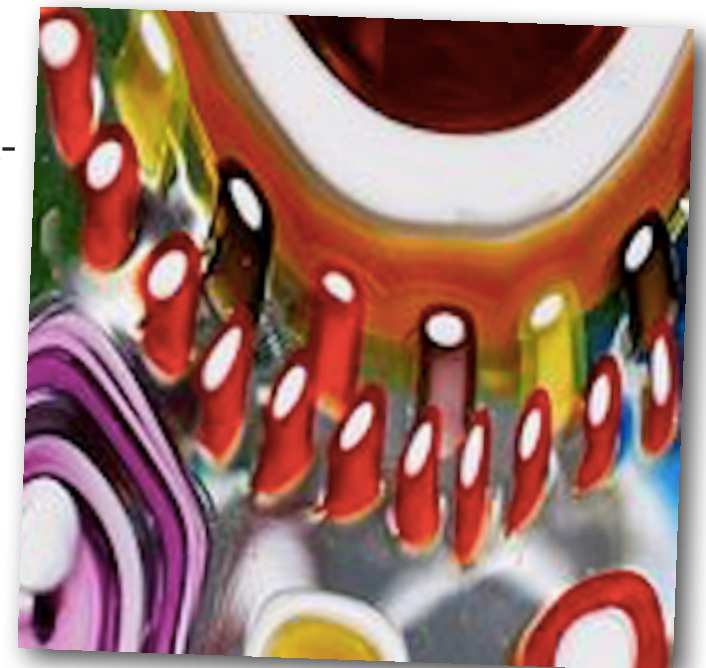
Two foundations of interest

Two specific types of foundations are particularly relevant to Stakeholder Health: hospital foundations and health conversion foundations. Each has an intimate linkage to health care organizations, but they have very different lineages, purposes and lines of accountability.

- Many hospitals set up a foundation to raise funds from individuals and organizations. These **hospital foundations** channel charitable giving to projects aligned with the donors' interests and the hospital's strategic priorities, which might include an expansion of a facility, new equipment, patient support services or subsidies for medical care.
- **Health conversion foundations** (also called "health legacy foundations") are formed when a nonprofit hospital, health care system or health plan is either acquired by a for-profit firm or converted to for-profit status. The proceeds from these transactions are transferred into the endowment of a foundation that maintains the general mission of the entity which was sold (that is, improving or advancing the

health of the population served by the entity). These conversion foundations began emerging in the 1980s as for-profit corporations extended their market reach by acquiring nonprofit hospitals. Many of them affiliated with religious denominations. A second spate of foundations was formed in the 1990s, including large ones in California and other states through the conversion of Blue Cross Blue Shield plans from nonprofit to for-profit status. Another large cohort of over 300 foundations has come into existence over the past five years as the health care market has adjusted to the Affordable Care Act. The most recent census identified **306 conversion foundations** that submitted their annual Form 990 to the IRS in 2010. **Together they held a total of \$26.2 billion in assets.** A more recent census is not available, but it's safe to say that at least another 100 have been established since 2010.

The assets of conversion foundations range from less than \$10 million (for foundations formed when small hospitals are acquired or closed), to more than \$3 billion (for foundations such as the **California Endowment** and the **Colorado Health Foundation**, formed when large systems or health plans are sold or

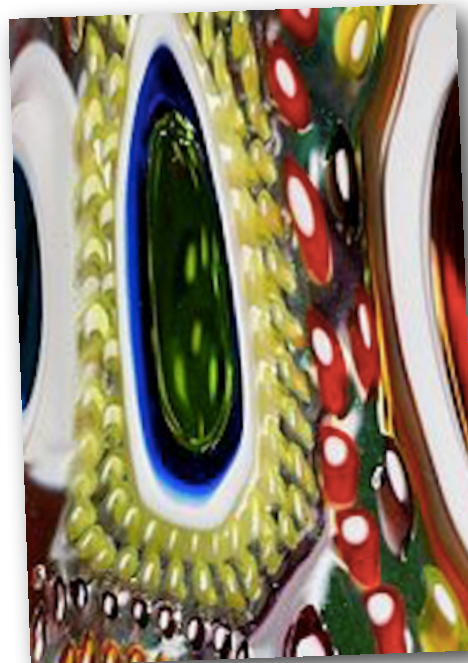


converted). The largest conversion foundations typically have a statewide focus, but most serve a particular community or sub-state region. Many of these locally oriented foundations award at least \$5 million per year in grants.

The most obvious philanthropic partners for Stakeholder Health systems will be the foundations that are affiliated with their collaborating hospital(s). But health conversion foundations may actually be more crucial to the work because, generally, they have more staff and a higher leadership profile in the community. And even non-health foundations, especially community foundations, can add value because they often fund work that addresses various social and economic issues that influence health.

The financial assets that foundations can bring to Stakeholder Health work are obviously valuable, especially because foundations often have a great deal of discretion in deciding how and where to invest their grant dollars. Yet, it is crucial to recognize that foundations are more than funders. They can bring many other resources and can take a variety of actions that enhance the effectiveness and impact of a Stakeholder Health initiative. To better recognize this strategic value, it is useful to take a deeper look at the business of philanthropy.

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Resources

Foundation Center, "Sustained Growth in an Expanding Field: 2014 Columbus Study Findings," July 2015. This report from the Foundation Center identifies growth trends in the community foundation field during FY 2015. These trends include changes in assets, gifts, and grants in an effort to add context to the ways in which individual organizations can partner with community foundations.

Grantmakers for Effective Organizations, "GEO 2015: Strengthening Nonprofit Capacity," February 2015: This report from Grantmakers for Effective Organizations focuses on improving the ability of grantmakers to improve the capacity of the non-profit organizations that they are awarding grants to.

Greater Rochester Health Foundation, "Neighborhood Health Status Improvement Initiative," January 2013: This powerpoint presentation from the Greater Rochester Health Foundation outlines the ways in which asset-based community development grants have been used in Rochester to improve the health of the city's neighborhoods.



Fostering Partnerships Between Hospitals & Foundations

By Doug Easterling, Allen Smart and Laura McDuffee

If foundations have such a vital role to play in Stakeholder Health, then the logical question is why hospitals have so far neglected to fully engage them? One answer is that hospital executives don't fully recognize what foundations are capable of doing. Foundations are often viewed as organizations that have money to contribute to charitable projects and not much more. This may be true for the hospital's own internal foundation (which typically disburses funds according to the hospital's strategic plan), but other foundations in the community may well operate quite differently. Many of them, as we have noted, are highly strategic entities with ambitious goals and a broad ability to catalyze change.

There is a second important reason that hospitals often might not reach out to include foundations as co-designers or co-leaders of an initiative: hospitals tend to operate autono-

mously. Because of their extensive financial resources and their status as an economic engine for the community, hospitals have grown accustomed to deciding for themselves what they want to accomplish and how they will go about getting there. Partnering with a foundation on a large-scale initiative requires reaching out in unfamiliar ways and letting go of some of the control they are accustomed to exercising.

What would happen if hospitals were able to acknowledge the value that foundations can bring to their Stakeholder Health work? Would foundations take them up on the invitation? In our interviews with foundation executives, as well as our own



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personal experience, we have witnessed a great deal of skepticism, suspicion and chagrin on the part of foundations when it comes to the idea of partnering with hospitals. There is a common perception among foundations (at both staff and board levels) that hospitals too often ask for outsized grants for projects that are entirely within the hospitals' own self-interest.

Consider a typical health conversion foundation that has a pool of \$10 million to grant each year to improve health in its service area (often a county or multi-county region). Is it surprising that the staff and board will hesitate to fund the local medical center's multi-million dollar request for capital expansion or an endowed chair? A million dollar grant proposal might look "normal" to a medical center (it submits hundreds of these per year to the National Institutes of Health), but it may stir resentment among the foundation's program officer who reviews a hundred proposals from local nonprofits in the \$30,000 to \$50,000 range. Whereas the proposals from community-based organizations have clear and obvious payoff to local residents, large proposals from the hospital may be viewed as benefiting a few highly paid administrators or scientists who are narrowly focused on their own particular agendas. Especially when it comes to proposals for biomedical research, we have heard from more than a few executives from health foundations that this is a "black hole" for their precious grant dollars.

Another factor that makes foundations disenchanted with hospitals and academic medical centers is the central role of devel-

opment offices as intermediaries between hospitals and foundations. Many hospitals treat "foundation relations" as completely under the purview of the development office, which acts as the gatekeeper for any and all requests or inquiries that originate within the hospital. Foundation staff often complain that development staff they interact with know little to nothing about the content of the proposals coming over from the medical center. And even when they are knowledgeable, they focus more often on the hospital's success than on the larger community's well-being.

These experiences--receiving outsized grant proposals from the development office--leave foundations with a jaded view of hospitals. This makes them suspicious of hospital-led initiatives, even when those initiatives have the potential for substantial improvements in community-wide health. Likewise, when foundations are developing their own large-scale initiatives they tend to overlook hospitals as potential partners and instead recruit community organizations where there is a positive track record of working together. Foundations are much more likely to partner with the local health department or school district than with a local hospital.

Creating a New Equilibrium

This institutionalized tension between hospitals and foundations is unfortunate in many respects. They are, in fact, natu-



ral allies when it comes to Stakeholder Health, or any large-scale effort to improve community health. Equally important, there is reciprocal value when they work together: foundations can help hospitals achieve their goals, and hospitals can help foundations achieve theirs.

Hospitals can benefit in a number of ways from the expertise, experience and relationships that local foundations have built in carrying out their work. Especially with the emphasis on value-based care under World 2.0 (see chapter 10), hospitals need to expand and adapt their strategies for patient care and transitional care. They also need to establish networks of community-based supports to promote the health of patients before and after their hospital stays. The partnerships that foundations already have with service agencies, faith-based organizations, coalitions and grassroots groups are precisely what hospitals need as they create accountable care organizations and enter into contracts that require them to effectively manage population health. Hospitals can also benefit from foundations in terms of learning about the social determinants of health and how to influence those determinants, given that foundations operate within and across multiple systems, providing them with a rich understanding of how health is created and which roles that various local agencies play in that process.

Foundations likewise have much to gain from partnering more closely with hospitals. While foundations are in the enviable position of having large sums of discretionary funds to invest each year, they are inherently constrained in their ability

to achieve their strategic goals. Whereas, their staff make grants, lead community-change efforts and connect people and organizations to capacity-building opportunities, they do not directly carry out the on-the-ground work that brings services to residents or changes conditions within the home or the neighborhood. Foundations rely on their grantees and partner organizations to act as agents in implementing their strategies. Because of their size, resources and reach, hospitals are

thus potentially one of the most important organizations that foundations can work with to achieve their goals.

Given that hospitals and foundations have mutually reinforcing interests, how can we encourage productive partnering? We offer three modest proposals.



First, we advise hospitals and foundations to take a second look at one another, and a deeper look at one another's assets and interests. It is crucial for hospitals to recognize that foundations are more than funders. We recognize that foundations are in the business of making grants and that this is what makes them important and appealing to organizations throughout the community. But it doesn't take much investigation or conversation to begin to recognize the many nonfinancial resources that foundations can bring to ambitious community-change work. Conversely, foundations would be well-served in recognizing the role that hospitals can play when they move beyond their own walls. Especially with the advent of accountable care organizations and other innova-

tions in the insurance marketplace, we are beginning to observe hospitals and healthcare systems focusing on community health and social determinants of health in previously unimaginable ways. Foundations may discover that at least some hospitals are coming around to a perspective that aligns with their own.

Second, we encourage the leaders of hospitals and foundations to reach out to one another on a periodic basis to explore their respective and shared interests.

Hospitals and foundations each have a tendency to act autonomously when developing large-scale initiatives. These two institutions can strengthen their strategies by listening to one another and incorporating each other's perspectives and expertise. The more that local organizations understand one another's interests, strategies and plans, the more that they can find shared opportunities, leverage one another's work and create synergy. This applies not only to hospitals and foundations, but to all organizations that are developing large-scale strategies to improve community health and well-being.

Third, we recommend using the Stakeholder Health's perspective as a guide for developing shared strategy.

One reason that hospitals and foundations have historically taken different paths to improve community health is that they have been following different road maps. Hospitals are guided by the idea of delivering services to patients one at a time. This is the paradigm of clinical medicine and until recently it provided the framework for invoicing and receiving payment. Foundations in contrast have sought to maintain

and improve health at a population level, which has led them to the paradigm of public health which emphasizes prevention, health education, policy approaches to behavior change, community-based organizations and social determinants of health.

Stakeholder Health brings the public health paradigm squarely into healthcare organizations, while still finding an important place for their medical care and the substantial financial, human and physical resources. Just as importantly, Stakeholder Health frames the business of health improvement as a partnership among multiple organizations that complement one another. It also serves as a blueprint for a theater where hospitals, foundations and many other organizations have their own distinct role to play. While some of these players may try to outmaneuver one another to be the lead actor, the real test of a well-functioning ensemble is its ability to draw out the best from one another.



The Business of Grantmaking

By Doug Easterling, Allen Smart and Laura McDuffee

Most foundations disburse their charitable dollars through some sort of grantmaking process. While grantmaking is the defining element of philanthropy, it is not necessarily the most powerful thing that foundations do. A growing number of foundations view their core business as **catalyzing change** — specifically, change that leads to the impacts referenced in the foundation’s mission (e.g., improving health, reducing poverty, creating more vibrant communities, eradicating injustice or racism). They use a variety of strategies that extend well beyond grantmaking to stimulate change at the individual, organizational, community and societal levels. These include: increasing the capacity of nonprofit organizations and government agencies, encouraging these organizations to adopt more effective programs and strategies, establishing

new organizations, building the leadership skills of established and emerging leaders, activating local residents and officials to take more initiative and to think more creatively, encouraging changes in public

policy (either directly through advocacy or indirectly through policy research and awareness-raising), and leading communities through a process of soul-searching and transformation. Below we present examples of each of these “beyond-grantmaking” strategies.

Building organizational capacity

National foundations typically have access to a pool of well-established, highly functioning nonprofit organizations that carry out work in line with the foundation’s interests. In contrast, foundations operating in a particular community or region may find it much more challenging to find strong nonprofits ready to do the type of work the foundation wants to support. For this reason, many foundations have gone into the business of building the capacity of nonprofit organizations. This provides the foundation with more effective partners, while strengthening the nonprofit sector in communities and regions where the foundation has decided it has an interest.



In a recent survey of foundations (restricted to those that have at least one paid staff position), **Grantmakers for Effective Organizations** (GEO) found that 77 percent are investing at least some resources in building organizational capacity among their grantees. These investments include grant funding dedicated to training or hiring an organizational development consultant. Alternatively foundations sometimes hire consulting firms directly and make their services available to a cohort of nonprofits within a community or region. In either case, the intent is to strengthen nonprofit organizations in areas such as program development, strategy, fundraising, communications, technology and evaluation.

Establishing New Organizations

As a foundation scans the nonprofit landscape looking for potential grantees and partners, it may find that there are gaps not only in capacity but also in mission. It may have a clear and informed strategy for achieving a particular improvement in health or quality of life, but come up short when trying to identify organizations to play key roles in that strategy. One option is to draw a local organization into new work that supports the strategy, but this approach runs the risk of encouraging mission creep. Even if the foundation can entice an organization into new territory with a grant, this is arguably an irresponsible use of the foundation's power and resources.

An alternative approach for the foundation is to create a new organization that directly addresses the identified gap. The **Rapides Foundation** in Alexandria, Louisiana, has exercised

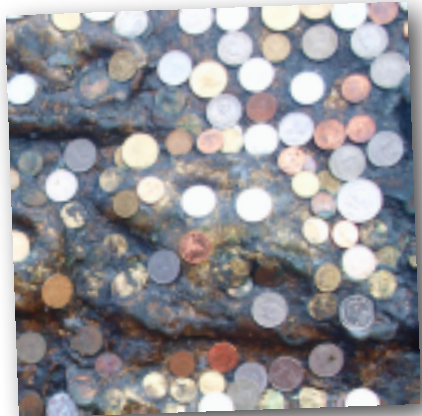
this option on a number of occasions because it could not find organizations in its largely rural target area that were suited to carrying out work that the foundation regarded as crucial. In 2001 the foundation established the Cenla Medication Access Program (CMAP) to improve people's access to medication by offering free or reduced-cost prescriptions to eligible clients.

Leadership Development

Foundations establish programs to build capacity not only at the organizational level, but also the individual level. While these programs generally provide participants with rich experiences (even life-changing ones), they have been criticized for their focus on individualized development and remote training. Participants come together for intense sessions that leave them with a variety of new skills and tools, but then return to an environment where those skills, tools and new way of looking at the world are foreign and possibly threatening.

Foundations around the country have established such regionally or locally oriented leadership development programs. Many focus on civic leadership rather than organizational leadership. For example, the **Blandin Foundation** in northern Minnesota has trained more 7,000 residents from 600 rural communities in creating shared meaning, building social networks, and mobilizing people, resources and power. Other rural funders, such as the **Ford Family Foundation** in Roseburg, Oregon have developed similar programs, taking advantage of what their peers have learned over the years.

Conversion foundations in particular have come to recognize that leadership development is one of the critical strategies for improving the health of communities. The **Kansas Health Foundation** is arguably the greatest proponent of this pathway



to health. It established the Kansas Community Leadership Institute in 1992, attracting a range of leaders, including hospital administrators, public health officials, nonprofit leaders and county extension agents. That program proved insufficient to meet the demand for leadership development across the state, so in

2005, the foundation invested \$30 million to establish the Kansas Leadership Center.

Activating People

Community change occurs through the actions of many people who display varying levels of leadership. Some will feel comfortable participating in leadership development training, but others view themselves as just doing the necessary work. In at least a few communities, foundations have played a key role in activating residents and mobilizing neighborhoods to take action to improve their health and well-being.

Facilitating Planning and Problem Solving

Foundations promote improvements in health beyond individual and neighborhood levels. Health conversion foundations especially have developed initiatives that bring local stakeholders together to identify critical health issues that need resolv-

ing on a community-wide level. These initiatives require multiple organizations to sign on for a long-term process of collaboration, planning, and carrying out coordinated work. During the planning phase, the group typically assesses the community's health issues, prioritizes a limited number of focus areas, identifies underlying factors that offer opportunities for improving health, and selects a set of programmatic and policy strategies that operate on those leverage points. At the end of the planning process, the group generates a plan that lays out what each of the participating organizations will do to advance the overall strategy. This typically is submitted to the funder with a proposal for grant funding to support specific elements of the plan. The funder then reviews the products of the planning process and decides which programs, activities and organizations to support through an "implementation grant." These grants typically cover expenses over at least two years, and sometimes up to five.

Introducing Innovations

Foundation-sponsored community health initiatives often fall into the category of disruptive innovations. By bringing a more comprehensive, intentional and data-driven approach to strategy design, they disrupt the community's prevailing way of advancing health. And they are innovative in the sense that local actors engage in a form of thinking, problem-solving and planning that departs from normal practice. Though the planning model might not be innovative in an absolute sense, it is novel to the particular community where it is introduced.

Foundations are well-positioned to identify innovations and introduce them into community decision making, problem-solving and strategizing. Their staff often have at least some content expertise in health care, public health and social change, and more specifically, are usually familiar with current research literature on evidence-based and emerging practices. More than most nonprofits, foundations are able to set aside dollars for staff development and attending national meetings. The philanthropic sector is rich with affinity groups that organize annual conferences, facilitate peer learning and disseminate research findings (e.g., [Grantmakers in Health](#), [Grantmakers for Effective Organizations](#), [Council of Foundations](#), [Neighborhood Funders Group](#)). This provides foundation staff with multitudes of ideas to enhance the work of grantee organizations and communities, including practices that highlights the benefits and evidence associated with innovation and incentivizes grantees to adopt it.

Raising Public Awareness of Key Issues

Foundations across the country (especially national and state health foundations) have built sophisticated communications departments that devise and deliver campaigns aimed to reach specific target audiences with key messages about particular health issues. These campaigns have helped to elevate onto the public agenda issues such as homelessness, childhood obesity, suicide, opioid abuse, teen pregnancy and bullying. Such awareness-raising has paid off with wide-ranging investments and programming on the part of government agencies, nonprofits, businesses and coalitions.

Advocating for Policy Change

Health foundations have been particularly active in advocating for their state legislatures and governors to expand Medicaid Expansion as permitted under the Affordable Care Act. For example, the [Colorado Trust](#) joined with the [Colorado Health Foundation](#) to support advocacy and organizing efforts throughout the state. This included messaging and analysis directed at lawmakers, as well as a more broad-based campaign to build “public will” for Medicaid Expansion. The foundations provided funding and technical assistance to advocacy organizations around the state to build their capacity.

Leading Structural Change

The strategies described so far correspond to various leverage points for improving community health and quality of life – strengthening the capacity of people and organizations, expanding and improving the mix of programs and services that are available to local residents, promoting more deliberate and informed planning, bringing more residents into the life of the community, and changing policy so that it better supports the health of local residents. A handful of foundations have gone even further and taken the lead in changing the fundamental character of the communities they serve.

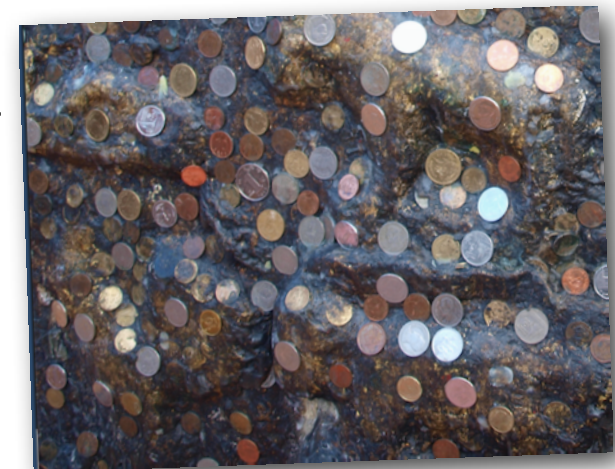


Photo: "Money Coins on Metal Texture" by Iwan Gabovitch, Flickr