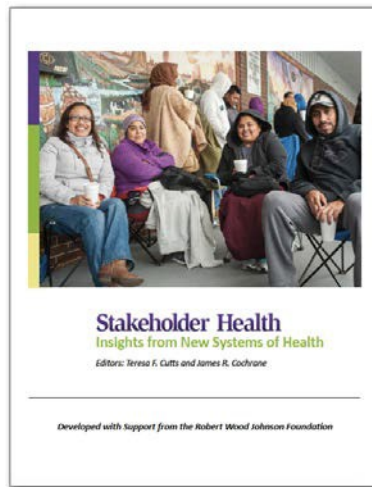# Stakeholder Health

Chapter 9

Philanthropy, Health Systems and Community Health Improvement

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Philanthropy, Health Systems and Community Health Improvement

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Introduction

Our Stakeholder Health "movement" is intentionally disruptive. It calls for hospitals and health care systems to re-imagine their role in advancing health. Rather than diagnosing and treating patients one at a time, healthcare organizations are being challenged to intervene in ways that maintain and improve the health of entire populations.

This new way of doing business requires an expanded perspective—seeing the whole person full of complexities, challenges and assets, rather than honing in on a particular illness, chronic condition, injury or set of symptoms. Likewise, Stakeholder Health redirects our sight upstream—moving from the immediate proximal causes of mortality and morbidity to the more fundamental social and economic determinants that either undermine or enhance health.

By acknowledging the broad and complex range of factors that determine health, one necessarily must accept the limited scope of influence of any single institution or sector, including health care. Stakeholder Health (HSLG, 2013, p. 14) thus counsels hospitals and healthcare organizations that they "do not need to carry the freight of solving complex social issues on their own. [Instead] they can strategically align their resources and efforts with those of others who specialize in [housing, transportation, education, agriculture, public health, economic development and business]" (HSLG, 2013, p. 14). Cross-sector partnering is a core element of the "accountable communities for health" (ACH) concept, which calls for healthcare organizations to enter into coalitions with others from public health, education, business, social services, faith and the larger community (Hacker & Walker, 2013; Tipirneni, Vickery & Ehlinger, 2015).

Stakeholder Health defines a path whereby hospitals can work respectfully and synergistically with various partners who influence health, ranging from small churches and neighborhood associations to established institutions in the governmental, private and nonprofit sectors. Cross-sector partnering is similarly a core element of the "accountable communities for health" (ACH) concept, which calls for healthcare organizations to enter into coalitions with others from public health, education, business, social services, faith and the larger community (Hacker & Walker, 2013; Tipirneni, Vickery & Ehlinger, 2015).

Foundations are a natural partner for us, and in fact have a few distinct advantages over hospitals when it comes to our line of work. For example, foundations inherently seek to advance the health and well-being of populations rather than individual patients, clients or customers. Their accountability is typically linked to improving the lives of people rather than achieving targets for revenue or profit. Perhaps even more importantly for the purposes of Stakeholder Health, foundations have a broader scope of influence over the determinants of health than do health care organizations. They have close working relationships with nonprofit organizations and government agencies in many different sectors who operate on the full range of factors that influence health (e.g., public health, mental health, social services, housing, schools, child development). And they bring a wealth of assets that extend well beyond their bank accounts and investment portfolios.

Here we describe how foundations can be brought into the work of Stakeholder Health, especially in ways that go beyond providing financial support for projects and programs. Foundations have shown that they have the means and the skills to convene actors from throughout a community, to publicize issues with institutional leaders and the broader public, to advocate for policies and other systems-level remedies, to inject innovative ideas into the development of community-health strategies, and to build the capacity of the people and the organizations that need to be engaged in the work. Hospitals have much to gain and to learn through partnering with foundations. On the flip side, foundations can come closer to their goals by forging stronger and more strategic alliances with hospitals, something that many foundations have been reluctant to do. In fact, there are significant historical tensions between hospitals and foundations, a critical aspect that we will deal with later.

The Foundation Landscape

Before probing how hospitals can work productively with foundations, it is useful to present a few fundamentals on how foundations are structured and how they go about their work. At the most general level, a foundation is an organization that disburses money for activities that the Internal Revenue Service regards as "charitable."

When the topic of philanthropy arises, one typically thinks of 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 others 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% 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% of their assets each year. However, since fundraising foundations rely more on ongoing donations than on endowments, this statistic is less meaningful.

All this to say, when imagining how foundations can support the work of Stakeholder Health, it is useful to think in terms of specific types of foundations rather than the whole sector (see sidebar, on the most prominent types of foundations, *Taxonomy of Grantmaking Foundations*, which is intended to assist in navigating an admittedly complicated landscape).

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.

TAXONOMY OF GRANTMAKING FOUNDATIONS

- **Family foundations** are endowed by a wealthy benefactor who defines the mission and funding priorities. Typically these are private foundations (because there is a single source for the charitable funds). As such they are required to pay out at least 5% of their assets each year for charitable purposes (which include grants and qualifying administrative expenses). Most but not all family foundations are designed to operate in perpetuity, based on the premise that investments will return more than 5% each year. Sometimes the founder sets up a board structure that keeps control over the foundation within the family, while other times the board will be made up of a mix of family and non- family members. The mix often changes over time. The Ford Foundation began as largely a family affair when Henry Ford died, but it became an independent entity that actually feuded with Henry Ford II in the 1970s (MacFarquhar, 2016). Some foundations are relatively closed when selecting grantees, while others have a more transparent and inclusive process.

- By definition, private foundations derive the majority of their assets from a single source, but this source is not always a wealthy individual or family. **Corporate foundations** are private foundations that disburse charitable funds on behalf of the parent corporation. This segment of philanthropy accounts for a major portion of the charitable dollars that are given in the U.S. each year. Much of this giving is directed toward charitable purposes (especially capital campaigns and sponsorships) within the communities where the parent corporation has offices. But an even greater amount is given by the "patient assistance foundations" that provide free or reduced-cost prescriptions to those without the means to pay. These patient assistance foundations are linked with different pharmaceutical firms. Eight of the ten most "generous" foundations (of any type) fall into this category. The patient assistance foundations associated with AbbVie, Bristol-Myers Squibb, Johnson & Johnson, Merck, Genentech, Pfizer, GlaxoSmithKline, and Lilly each reported over $500 million in charitable giving in 2013 (Foundation Center, 2015).

- A foundation is classified as a "public charity" by the IRS if its funding comes from multiple contributors within the "general public," or alternatively, it is supported by a governmental unit or tax-exempt income. Most public charities spend those dollars on their own programming (i.e., the "nonprofit organizations" that we typically think of), but many of the biggest **public charities** are grantmaking organizations. The United Way organizations that raise and distribute dollars in most U.S. communities are a prominent example.

- **Community foundations** are one of the most important grantmaking organizations that fit within the public charity category. A community foundation raises funds from local donors and provides these donors with administrative, programmatic and investment services. Donors can either set up their own distinct funds, each of which has a particular funding priority, or contribute to the foundation's discretionary fund. Some of the community foundation's grantmaking is directed by individual donors, while some grants are awarded by the board of trustees taking into account the staff's recommendations. The boards of community foundations are usually comprised of community leaders representing different institutions and sectors.

- A **hospital foundation** raises funds from individuals and organizations, and then disburses those funds in support of a particular hospital. When that hospital is a nonprofit organization, the foundation if often set up as a unit of the hospital (technically referred to as "supporting organizations"). In contrast, for-profit hospitals often find it advantageous to establish a distinct organization that is recognized by the IRS as a public charity.

- **Health conversion foundations** (also called "health legacy foundations") are created when a nonprofit hospital, health care system or health plans is sold to a for-profit firm or converted into a for-profit entity. Federal tax law requires that the proceeds from the transaction remain within the nonprofit sphere and be used for comparable purposes (e.g., to improve the health status of the same population that was served by the entity that was sold or converted). Typically a new health foundation is created. It is a separate legal entity with its own mission and governance structure.

- Philanthropy also occurs through **trusts** that are managed by financial institutions. A trust is either set up by a living donor or established as a condition of the will when a donor dies. Rather than being governed by a board of trustees, the financial institution serves as the trustee and controls the disbursement of grants, investment decisions and the hiring of staff. One example of a trust that funds health projects is Kate B. Reynolds Charitable Trust in Winston-Salem, NC, which is a trust account of Wells Fargo. When the Kate B. Reynolds Charitable Trust was initially established (upon the death of Mrs. Reynolds), the will stipulated that there would be three trustees, two of Mrs. Reynolds' relatives and Wachovia Bank (which was then based in Winston-Salem), and that Wachovia would become the sole trustee upon the death of the two human trustees. Although the Trust does not have a governing board, the Trustee has convened two advisory boards which review and provide input on strategy and grantmaking.

- 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 (i.e., 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 non-profit 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 has come into existence over the past 5 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 (Niggel & Brandon, 2014). A more recent census is not available, but it is 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 the majority 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.

The Business of Philanthropy

Most foundations disburse their charitable dollars through some sort of grantmaking process. The many different versions of grantmaking depend on a foundation's mission, strategy, size of staff, role of the board, philosophy and culture. The foundation might issue an open request for proposals or it might invite proposals from a small group of pre-screened organizations. It might specify particular types of work that are open for funding or alternatively leave it up to applicants to propose their preferred projects. Grants might support a specific project, the core operating expenses of the grantee organization, or the building of organizational capacity. Some foundations fund the same organizations year after year, while others limit the duration of funding. Some want to invest in innovative project ideas while others are more conservative and focus on evidence-based programs. More generally, each

foundation has its own interests, goals and philosophy about what constitutes a "good grant." As such, some foundations will have an affinity for the work of Stakeholder Health while others will regard this as someone else's work.

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

Foundations rely on nonprofit organizations, government agencies and individual people to carry out the day-to-day work that is required to advance their mission, whether it is promoting health, improving educational outcomes, moving people out of poverty, strengthening families, building vibrant communities, creating a more just society, or something else equally as ambitious. This means that a foundation's ability to achieve its goals depends in large part on the capacity of the organizations who serve as its grantees.

National foundations typically have access to a pool of well-established, highly functioning nonprofit organizations interested in carrying 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 that are ready to do the type of work that the foundation is interested in supporting. As such, many foundations have gone into the business of building the capacity of nonprofit organizations. This work provides the foundation with more effective partners, while at the same time 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 (GEO, 2015). These investments include grants with 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 on factors such as program development, strategy, fundraising, communications, technology and evaluation.

The Health Foundation for Western and Central New York (HFWCNY), a health conversion foundation based in Buffalo, established a fairly elaborate capacity building program, GetSET (Success in Extraordinary Times) for health and human service organizations in western New York (HFWCNY, 2015). The impetus for the program was the rapidly changing fiscal environment that is confronting service providers that depend on Medicaid and other government sources for revenue. GetSET uses a team-based approach to assist these organizations in strengthening their strategy, operations and structures. A self-assessment at the outset of the program provides the participating organizations with

information on how they are doing with regard to various core competencies. Each organization in the cohort formulates a capacity-building plan and then works on those issues through a process of training, consulting and peer learning. The foundation supports the training and consulting and also provides participating organizations with grants to help implement their organizational changes.

Some foundations have emphasized specific aspects of organizational capacity that they believe are lacking among their grantees and partner organizations. The REACH Health Foundation, a conversion foundation located in Merriman, Kansas, introduced a Cultural Competency Initiative in 2009 which provided health and human service organizations in the Kansas City region with individualized technical assistance to improve their services to uninsured and underserved populations. This assistance included organizational assessment, coaching, policy development and change management. Over time this program has evolved to emphasize peer learning and networking. More than 60 organizations now participate in the Cultural Competency Learning Community. Three other health funders in the region have partnered with REACH to provide additional financial support and in order to spread the program to more organizations and more communities (REACH, 2015).

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 this approach runs the risk of encouraging the organization to diverge from its mission and goals. 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, a divergence from original mission goals. 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. Patient Assistance Program specialists employed by the foundation assist rural clinics and primary care practices with accessing these medications. CMAP has grown beyond the foundation's funding region and is now offered statewide (Rapides, 2015).

Edgecombe County, one of the Kate B. Reynolds Charitable Trust's Healthy Places NC communities

LEADERSHIP DEVELOPMENT

Foundations establish programs to build capacity not only at the organizational level, but also the individual level. The vast majority of these individually oriented programs emphasize leadership skills of one sort or another. The Robert Wood Johnson Foundation and the W.K. Kellogg Foundation each have a long history of leadership development programming to support leaders in fields such as health policy, public health, nursing, academic medicine, health equity and social change. These programs recruit participants nationally or regionally, typically through a competitive process. Some programs are geared towards leaders with established track records and positions of influence, while others are oriented toward emerging leaders or early career professionals who show particular promise. In most cases, the program brings together a cohort of participants in one or more leadership-development training sessions, typically delivered by a highly regarded training group such as the Center for Creative Leadership (CCL) or the Kennedy School of Government at Harvard. Many of these programs also support a process of peer mentoring and learning and some provide each participant with a coach.

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. This makes it difficult for the newly trained leader to apply the competencies that he or she has built. The Kate B. Reynolds Charitable Trust in Winston-Salem, North Carolina, addressed this issue by organizing leadership development sessions within the counties where it seeks to build capacity through its Healthy Places NC (HPNC) initiative. The Trust contracted with the Center for Creative Leadership, which is headquartered in nearby Greensboro, to design and deliver a leadership program appropriate to organizational leaders in rural communities who can play a role in improving population health. It brings together participants with a shared interest (e.g., behavioral health, childhood obesity) in an intensive experiential program to develop "boundary-spanning leadership," which CCL defines as "the capability to establish direction, alignment, and commitment across boundaries in service of a higher vision or goal" (Yip, Ernst & Campbell, 2016). CCL also provides individual coaching and consulting support to help the cohort develop a collective project or strategy

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 (Blandin, 2015). 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. The Center has developed its own model of civic leadership (built on the concept of "adaptive leadership"), and a multi-layered curriculum to train leaders from multiple sectors and with different levels of experience as leaders (Chrislip & O'Malley, 2013).

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.

One example is the Greater Rochester Health Foundation in upstate New York which uses a community organizing strategy to improve the physical, social and economic environments of neighborhoods (Zappia, Puntenney & Snyder, 2013). This grassroots orientation grew out of the foundation's experience in working with local residents to carry out a program to remove lead-based paint from homes throughout the city. With its Neighborhood Health Status Improvement initiative, the foundation funded a community organizer position in 10 neighborhoods and rural communities throughout the region. The organizers are trained in the Asset-Based Community Development (ABCD) paradigm of Kretzman and McKnight (1993), reviewed in Chapter 6 of this volume, which focuses on resident-led efforts to improve the quality of life by drawing on the community's own assets.

The ABCD approach has attracted the attention of a number of foundations across the country, especially community foundations. Beginning in the 1980s, community foundations in Denver, Colorado and in Winston-Salem and Greensboro, North Carolina began training residents and nonprofit leaders on the ABCD model and funding the asset-mapping work that is central to it.

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 resolving 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.

These planning-based health initiatives began to take root in the early 1990s with The California Wellness Foundation's Health Improvement Initiative (Cheadle, Beery, Greenwald, Nelson, Pearson & Senter, 2003); The Colorado Trust's Colorado Healthy Communities Initiative (Conner & Easterling, 2009); Sierra Health Foundation's Community Partnerships for Healthy Children Initiative (Meehan, Hebbeler, Cherner & Peterson, 2009); Robert Wood Johnson Foundation's Urban Health Initiative (Silver & Weitzman, 2009); and the Community Care Network demonstration program developed by the Health Research and Education Trust in partnership with the American Hospital Association, VHA Inc., and the Catholic Hospital Association (Hasnain-Wynia, 2003). More recently, foundations such as the Kansas Health Foundation, the Health Foundation of South Florida, the New York State Health Foundation and The Duke Endowment have launched additional initiatives that call for a variety of local organizations to come together to create a shared strategy for improving the health of their community. This recent spate of activity has been driven at least in part by the introduction of "collective impact" as a strategy for achieving large-scale change (Kania & Kramer, 2011).

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 highlight the benefits and evidence associated with innovation and incentivizes grantees to adopt it.

Innovations that foundations have brought to local organizations, institutions and collaborative bodies include: evidence-based programs to improve child development, practice guidelines for clinicians, tools for assessing clients' needs and goals, quality improvement processes, model legislation to reduce tobacco use and financing reform that encourages cross-agency collaboration.

New frameworks for thinking and problem-solving are a powerful but often overlooked form of innovation. Achieving meaningful progress on entrenched problems invariably requires more than finding and implementing an effective program or two. The critical work happens upstream when actors are analyzing the situation and formulating strategy. Whether those actors find breakthrough strategies depends more on their mindset than the specific programs they come up with. A systems-level framework can provide them with a wide-angle lens that illuminates the local landscape and shows how people, organizations and issues inter-connect with one another (Easterling, Arnold, Smart & Jones, 2013).

One of the most innovative and powerful of these conceptual frameworks comes from County Health Rankings & Roadmaps (CHR&R), a program of the University of Wisconsin Population Health Institute in collaboration with the Robert Wood Johnson Foundation. Building on the pioneering work of Michael McGinnis and William Foege (1993), the CHR&R framework recognizes that the health of a population is determined in large part by factors that fall outside the realm of clinical care, including health behaviors, the physical environment, and social and economic factors. Each year, the CHR&R program uses an algorithm that reflects what they view to be the actual determinants of health to compute a Health Outcomes score and a Health Factors score for every U.S. county. Counties are then ranked from most to least healthy within each state. These CHR&R data generate a great deal of local and national media attention, and also serve as the basis for health planning in communities throughout the country. According to the CHR&R website, "the Roadmaps are helping communities bring people together from all walks of life to look at the many factors that influence health, focus on strategies that we know work, learn from each other, and make changes that will have a lasting impact on health" (UWPHI, 2015). While the groups typically begin with an emphasis on their county's ranking, the exploration process is guided by the expanded conceptualization of health articulated in the CHR&R framework.

The Kate B. Reynolds Charitable Trust has incorporated CHR&R into its Healthy Places NC (HPNC) initiative. Shortly after the launch of HPNC in each county, a representative from the CHR&R project comes to present the conceptual model, along with detailed health data for that specific county (typically in three separate forums targeted to different audiences). The CHR&R data and conceptual framework spur new thinking, conversation, innovation and cross-sector networking, and this materially changes how local actors are tackling the health issues facing their communities. In particular, it fosters more comprehensive, systems-level strategizing. The Clinton Foundation has adopted a similar approach, incorporating the CHR&R framework into its Clinton Health Matters Initiative, which supports community-based assessment and planning across the U.S.

RAISING PUBLIC AWARENESS OF KEY ISSUES

The CHR&R example illustrates another strategy available to foundations: raising public awareness and consciousness on critical 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.

Foundations have been particularly active in raising public awareness about access to health care. For more than two decades, the Commonwealth Fund and the Kaiser Family Foundation, working with nonprofits such as Families USA, have visibly publicized the proportion of Americans without health insurance. A number of state-level health foundations have stepped into this arena too and commissioned studies that provide a more fine-grained picture of who does and doesn't have insurance coverage within their own state. For example, The Colorado Trust in 2008 funded the Colorado Department of Health Care Policy and Financing to develop and implement the Colorado Household Survey (COHS), which asks multiple questions about insurance status (Colorado Trust, 2009). This survey was able to demonstrate how insurance status varied by region and demographic group—in a much more precise manner than had been previously known. Moreover, these data helped set the stage for a more informed and objective debate around the value of proposals such as the Affordable Care Act.

ADVOCATING FOR POLICY CHANGE

As foundations get into the business of raising issues on the public agenda, they naturally (and sometimes intentionally) find themselves in the midst of policy advocacy. Depending on their tax status (either private foundation, public charity or 501(c)(4) organization) and the risk tolerance of their boards, foundations can be either upfront or behind-the-scenes when advocating for a particular policy.

Some health foundations have been particularly active in advocating for their state legislatures and governors to expand Medicaid 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 provided to 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. Elsewhere, foundations have sponsored studies that provide evidence of the various benefits that will accrue to states if they expand Medicaid (e.g., increased proportion of residents have access to health care, more federal dollars coming into the state, more jobs for health professionals, better balance sheet for rural hospitals).

Using the Community Health Rankings & Roadmaps model to support community health planning

Foundations have also taken the lead in advocating for policy change that goes well beyond Medicaid and the Affordable Care Act. One example is The Con Alma Health Foundation, a statewide health conversion foundation based in Santa Fe, New Mexico, which has publicized the detrimental public and environmental effects of a proposal to downgrade New Mexico's water quality standards. The change would potentially affect wildlife, ranchers, and a number of indigenous communities that depend on the Pecos and Rio Grande Rivers for drinking water. In addition to its own role in raising public awareness, the foundation funds Amigos Bravos, a conservation organization guided by social justice principles, to organize political participation within the affected communities (Con Alma, 2015). As a public charity, Con Alma cannot lobby for or against particular pieces of legislation (or fund other organizations to do so on its behalf), but it can carry out and support a broad range of advocacy initiatives that raise public awareness around the underlying issues.

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.

Leading such community change is illustrated by the Incourage Community Foundation in Wisconsin Rapids, Wisconsin (Easterling & Millesen, 2015). The economy of the region, devastated by a downturn in the papermaking industry and a crash in the price of cranberries in the early 2000s, hemorrhaged not only jobs but also the business executives who had served as civic leaders. The community foundation, working together with the local economic development agency, promoted the idea that the region would not recover by trying to recruit new firms, but instead needed to encourage entrepreneurship and collaborative problem-solving among local residents. More radically, they argued that this recovery would require a shift in the local culture. The traditional economy and political structure had fostered a paternalistic culture that had created a sense of dependency among residents. It designed a new leadership development program—Advanced Leadership Institute—that challenged established leaders to think more inclusively and emerging leaders to step forward with their own ideas and initiative. This was one aspect of a 4-year Community Progress Initiative, which also included community planning

processes, the creation of local charitable funds, training programs for fledgling entrepreneurs, venture capital funds, mentoring for business owners, the creation of industry clusters, and study tours to other communities suffering economic upheaval. This work has since led to the emergence of new leaders, increased collaboration across institutions, reduced divisiveness, and nationally recognized initiatives to retool the local workforce and promote new industry. Changes occurred not only among individual participants, but also at a structural level, with the culture beginning to shift from one defined by dependency and paternalism to one where all residents feel personal responsibility and take initiative.

RELEVANCE TO STAKEHOLDER HEALTH INITIATIVES

These examples illustrate a variety of ways in which foundations can support a community-wide or society-wide effort to improve health. Many of these strategies can be directly applied to the work of Stakeholder Health. Some examples of how a foundation could add significant value to a local Stakeholder Health initiative include:

• Providing **targeted funding for key projects** or programs included within the health-improvement strategy. Foundation funding is particularly valuable when setting up a new program or service.

BEHIND THE SCENES CONVENING

Comprehensive solutions require full and serious participation from all organizations that have influence over the issues at hand. In practice most community-based planning efforts will have at least a few holdouts and disengaged participants. Foundations can use their position as community leaders to draw these organizations into the process and to encourage them to participate more enthusiastically and collaboratively. This role is particularly valuable in communities that have competing healthcare systems.

The Mid-Iowa Health Foundation in Des Moines played this neutral convener/arm-twister role in a collaborative effort that brought together the local health department, an affordable housing organization, and all three of the community's hospitals to address the issue of asthma in low-income children. Their effort began when the foundation staff attended a meeting organized by local school nurses to hear about the health issues facing Burmese refugees. According to the CEO, Suzanne Mineck,

> *"We were discussing helping the Burmese refugee population identify a medical home and there was a Burmese mom that was sitting in on the conversation with the head of all of the school nurses. We were almost done with the meeting and then this lovely Burmese mom who spoke very little English turned to me and, she knew we were funding the project, and she said first how grateful she was for our support and how much she and the Burmese community appreciated it, but that I needed to know that her son would never be healthy. She could take her son to the doctor every day but if she brought him home to a home that has cockroaches and no heat he would never be healthy. That was profound moment for me. It's one thing to hear yourself talk about social determinants. It's another to really feel them and what that means.*
>
> *That was well over 3 years ago. I started having conversations with the Polk County Housing Trust Fund and the public health department. 'What do we do here?' This led to developing a successful proposal to the 'BUILD Health Challenge' program. All three of our hospital institutions came together to participate in the initiative. Our health department, the housing world, our schools have come together and we're doing a project to reduce the cases of chronic pediatric asthma in a poor zip code area in our community. We are working with the hospitals and school nurses to identify kids with chronic pediatric asthma. We go into their homes and do an environmental scan and also a social needs scan.*
>
> *The hospitals each put in dollars and in-kind support. More importantly, Build Health was interested in data, which required that hospital leaders be at the table throughout the implementation of the program."*

When asked how she was able to get all three hospitals to join together on a common project, Suzanne replied that it was all about relationships. "The public health director had a good relationship with one CEO. I had good relationship with another CEO. And at some point it came down to positioning. We made an invitation to become part of something that was noticeable if they were not involved."

- Supporting the **development of organizational capacity** among any or all of the organizations involved in carrying out the strategy. Capacity building is particularly important for organizations that have new programs to deliver or that need to expand their operations and staff to meet the new expectations assigned to them. This could come in the form of grants that fund new positions, technology, training and coaching. Alternatively the foundation might create a capacity-building program that serves the interests of multiple organizations from across the community.

- Supporting the **development of needed leadership skills** among actors who are key to implementing the strategy. As with organizational capacity, the foundation can either provide funding for leadership training to the organizations where these actors are based, or alternatively, sponsor a leadership program that trains an entire cohort of key actors.

- Sponsoring **community assessments and other research** that allows for a smarter strategy. These studies can take a number of forms, including a drill-down on how specific health issues manifest themselves in the community, a root cause analysis of thorny problems, a mapping of community assets, and an analysis of how various information systems and operational procedures need to adapt in order to support shifts in institutional strategy. Foundations can also pay the costs associated with co-learning, both within and between communities.

- Supporting **awareness raising, agenda setting and policy advocacy** that, taken together, creates an "enabling context" for the new way of thinking and working that Stakeholder Health seeks to cultivate. Such educational and advocacy work can be carried out either by the foundation directly or by nonprofits that the foundation supports. Alternatively the foundation can support a community organizing process that brings residents throughout the community into advocacy roles.

One of the most crucial functions that foundations can play in a Stakeholder Health initiative is to **facilitate the overall process of collaborative problem-solving and collective action**. Stakeholder Health explicitly acknowledges that hospitals and healthcare organizations do not have influence over most of the factors that influence the health of the community—or even the health of their patients. We need to engage in "transformative partnerships" with a broad range of organizations working in the areas of housing, education, transportation and economic development.

Foundations are, in fact, well positioned to convene cross-sectoral partnerships, especially where there are turf issues, competing interests, power differentials and/or oversized egos. These situations call for institutional leaders who are well known and widely respected throughout the community, who are focused on the community's overall well-being rather than their own parochial interests, and who are willing and able to create an open and inclusive problem-solving space. In most cities of any size, there is at least one foundation that has the standing and credibility to play this role. And, because foundations are connected to a multitude of local organizations, while also being politically and financially independent,they have a number of advantages over hospitals, health departments and other institutions that typically take the lead over community planning efforts.

Foundations can continue to play an active leadership role once the key players have come together to look at what they might do to improve community health. This can include facilitating meetings and keeping the process moving toward informed and strategic solutions. Foundations often talk about their role as a "neutral convener," signifying that they are able to stay above the fray and focus on larger goals and the community's overall interests. While one might argue about whether they are really "neutral," it is fair to say that foundations are uniquely situated to serve as guardians of planning processes, ensuring that all partners are heard and that the group doesn't head toward a solution that disregards legitimate interests and perspectives.

In addition to their out-in-front role facilitating and maintaining the integrity of a process, foundations can also operate behind the scenes to bring key players to the table and keep them there when the

Kate B. Reynolds Charitable Trust Healthy Places

process gets dicey. In this sense, foundations sometimes serve as chaplains, allowing partners to vent their frustrations while bringing them back toward their mission and the opportunities at hand.

OCCASIONAL TENSIONS BETWEEN HOSPITALS AND LOCAL HEALTH FOUNDATIONS

The previous section demonstrated that foundations can contribute to Stakeholder Health efforts, not only with financial resources, but also a broad array of "beyond-grantmaking"strategies. Many communities will have at least one foundation with considerable experience in the business of facilitating collective problem-solving, building organizational capacity, developing community leaders, and cultivating systems change.

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 autonomously. 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? This certainly occurs in some communities. For example, Interact for Health, a health conversion foundation in Cincinnati, developed a partnership with Cincinnati Children's Hospital to increase the number of school-based health centers operating within public schools in the region. The foundation has long been active in establishing and funding school-based health centers. The children's hospital has a special interest in preventing and managing childhood asthma, and saw the value of school-based health centers as a means

to advancing this interest. As a result of their collaborative efforts, the hospital took over the management of a center in a school that serves low-income students. The foundation provides funding to support the center (Interact, 2015).

While examples like this demonstrate the benefits of foundations and hospitals working together around a common agenda, we have also witnessed skepticism, suspicion and chagrin on the part of foundations when it comes to the idea of partnering with hospitals. Especially among health foundations that make grants in one particular community, the staff and board sometimes believe 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.

Another factor that makes foundations disenchanted with hospitals and academic medical centers is the central role of development 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. Development staff may or may not have a solid understanding of the projects that are being proposed for funding, especially research studies.

CREATING A NEW EQUILIBRIUM

The tension between hospitals and foundations that occurs in many communities is unfortunate in many respects. Hospitals and foundations are, in fact, natural allies when it comes to 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. Their staff make grants, lead community-change efforts and connect people and organizations to capacity-building opportunities, but 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 and to sustain programs that the foundation has helped create. 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. While their financial resources often attract the most attention, foundations can have an even greater impact on community health through their convening, advocacy, capacity building and influence. 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. 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 innovations 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.

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