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Finding Leverage over the Social Determinants of Health:

Insights from a Study of 33 Health Conversion Foundations

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Abstract

Health conversion foundations are increasingly addressing the social determinants of health (SDOH) with their grantmaking but there has been little systematic analysis of this emerging body of work. To support field building we analyzed the strategic frameworks of 33 conversion foundations from throughout the U.S. that have a reputation for addressing social and economic issues. Interviews were conducted with 48 foundation leaders. Collectively the 33 foundations are seeking changes within 8 distinct SDOH domains; community-building, educational success, and parenting/early childhood are the most prevalent.

The 33 foundations vary in terms of how much they are investing in SDOH issues, their theoretical orientation to these investments, the degree of change they are seeking and strategies to affect that change. We identified five strategic pathways for improving social and economic conditions:

1) Supporting program expansion and improvement
2) Building organizational capacity
3) Building higher-functioning inter-agency systems
4) Creating or changing policy
5) Stimulating broader and deeper social change

These pathways range from improving existing institutions to changing who has political power. Health equity funders stand out as having more disruptive strategies to address SDOH. By focusing on the structural factors that are responsible for health disparities, health equity funders tend to adopt a more activist or disruptive role within their "community" (either local, regional or at a state level).

Findings from the study can assist health foundations in clarifying how and why they want to improve social conditions, and in identifying appropriate directions for moving forward. Foundations seeking to change social and economic conditions should:

- Think strategically
- Clarify the level and type of change they are seeking
- Consider how the organization needs to adapt
- Invest for the long haul

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Introduction

For many years, the business of health philanthropy was viewed as making grants to organizations that provide health-oriented programs and services. However, health foundations are increasingly breaking free of this narrow framework. They are looking more expansively and ambitiously at what they can and should do to improve the health of the people they serve. For a growing number of health foundations, this means investing at least some of their grant dollars and other philanthropic resources in efforts to improve social, economic and political conditions within the communities they serve. These foundations often refer to this line of work as moving upstream to address the social determinants of health (SDOH). As a health foundation shifts its attention and resources toward non-health determinants of health, it will inevitably find itself in unfamiliar territory, needing to learn about new issues, new organizations, new program models and new strategies for creating impact. That territory is especially complex and tricky in the SDOH domain because the issues that need addressing invariably involve disparities, race, wealth, power and privilege.

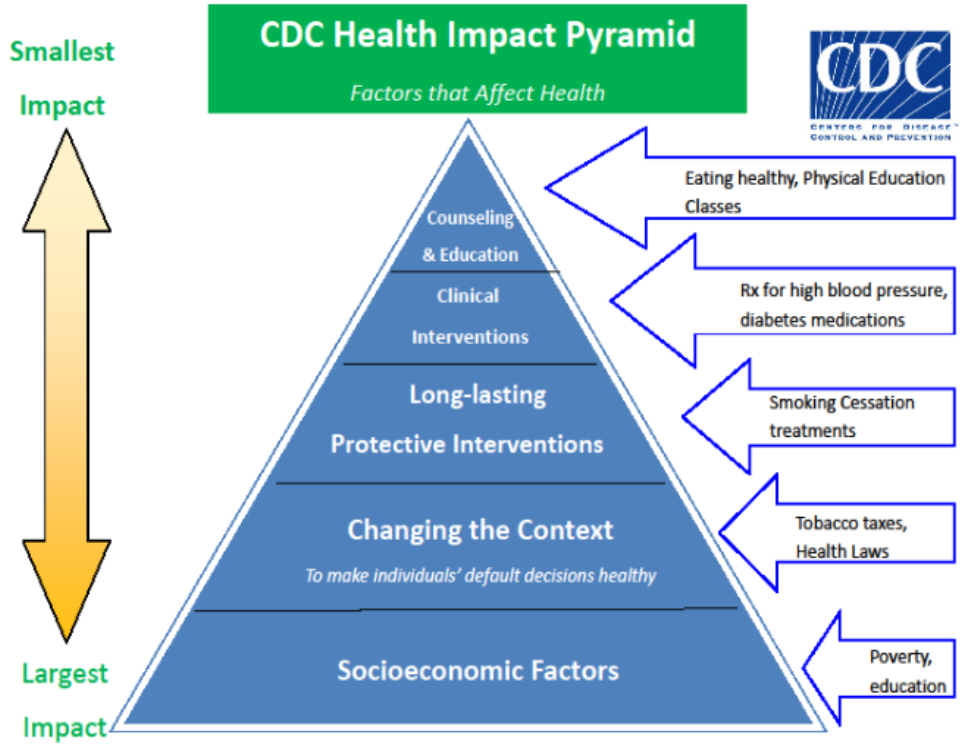
This monograph provides guidance to health foundations that are developing strategies to address the social and economic factors that influence health, as well as foundations that are considering whether or not to enter the SDOH domain. Drawing on a study of 33 health conversion foundations (foundations created with the proceeds of a sale, acquisition or conversion of a nonprofit health care organization) that are at least somewhat active in the SDOH, we present a variety of strategy options. In particular, we explore the different social and economic factors that health conversion foundations are seeking to influence, the specific conditions they want to bring about, the different ways they are using their grantmaking and other philanthropic capital to achieve impact, and the various frameworks, motivations and philosophies that conversion foundations bring to their SDOH work. Our interviews with CEOs and other foundation leaders underscore how important it is for any foundation considering this line of work to clarify its theory and values around social change before rolling out its strategy.

Moving Upstream

An ever-increasing body of research demonstrates that factors such as income, employment, housing, education, neighborhood conditions, political power and social standing exert a powerful impact on one's health status and life expectancy (e.g., Williams & Collins, 1995; Pickett & Pearl, 2001; Wilkinson & Marmot, 2003; Robert Wood Johnson Foundation, 2008; Braveman, Egerter & Williams, 2011). While it is important that everyone have access to affordable, high-quality medical care, this is not enough to ensure that a person is able to lead a long and healthy life. The social, economic and political context in which people live and work generates a particular mix of resources, opportunities, obstacles and threats which determine to a great extent the level of health that can be achieved.

Knowing that health depends to a great extent on social and economic factors has important implications for institutions that are in the business of improving health. While he was Director of the Centers for Disease Control and Prevention (CDC), Thomas Frieden publicized the Health Impact Pyramid, which describes the different levels at which health institutions (and society more generally) can intervene to improve health. The Pyramid is shown in Figure 1. At the base of the pyramid (Tier 1) are socioeconomic factors such as poverty and education. From Frieden's perspective, this is the level at which society should focus its resources: "interventions that address social determinants of health have the greatest potential public health benefit." (p. 594).

Figure 1. CDC Health Impact Pyramid



Health foundations are increasingly appreciating the critical role that social and economic conditions play to influence the health of individuals and communities. Many of them are actively developing strategies to improve these conditions. This trend was highlighted by Grantmakers in Health (GIH) in its September 2017 *GIH Bulletin (GIH, 2017).* Drawing on a recent survey of GIH's current and former board members (each of whom has experience as a CEO or vice president of a health foundation), Faith Mitchell reported that several survey respondents "identified the social determinants of health as a primary challenge – now and in the future – for health philanthropy." Mitchell pointed to the following comment from one GIH board member as an illustration of this view:

> *If we know the social determinants are responsible for the majority of health outcomes, we should consider how to shift funding upstream, toward root causes and prevention, using the $3.2 trillion in the health system to do so.*

Another GIH board member specifically called out the need for health foundations to deploy more intentional and impactful strategies to address social and economic determinants of health:

> *We have to keep the focus on the social determinants of health and population health, showing and demonstrating the proof of concept and spreading and scaling effective strategies.*

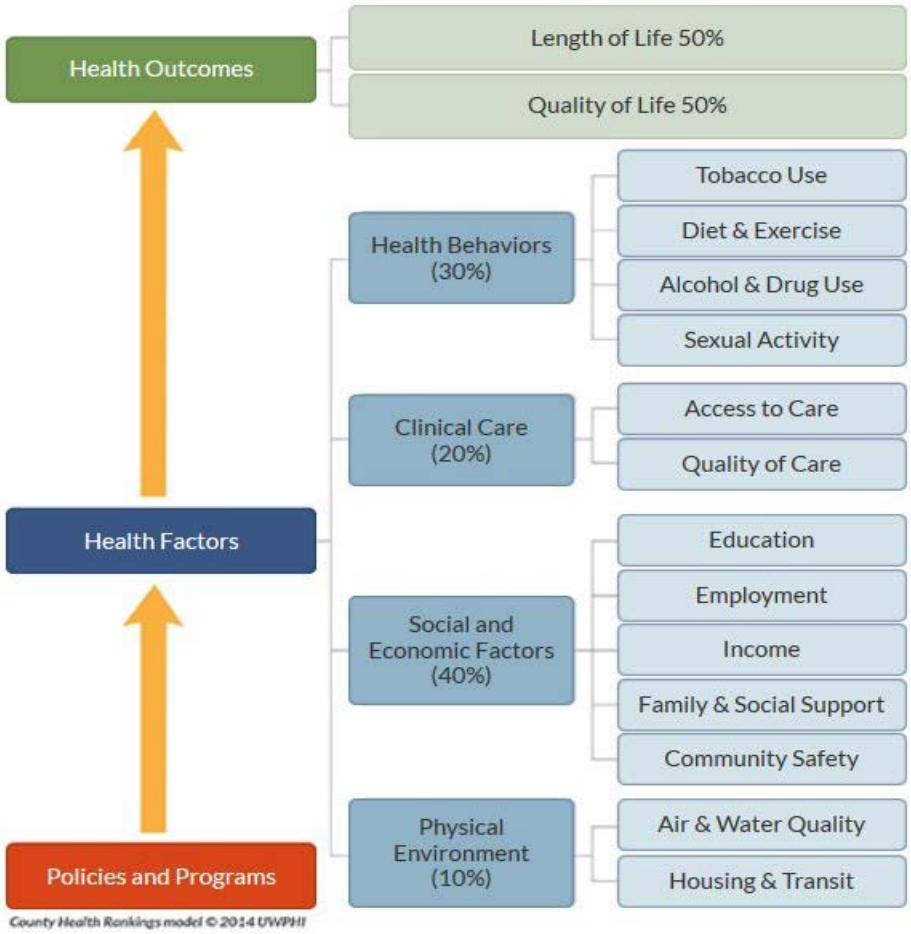
Early Philanthropic Work to Address Social Determinants

Over the past decade, a handful of national and statewide health foundations have implemented innovative initiatives and grantmaking strategies that seek to improve health by addressing social and economic conditions. For example, RWJF's "Invest Health" is supporting 50 mid-sized cities in taking action that will improve employment, housing, safety and other conditions in low-income neighborhoods (Invest Health, n.d.). At a larger level, the Foundation's "Culture of Health" framework recognizes the importance of considering community health from a holistic or ecological perspective. The Foundation's recently retired CEO, Dr. Risa Lavizzo-Mourey, described why this expanded perspective is crucial in her 2012 essay, *Why Health, Poverty and Community Development are Inseparable.*

> *Although it is essential, increasing access to health care is not sufficient to improve health. There is more to health than health care. In fact, health care plays a surprisingly small role among the factors that contribute to premature death… With this in mind, we have broadened our foundation's strategies to embrace improving health where it starts: in the places where people live, learn, work, and play* (Lavizzo-Mourey, 2012, p. 216).

RWJF's emphasis on the broader social, economic and political determinants of health is reinforced each year with the release of an updated County Health Rankings and Roadmaps (CHRR) report, which is jointly produced with the University of Wisconsin Population Health Institute. Each county in the U.S. is assigned a *health outcomes* score and a *health factors* score, and then those scores are used to rank counties within each of the 50 states. The algorithm for calculating a county's *health factors* score places a high weight on the social and economic conditions present in that county. Building on a large base of epidemiological research, the Wisconsin research team concluded that social and economic factors account for 40% of the variation in health outcomes, twice as much as clinical care (University of Wisconsion, n.d.). The high contribution of social and economic factors is illustrated in the CHRR model which accompanies the data each year (see Figure 2).

Figure 2. University of Wisconsin County Health Rankings Model



Health Conversion Foundations and Social Determinants

RWJF has played prominent roles in demonstrating why and how foundations can operate on upstream determinants of health. The Foundation's leadership and innovation at the national level is replicated at the state, regional and local levels by a growing number of health foundations, especially health conversion foundations. Health conversion foundations are created when a nonprofit health organization (e.g., hospital system, physician practice, health insurance plan) is involved in a sale, acquisition, merger, conversion or other transaction that generates proceeds that need to remain in the nonprofit sector (Standish, 1998; Frost, 2001; GIH, 2005; Niggel & Brandon, 2014a; GIH, 2017). The two most common scenarios are (a) the conversion of a health plan (e.g., Blue Cross Blue Shield) from nonprofit to for-profit status and (b) the sale of a nonprofit hospital or health system to a for-profit firm that is seeking to expand into a new market. When these sorts of transactions occur, the proceeds are typically used to create a new foundation that maintains the general mission of the nonprofit entity that was sold (i.e., improving or advancing the health of the population served by the entity). (See Sidebar for further information on health conversion foundations.)

Health Conversion Foundations

Health conversion foundations *(*sometimes referred to as "health legacy foundations") are created when a nonprofit health organization (e.g., hospital system, physician practice, health insurance plan) is involved in a sale, acquisition, merger, conversion or other transaction that generates proceeds that need to remain in the nonprofit sector (Standish, 1998; Frost, 2001; GIH, 2005; Niggel & Brandon, 2014a; GIH, 2017). The two most common scenarios are the conversion of a health plan (e.g., Blue Cross Blue Shield) from nonprofit to for-profit status and the sale of a nonprofit hospital or health system to a for-profit firm that is seeking to expand into a new market.

When these sorts of transactions occur, the proceeds are typically used to create a new foundation that maintains the general mission of the nonprofit entity that was sold (i.e., improving or advancing the health of the population served by the entity). Another option is for the proceeds to be transferred to an existing foundation that serves the population served by the health organization that was sold or converted (e.g., a community foundation based in the same region as the health organization). A more complicated approach to handling the transaction is for the nonprofit health entity to stay in business but change its mission from delivering health care to making grants (i.e., disbursing funds derived from the sale or conversion).

The first conversion foundation was established in 1949 and the second in 1976 (GIH, 2017). Since then, the conversion sector has grown through a series of spurts which reflect successive trends and forces in the delivery, financing and organization of health care in the United States (GIH, 2017). The first spurt occurred in the mid-1980s when for-profit health care corporations began aggressively expanding 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. Additional conversion foundations were formed in the 2000s through the continued consolidation of hospital systems and health plans, with a special emphasis on acquisitions in rural regions. And then most recently, new conversion foundations have been formed as the health care marketplace adjusted to the policy requirements and financing mechanisms included in the 2010 Affordable Care Act.

There are now at least 228 health conversion foundations in the U.S. The most widely accepted figure is 242, which comes from GIH's recent census (GIH, 2017). The Bridgespan Group produced a somewhat lower figure of 228 (Hussein & Collins, 2017), but Niggel and Brandon (2014a) counted 306 conversion foundations as of 2010. The discrepancies reflect different search methods and differences in the criteria for counting a transaction. For example, there are differences of opinion as to whether an existing foundation that receives the proceeds from the sale of a nonprofit health organization should be viewed as a conversion foundation. Likewise, there is disagreement as to whether a "conversion" occurs when a nonprofit health organization is acquired by another nonprofit entity.

Regardless of the precise definition one adopts, it is safe to conclude that health conversion foundations are a sizeable and growing segment of philanthropy. Taken together, these foundations hold more than $26 billion in assets and make more than $1 billion per year in grants (Niggel & Brandon, 2014a; Hussein & Collins, 2017). These figures have grown considerably in recent years with improvements in the equity market, the establishment of additional conversion foundations and the release of funds held in escrow.

Conversion foundations vary tremendously in their size and reach. At the high end are The California Endowment, The Colorado Health Foundation, Missouri Foundation for Health, Episcopal Foundation for Health in Texas and Group Health Community Foundation in Washington State, each of which hold more than $1 billion in assets. While these large conversion foundations have attracted a great deal of public and political attention in recent years, it is important to recognize the resources and influence of small and medium-sized conversion foundations, many of which are the dominant funder in their respective community.

According to a recent census by GIH, there are at least 242 conversion foundations in the U.S. (GIH, 2017).[1] These foundations vary tremendously in their size and geographic reach. California, Colorado, Missouri, Texas and Washington State each have conversion foundations with over $1 billion in assets which serve either the entire state or a major portion of the state.[2] While these large conversion foundations have attracted a great deal of public and political attention in recent years, it is important to recognize that 80% of conversion foundations serve a more localized region (Niggel & Brandon, 2014a).

The country's largest health conversion foundation, **The California Endowment**, has focused on social and economic determinants for a decade, particularly with its "Building Healthy Communities" initiative. The Endowment's website lays out the following rationale for this line of work (http:/www.calendow.org/why-place/):

> *We know that when it comes to your health, your zip code matters more than your genetic code. Zip code is shorthand for neighborhoods and it is there that chronic stress-inducing conditions shape the present and future of the residents. For instance, in Alameda County, an African-American child from East Oakland can expect to live 15 fewer years than a White child from the Oakland Hills, only several miles away. We know that this difference can't be explained by access to health care or genetics, which are important, but a small part of the story. What really matters are the "social determinants of health" or the neighborhood conditions in which people are born and grow-up.*

Another California-based conversion foundation, **The California Wellness Foundation**, operates from a similar philosophical framework. According to its website (http://www.calwellness.org/about_us/mission_goals_philosophy.php):

> *The Foundation's grantmaking is grounded in the social determinants of health research that states that where people live and work, their race and ethnicity, and their income can impact their health and wellness. It's the Foundation's desire to help "level the playing field" so that everyone has access to good-paying jobs, safe neighborhoods and quality health care services.*

Conversion foundations throughout the country are expanding beyond narrow views of health and health care to address a broader set of determinants. **The Colorado Health Foundation**, the country's second largest conversion foundation, adopted "Social Determinants of Health" as one of its funding areas (Colorado Health Foundation, n.d.). **Vitalyst Health Foundation**, a Phoenix-based conversion foundation, is emphasizing transportation. The foundation's 2013 annual report spelled out the rationale as follows:

> *[The foundation] has been moving upstream from basic health needs towards root causes of health improvement for 17 years. Together with a grassroots working group and the City of Phoenix, we are working on the adoption of a Complete Streets policy to positively influence the ways we move in and connect with our communities. Streets are a city's lifeblood, to the point that key city streets are often referred to as "arterials"* (Vitalyst, 2013).

Addressing social and economic determinants is in many ways a natural strategic direction for conversion foundations. Nearly all of these foundations have a mission along the lines of "improving the health of the people" of a particular region. Even though their endowments are derived from the sale or conversion of a

[1] The Bridgespan Group produced a somewhat lower figure of 228 (Hussein & Collins, 2017), while Niggel and Brandon (2014a) counted 306 conversion foundations as of 2010. The discrepancies reflect different search methods and differences in the criteria for counting a transaction.

[2] These are The California Endowment, The Colorado Health Foundation, Missouri Foundation for Health, Episcopal Foundation for Health in Texas, and Group Health Community Foundation in Washington State.

health care organization, most conversion foundations extend their grantmaking to social service agencies, schools and other organizations that seek to improve physical, mental or spiritual health but are outside the health care system. It does not require a huge leap in logic to invest in organizations that address issues such as poverty, employment, education, housing, transportation, racial discrimination and social cohesion, which we know are important upstream determinants of health.

A number of thought leaders in health philanthropy, including GIH and RWJF, are encouraging conversion foundations to follow this logic and focus explicitly on these upstream determinants. Sabrina Niggel made a strong case in this regard in a 2014 *Health Affairs* article (Niggel & Brandon, 2014b) and a follow-up blog post (Niggel, 2014). In that post she highlighted five conversion foundations that had developed initiatives to improve the social and economic context within which people live:

- **St. Luke's Foundation** in Cleveland, Ohio, which seeks to improve social conditions, the physical environment and community design within selected neighborhoods in its Strong Communities program;
- **The Sisters of Charity Foundation of South Carolina**, which launched a fatherhood-engagement initiative in 1997 that seeks to improve the health of children and their fathers by strengthening their relationships to one another;
- **The Horizon Foundation** in Maryland, **the REACH Healthcare Foundation** in Kansas and the **Healthcare Foundation of New Jersey**, all of whom are supporting new training for health care providers so that they can better recognize and address the social issues affecting their patients.

Conversion foundations with a local or regional service area are especially well suited to address social and economic determinants. They can tailor their grantmaking and other philanthropic resources to community-specific issues, conditions and systems. In addition, locally and regionally-oriented conversion foundations are often the dominant philanthropic institution in their communities. These foundations can take advantage of their visibility and influence to stimulate new work and new ways of thinking that lead to improved community health, including more deliberate and strategic action on the social and economic determinants of health.

Although there is plenty of reason for conversion foundations to focus upstream, only a small portion of them are actively operating in this space. Our review of the field suggests that the figure is less than 20%. Most conversion foundations continue to focus their grantmaking and other philanthropic work on improving the healthcare system, expanding access to health services (including prevention), educating the public on how to reduce their risks and maintain their health, and other issues that fall more narrowly within the domain of health.

One of the major obstacles to further expansion into this area of work is uncertainty about how to enter. The SDOH space is huge and complex – much more so than making grants to health-related organizations (and even that is a complex landscape). Expanding the universe of potential grantees to include organizations that work on housing, transportation, economic development, public education, child care, etc. runs the risk that the foundation's resources will be diffused so broadly as to preclude any chance of impact.

To help health foundations make more informed choices about whether and how to address social and economic determinants, we partnered with RWJF to study the approaches and strategic thinking of 33 health conversion foundations from across the U.S. that have reputations for leadership in this area. The study was designed to identify and elevate strategies that foundations can use to improve the conditions that influence health, as well as to learn what is required for foundations to be strategic and effective in this domain of work.

The remainder of this report describes the methods, sample and findings from the study. After describing our selection of foundations, approach to gathering information and the characteristics of the foundations, we

discuss the level of investment the foundations made and dig more deeply into the origins of funding in social determinants of health. We then explore the influences and rationales behind funding strategies, identify distinct areas of focus, and examine the ways foundations are influencing change. These discussions are organized around the following questions:

- Why are conversion foundation focusing on social and economic issues?
- Which social and economic conditions are they seeking to change?
- How are they using their resources to produce these changes?

We end with a discussion exploring what it means to be working in the field of social determinants of health and draw out lessons learned from our interviews and our analysis. We conclude with thoughts about current and future work in the social determinants of health.

Study Design and Methods

This study was designed to gain an in-depth understanding of the strategies that innovative conversion foundations are using to address social determinants, the frameworks that these foundations bring to the work, the developmental process that they underwent in order to arrive at their current approach, and their plans and aspirations for the future. To meet these objectives, we collected and analyzed programmatic and organizational information from 33 conversion foundations. We also conducted semi-structured interviews with at least one leader from each foundation, typically the CEO.

Our sampling frame for the study was health conversion foundations that were known to be investing in improving social and economic conditions through some combination of grantmaking, convening, advocacy and leadership work. We wanted to include a diverse mix of conversion foundations across the country in order to gain a broad view of how this segment of health philanthropy is developing. Thus we included not only the large statewide conversion foundations that are widely recognized as investing in social determinants, but also the less recognized locally and regionally-oriented foundations that are actively working in this area. With the assistance of Abbey Cofsky and Jane Lowe at RWJF, Kate Treanor at GIH, and Allen Smart at Campbell University, we were able to identify a diverse list of 38 conversion foundations from across the country.

For each of these 38 foundations, we emailed an invitation to participate to either the CEO or another foundation leader who was known to be central to the social-determinants work. When we received a response, we followed up with another email or phone call to schedule a telephone interview with the person we had recruited. In some cases, that person recommended that we talk to another representative of the foundation – either instead of or in addition to the person we recruited. In cases where we did not hear back following our initial email, we followed up with a second email. On occasion, Abbey or Jane also followed up with an email or phone call to reinforce the importance of the study. Of the 38 foundations that we invited to participate, we were able to schedule interviews with leaders from 33 (87% participation rate).

For each of the 33 foundations in the sample, we compiled, reviewed and synthesized materials available on websites related to the foundation's history, organizational structure, philosophy, strategic priorities, grantmaking, educational resources, advocacy and evaluation approaches and findings. This information was used to characterize each foundation with regard to the level and breadth of investment in SDOH, as well as the particular SDOH issues that the foundation was seeking to affect.

Interviews with foundation leaders were conducted between December 2015 and July 2016. These provided a fuller view of the nature of each foundation's strategy, how strategies were developed, what they were seeking to achieve, the underlying logic and outcomes to date. We elicited this information with an interview protocol that covered the following topics:

These interviews covered the following topics:

- The foundation's origins, history and mission;
- The interviewee's history with the foundation;
- Strategic frameworks that guide the foundation's work;
- How and how much the foundation addresses social and economic factors ;
- Exemplar initiatives – intent, approach, results and lessons;
- Observations and reflections on the foundation's larger body of work; and
- Future directions for the foundation and for the larger field.

We also used the interviews to identify and obtain specific materials that would provide a more complete view of the foundation's history, philosophy, theory of change, strategy, programmatic initiatives and lessons learned.

For 21 of the 33 foundations in the study, we conducted a single interview with a single representative of the foundation. For 8 of the foundations, we conducted a single interview with multiple representatives. And for the remaining 4 foundations, we conducted multiple interviews with different representatives. Altogether, we conducted 39 interviews and talked with 48 representatives. The CEO was interviewed for 27 of the foundations. The individuals interviewed are listed in Appendix 1.

Interviews were transcribed and analyzed to characterize each foundation's strategic orientation, priority issues, and approach to achieving impact. We extracted quotes that reflect the foundation's orientation and strategies. These data were used to develop conceptual frameworks and typologies that depict the variation in approach we observed across foundations, particularly with regard to strategic pathways and leverage points. Those frameworks and typologies were vetted with interviewees through follow-up email exchanges, as well as with participants at a break-out session at the 2017 annual conference of GIH. The frameworks underwent significant revision and refinement based on the feedback from interviewees and conference participants.

Participating Foundations

The 33 foundations that agreed to participate in the study are listed in Table 1. This table also shows the location of each foundation, the scale of the service area, year established, type of legal entity, amount of assets and annual grantmaking.

Table 1. Foundations Participating in the Study

Name	Office Location	State(s)	Service Area	Year Est. [1]	Legal Entity	Assets - in millions [2]	Annual grantmaking 2015 - in millions [3]
Vitalyst Health Foundation	Phoenix	AZ	Statewide	1995	501(c)(3) public charity	$120.9	$3.4
The California Endowment	Los Angeles	CA	Statewide	1992	501(c)(3) private foundation	$3,698.2	$184.5
The California Wellness Foundation	Los Angeles	CA	Statewide	1992	501(c)(3) private foundation	$941.1	$33.8
The Colorado Health Foundation	Denver	CO	Statewide	1995	501(c)(3) private foundation[4]	$2,271.1	$64.9
The Colorado Trust	Denver	CO	Statewide	1985	501(c)(3) private foundation	$458.9	$9.8
The Connecticut Health Foundation	Hartford	CT	Statewide	1999	501(c)(3) private foundation	$109.7	$3.0
Foundation for a Healthy St. Petersburg	St. Petersburg	FL	Single County	2013	501(c)(3) private foundation	$196.4	$0.1
Healthcare Georgia Foundation, Inc.	Atlanta	GA	Statewide	1995	501(c)(3) private foundation	$117.7	$3.5
Mid-Iowa Health Foundation	Des Moines	IA	Single County	1984	501(c)(3) private foundation	$15.8	$0.5
REACH Healthcare Foundation	Merriam, KS	KS, MO	Multi-County	2003	501(c)(3) public charity	$133.1	$4.5
Health Care Foundation of Greater Kansas City	Kansas City, MO	KS, MO	Multi-County	2003	501(c)(3) public charity	$518.8	$20.2
Foundation for a Healthy Kentucky	Louisville	KY	Statewide	1997	501(c)(3) public charity	$55.4	$1.7
Baptist Community Ministries	New Orleans	LA	Single County	1995	501(c)(3) private foundation	$277.2	$8.7
The Rapides Foundation	Alexandria	LA	Multi-County	1994	501(c)(3) public charity	$256.0	$8.8
The Health Foundation of Central Massachusetts	Worcester	MA	Single County (5)	1996	501(c)(4) social welfare organization	$71.5	$2.5
Maine Health Access Foundation	Augusta	ME	Statewide	2000	501(c)(3) private foundation	$123.7	$3.9
Missouri Foundation for Health	St. Louis	MO	Multi-county	2000	501(c)(4) social welfare organization	$1,079.8	$50.3
Montana Healthcare Foundation	Bozeman	MT	Statewide	2013	501(c)(3) private foundation	$61.6	$1.2
John Rex Endowment	Raleigh	NC	Single County	2000	501(c)(3) private foundation	$75.4	$3.3

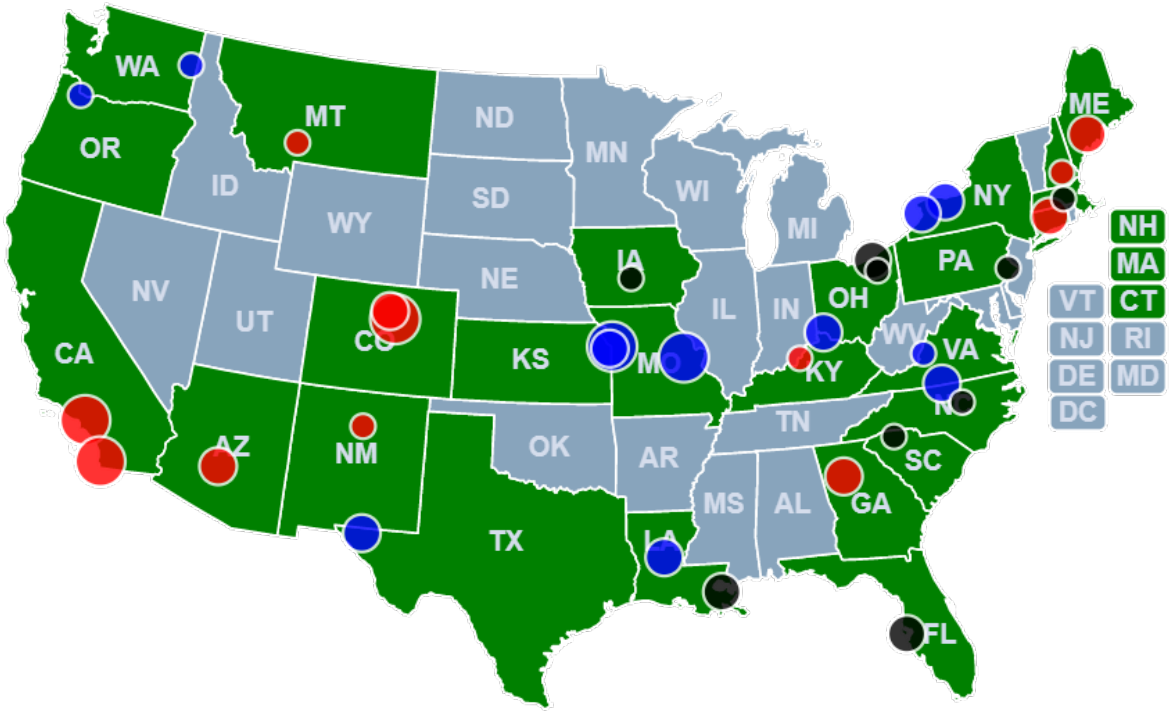
Name	Office Location	State(s)	Service Area	Year Est. [1]	Legal Entity	Assets - in millions [2]	Annual grantmaking 2015 - in millions [3]
Endowment for Health	Concord	NH	State	1999	501(c)(3) private foundation	$85.3	$2.8
Con Alma Health Foundation	Santa Fe	NM	Statewide	2001	501(c)(3) private foundation	$25.1	$.6
Greater Rochester Health Foundation	Rochester	NY	Multi-County	2006	501(c)(3) private foundation	$238.8	$7.8
Health Foundation for Western and Central New York	Buffalo and Syracuse	NY	Multi-County	2000	501(c)(3) private foundation	$120.4	$2.5
Interact for Health*	Cincinnati, OH	OH, IN, KY	Multi-County	1997	501(c)(4) social welfare organization	$218.4	$6.7
Saint Luke's Foundation of Cleveland	Cleveland	OH	Single County	1987	501(c)(3) private foundation	$178.9	$8.9
Sisters of Charity Foundation of Cleveland	Cleveland	OH	Single County	1995	501(c)(3) public charity	$93.0	$1.7
Northwest Health Foundation	Portland	OR, WA	Multi-County	1995	501(c)(4) social welfare organization	$50.0	$3.5
HealthSpark Foundation	Colmar	PA	Single County	2002	501(c)(3) private foundation	$45.6	$.5
Mary Black Foundation	Spartanburg	SC	Single County	1996	501(c)(3) private foundation	$80.5	$2.9
Paso del Norte Health Foundation	El Paso	TX, MX	Multi-County	1995	501(c)(3) private foundation	$227.2	$10.2
Danville Regional Foundation	Danville, VA	VA, NC	Multi-County	2005	501(c)(3) private foundation	$219.9	$5.7
The Alleghany Foundation	Covington	VA	Multi-County	1995	501(c)(3) private foundation	$64.8	$5.0
Empire Health Foundation	Spokane	WA	Multi-County	2008	501(c)(3) private foundation	$77.5	$4.1

Notes:
1-Year that assets were release from sale or conversion
2-Taken from GIH 2015 Survey of Health Care Conversion Foundations
3-Taken from Guidestar tax forms. 2014 figures shown where 2015 figures not available.
4-The Colorado Health Foundation changed its tax status from 501(c)(4) to a 501(c)(3) private foundation in 2016.
5-The Health Foundation of Central Massachusetts serves Worcester County and the communities sharing the county border.

Geography

The 33 foundations are located in 25 different states in all regions of the country. The map in Figure 3 shows their location as well as the range of their grantmaking (local, regional or statewide) and size of assets.

Figure 3. Geographic Distribution of Participating Foundations



Key

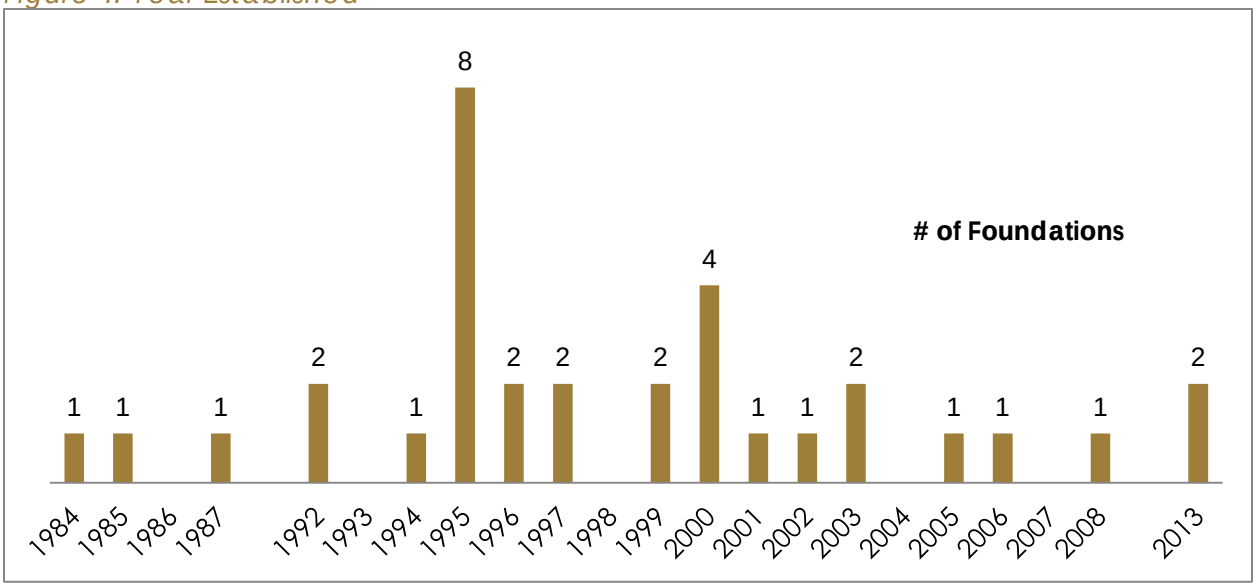
Black=Local	Small circle=Assets up to $100M
Blue=Multi-County	Medium circle=Assets between $100-$500M
Red=Statewide	Large circle=Assets over $500M

The sample includes a mix of statewide foundations (12) and foundations that make grants within either a single county (9) or a multi-county region (12). Four of the foundations with multi-county service areas are funding in multiple states, and one (**Paso del Norte**) makes grants in both the U.S. and Juarez, Mexico.

Organizational Features

Figure 4 shows the organizational age distribution of the sample. The oldest two foundations are the **Mid-Iowa Health Foundation** and **The Colorado Trust**, each of which was established more than 30 years ago (1984 and 1985 respectively). The youngest **foundations are the Foundation for a Healthy St. Petersburg and the Montana** Health Care Foundation, each established in 2013. Mirroring the conversion foundation field more generally, the vast majority of foundations in our sample (25 of the 33) were established between 1992 and 2003.

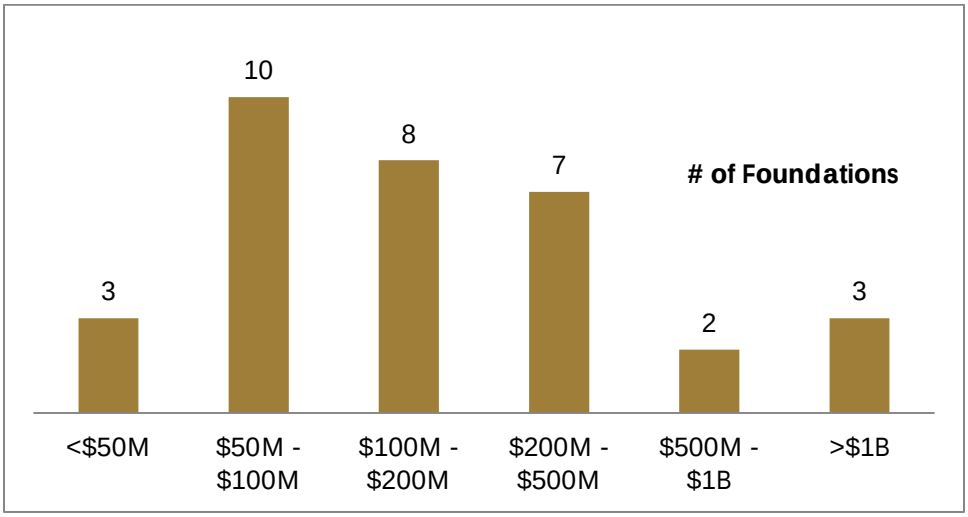
Figure 4. Year Established



The majority of the foundations in the sample (23 of 33) are 501(c)(3) private foundations. The remainder include six 501(c)(3) public charities and four 501(c)(4) social welfare organizations. One of the private foundations (**The Colorado Health Foundation**) transitioned from 501(c)(4) status during the time of the study.

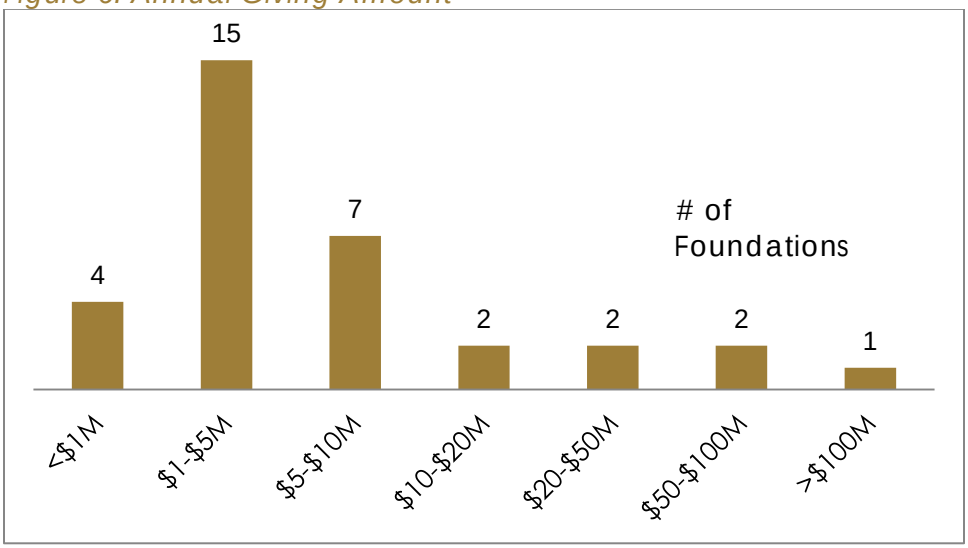
By design, the sample includes foundations of widely varying sizes. Measured by asset size, the smallest foundation is **Con Alma Health Foundation** in New Mexico with $25 million, while the largest is **The California Endowment** with $3.7 billion. Figure 5 shows how all 33 foundations distribute over this spectrum. Over half the sample (18 of the 33) have assets between $50 million and $200 million. The five largest foundations have assets above $500 million. Three of these five are statewide foundations in California and Colorado. The other large foundations are the **Missouri Foundation for Health**, which serves a several counties in the state, and the **Health Care Foundation of Greater Kansas City**, which serves a multi-county region in Missouri and Kansas.

Figure 5. Asset Size



Along with the wide range in asset size, the 33 foundations also vary widely in the level of charitable expenditures they make each year. These data are summarized in Figure 6. Based on reported giving in the most recent year available (2014 or 2015), four foundations gave out less than $1 million, while three gave out more than $50 million. It is important to point out that foundations contribute to health improvement efforts in many other ways than making grants to nonprofits. All four of the foundations with less than $1 million in annual grantmaking (**Mid-Iowa, Con Alma, HealthSpark and St. Petersburg**) have stimulated new work through community leadership, advocacy, convening and/or applying for funding from government agencies.[3]

Figure 6. Annual Giving Amount



[3] The low level of giving reported by the Foundation for a Healthy St. Petersburg in 2015 (less than $100,000) reflects the fact that the foundation was established in 2013 and was just beginning its grantmaking process.

Focus on Social and Economic Factors

Twenty-eight of the 33 foundations in the sample were making what we regarded as "extensive" investments of grant dollars and other philanthropic resources in one or more social determinants of health. By "extensive," we are referring to evidence such as multiple grants aligned around a particular SDOH goal, the convening of a community planning process around one or more SDOH issues, and foundation-sponsored advocacy and policy work to improve social and economic conditions. Some of these 28 foundations are focused on one or two targeted SDOH domains, while others are supporting a broader body of work to improve many different social and economic conditions.

The remaining five foundations had made at least some grants to address social and economic factors, but these investments were more isolated and did not reflect a larger commitment to addressing SDOH on the part of the foundation.

SDOH Orientation

While all 33 of the participating foundations had made grants that address social and economic factors, there is significant variation within the sample in terms of how much each foundation is focusing on SDOH and how central this work is to the foundation's overall strategy. Some of the foundations committed to an SDOH approach early in their history, while others came to that decision after a decade or more of more traditional health-oriented grantmkaing. Some are have well-formulated philosophical frameworks that specify the role that social and economic conditions play in facilitating and inhibiting the health of people and communities, while other foundations address social and economic factors on more of a case-by-case basis. We describe these contrasts in more depths in the following sections.

Origins of SDOH Grantmaking

Among the foundations in our sample, there are two distinct starting points for deciding to address social and economic factors. On the one hand are foundations such as **Danville Regional Foundation**, **The Rapides Foundation**, **The Health Foundation of Central Massachusetts** and **Mid-Iowa Health Foundation** which identified social and economic issues as key funding interests at a very early stage in their development. On the other hand are the many other foundations that have expanded their grantmaking into social and economic domains as they have learned more about the underlying causes of the more narrowly defined health issues which they initially focused on.

The Rapides Foundation in Alexandria, Louisiana is one of the foundations that incorporated social and economic factors into its funding priorities from the outset. Shortly after its founding in 1994, **The Rapides Foundation** contracted with Tulane University to conduct a community health assessment. Based on that assessment, the board adopted a set of priority issues that included not only health issues (health care access and health behaviors), but also social issues (education, economic development and community development). The foundation has continued to focus on this mix of issues. According to **The Rapides Foundation** president, Joe Rosier, the foundation is currently allocating 40% of its grant funds to health care access and health behaviors, 40% to education (pre-kindergarten through grade 12) with an emphasis on increasing high school graduation rates, and 20% to community development in order to increase median income and civic engagement.

The **Danville Regional Foundation** (DRF) in Danville, Virginia likewise chose from the outset to focus much of its grantmaking and community leadership work on education and economic development. From its beginning in 2005, DRF has emphasized the social context within which health is created. This approach is reflected in the foundation's vision statement: *DRF envisions a thriving Dan River Region that works well for everyone* (Danville Regional Foundation, n.d.). A large portion of the foundation's resources are focused on increasing educational attainment throughout the region. According to its website (http://www.drfonline.org/program-areas/education):

> *DRF knows that the first step towards transformation in any community begins with the educational opportunities available to its residents. From investments in early childhood education to public school programs to STEM to higher education opportunities, DRF looks to make investments that will benefit the entire community no matter their income level or background.*

For foundations like **The Rapides Foundation** and **Danville Regional Foundation**, paying attention to the social and economic determinants of health is deeply rooted in their philanthropic strategy. In some cases, the founding board engaged in a strategic assessment that pointed to the importance of investing broadly in the factors that advance health. In other cases, the first CEO brought a vision along these lines. In either case, a focus on social and economic factors appears to be part of their "organizational DNA" (David and Enright, 2015).

While some conversion foundations have acknowledged the importance of social and economic determinants from the outset, others have come to this position more gradually based on their experience and learning. This learning occurs on two levels. First, as the staff and board reflect on what the foundation has and has not accomplished with its initial grantmaking, they recognize the limitations of focusing the foundation's resources on organizations and programs that address health in narrow terms. The second way that foundations have learned about the value of investing in social and economic determinants is by paying attention to the growing body of research evidence. That research has become especially visible within philanthropy over the past decade.

One example of this transition in funding is **The Allegheny Foundation** in Covington, Virginia. The foundation's board decided to expand into specific social and economic issues following several months of learning and reflection facilitated by MDC, Inc. from Durham, NC and the subsequent adoption of a strategic plan in 2009. According to the executive director, Mary Fant Donnan, the board "really embraced the social determinants of health as essential for community change and determined that economic transformation was the highest priority…and educational attainment came in second."

Many other foundations in the sample follow a similar pattern of expanding their grantmaking into social and economic domains over time. This is particularly true for the larger foundations and for the foundations that serve an entire state. As these foundations were being established, they often attracted significant scrutiny from their state's Attorney General, other elected officials and advocacy groups such as Consumers Union – in order to ensure that the assets that were being transferred to the foundation would continue to be used to serve the health interests of the relevant population. In at least some cases, this scrutiny had the effect of discouraging grantmaking outside the domain of health and health care. As these large foundations have developed a track record of responsible stewardship and transparency, they have gained more discretion to innovate and to focus resources on upstream determinants of health.

Explicit versus Implicit Endorsement of SDOH

Although all the foundations in the sample are allocating at least some of their grantmaking to improve social and economic conditions, only some of them have adopted an explicit SDOH framework for their philanthropic strategy. This subset includes **The California Endowment**, **The California Wellness Foundation**, **The Colorado Trust**, **The Colorado Health Foundation**, **The Connecticut Health Foundation** and **The Greater Rochester (NY) Health Foundation**. Each of them have explicitly endorsed the idea that the health of the people they serve is strongly determined by social and economic factors. These foundations' websites often include SDOH-related descriptions, evidence and analysis, including statements such as "your health depends on your zip code."

Other foundations, in contrast, refrain from referring to "the social determinants of health" in their materials. Rather than adopting an overarching theory as to how health is created, these foundations focus their grantmaking on the specific issues they have identified as critical to the health of their populations. While most of these issues involve health care, health education or prevention, the foundation expands its eligibility criteria to accept grants in selected "non-health" areas. Implicitly the foundation may be operating from a SDOH lens, but the board and staff may shy away from embracing a larger theory about the role of the social determinants. For example, **Danville Regional Foundation's** president, Karl Stauber, indicated that "the board did not use 'social determinants of health' language, but the broad format almost requires a SDOH approach."

A number of the foundations in the sample have moved from an implicit to an explicit framework over time. This formalization in theory can be triggered through the learning process that occurs when the foundation begins

investing in "non-health" areas. Amy Latham, Vice President of Philanthropy at **The Colorado Health Foundation**, described their evolution in thinking:

> *We learned from [our earlier place-based initiative] that we have to have a social determinants lens when we approach any kind of community work. We learned that you can't influence the health of a community without talking about all the ways that the environment influences health, that poverty influences health, that civic engagement influences health. We've started talking about that much more explicitly… calling out social determinants as a framework and then figuring out where we come in within that framework.*

The Greater Rochester Health Foundation made a similar transition from an implicit understanding of the role of social determinants to an explicit endorsement of a SDOH framework. According to the foundation's president, John Urban, the County Health Rankings & Roadmaps model was crucial in deepening their analysis and their commitment to addressing social and economic determinants:

> *We were captivated by the work that the University of Wisconsin was doing in terms of identifying the different factors that impacted health status. We already knew enough to understand that what went on outside the health care system was at least as important as what went on inside it. But that was intuitive and the work at Wisconsin was much more rigorous and put a lot more shape to what was otherwise general intuition. That framework, while it has changed and more data is available, continues to be our touchstone.*

We emphasize this distinction between explicit and implicit endorsements of SDOH because it can influence the type of strategy the foundation adopts and how far upstream the foundation is willing to go. When a foundation explicitly embraces the SDOH framework, this often prompts deeper questioning about what the foundation should be seeking to accomplish with regard to health and the social conditions that lead to poor health. This deeper analysis in turn often stimulates more intentional investment in work to improve social and economic conditions. Fatima Angeles, Vice President for Programs at **The California Wellness Foundation** described this dynamic with regard to the foundation's increased focus on economic well-being:

> *Our focus on employment and asset building is one example. A few years ago that wouldn't have made the cut [for funding]... We would have made it much more connected to health and not just general employment and not just general asset building. But the board and staff said, 'Let's just call it what it is. If you want to be healthy don't be poor.' And one way of not being poor is making sure you have a job and you are building wealth. And the jobs you have are good jobs, they pay well, they have benefits, they have mobility upwards.*

This quote vividly illustrates that adopting the SDOH framework entails much more than simply making grants to a few organizations that work in the areas of education, job training, parenting, housing, transportation, etc. The SDOH framework raises the stakes for analysis and strategy-development, especially with regard to how the different social and economic factors relate to one another, why some people face conditions that undermine their health, and what the foundation can do to promote positive change in these conditions.

The Special Case of Health Equity Funders

We observed that there is especially strong commitment to addressing social and economic factors among the foundations that have adopted a "health equity" perspective. Four of the foundations in the sample (**Northwest Health Foundation**, **Con Alma**, **The Colorado Trust** and **The Connecticut Health Foundation**) have positioned themselves as "health equity" funders, and a number of others (e.g., **The California Endowment**, **The California Wellness Foundation**, **The Colorado Health Foundation**, **The Connecticut Health Foundation, Endowment for Health, Foundation for a Healthy St. Petersburg, The Missouri Foundation for Health, REACH Healthcare**

Foundation) speak of health equity within their philosophy and strategies. These foundations focus on improving the health of people who have been disadvantaged because of their race, ethnicity, socio-economic status or where they live. This is in contrast to other health funders who are aiming to enhance the *overall* health of the communities they serve. Even if a foundation succeeds in improving the health status of a population, this might leave important disparities in place.

For a foundation with a health equity orientation, it is critical to look upstream at the full range of factors that produce racial and ethnic disparities in health. For the equity funders in our sample, that has meant focusing on fundamental issues such as poverty, wealth, educational opportunity, political power and racism. From their standpoint, there is no way to advance their mission without addressing the social context within which people live. As such, health equity funders are especially likely to adopt a SDOH perspective.

In considering the SDOH orientation of health equity funders, we also observed that they tend to talk not so much about "the social determinants of *health*" as they do the "social determinants of *health disparities.*" This orientation is championed by World Health Organization (WHO) in its 2010 report, *A Conceptual Framework for Action on the Social Determinants of Health.* For example, **The Colorado Trust** states on its website that the foundation defines social determinants "via the World Health Organization as the complex, integrated and overlapping social structures and economic systems that include the social environment, physical environment and health services—structural and societal factors that are responsible for most health inequities" (The Colorado Trust, n.d.).

In WHO framework, health inequities stem from class divisions, political hierarchies and differential access to resources. Thus, when health-equity funders are addressing social determinants, they are focusing on structural factors such as racism and disparities in wealth and power which specifically impact those sub-populations with the worst health outcomes. Health equity foundations view their work not simply as improving social and economic conditions throughout their region, but rather changing the underlying structures in ways that create more opportunity for people who have historically been disenfranchised (and whose health has suffered as a consequence). In particular, health equity funders often view their role as remedying inequities in power and privilege. As we will see in later sections of the report, this perspective has important implications for the types of strategies that health equity funders use to address social and economic factors, and more especially their willingness to disrupt institutions and systems.

Which Social and Economic Conditions are Being Addressed?

We move here from the question of why health conversion foundations are addressing social and economic factors to the question of what types of effect they are seeking. Across the sample we observed a diverse mix of intended outcomes across multiple domains. This includes increasing civic engagement, increasing high school graduation rates, reducing out-of-school suspensions, improving opportunities for job training, increasing access to quality childcare, creating more transitional housing for the homeless, and making it easier for ex-offenders to re-enter their communities.

We categorized the foundations' SDOH work in into the eight domains shown in left-hand column of Table 2. The right-hand column shows a sampling of the specific changes that the foundations are seeking to achieve.

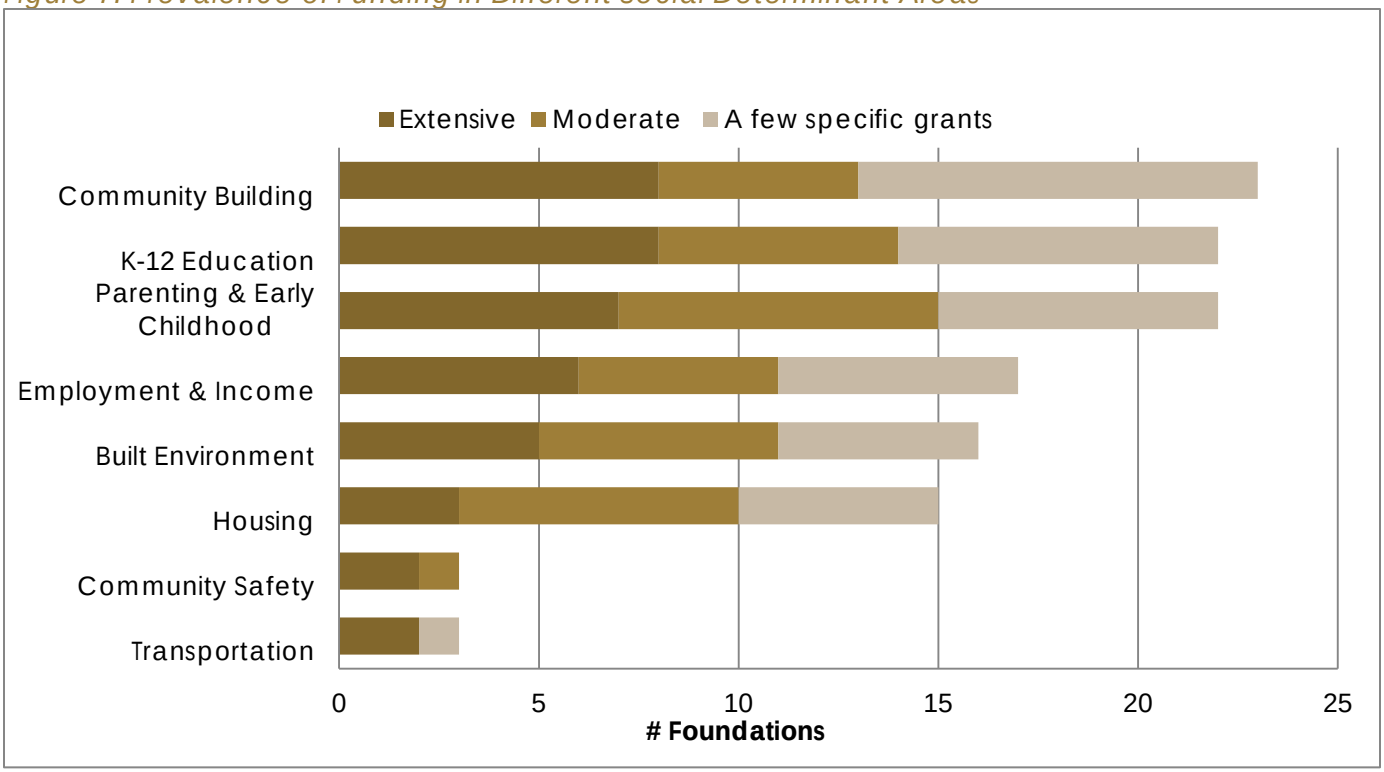
Table 2. Targets of the Foundations' SDOH Work

SDOH Domain	Targets for Change
Community building	Increased civic engagement; Improved sense of connectedness and trust; Collective efficacy and ability to set community wide goals
Educational Success	Increased educational attainment and graduation rates; More educational opportunities; Increased access to quality education
Parenting and Early Childhood	Parenting skills; Healthy family environment; Increased access to quality childcare
Economic Well-being	Increased job opportunities and workforce development; A growing, thriving economy with that is enticing to business and entrepreneurs; Increased homeownership and financial literacy.
Built Environment	Promotion of walkways, parks, trails and exercise routes; Conversion of former rail lines to exercise paths; Creation of public spaces to encourage community engagement and healthy activity
Housing	More affordable housing; Independent living for seniors; Reduced homelessness; More transitional housing
Community Safety	Violence prevention; Criminal justice reform; Better opportunities for ex-offenders to re-enter the community
Transportation	Transit-oriented urban development; Expansion of transportation options to promote healthy activities and reduce traffic; Increased availability of public transportation in underserved communities

Table 2 provides a composite picture of the various ways that the foundations in our sample are trying to influence social and economic conditions. Each foundation focuses on its own particular subset of issues. We assessed each foundation's SDOH portfolio by reviewing the grants and initiatives listed on the foundation's website. For each domain, we assessed whether the foundation was: *a) doing no work in the domain, b) making a few isolated grants, c) doing "moderate" grantmaking (in terms of size and number),* or *d) focusing "extensively" on this domain as an area of investment (either with multiple grants or a focused initiative).*

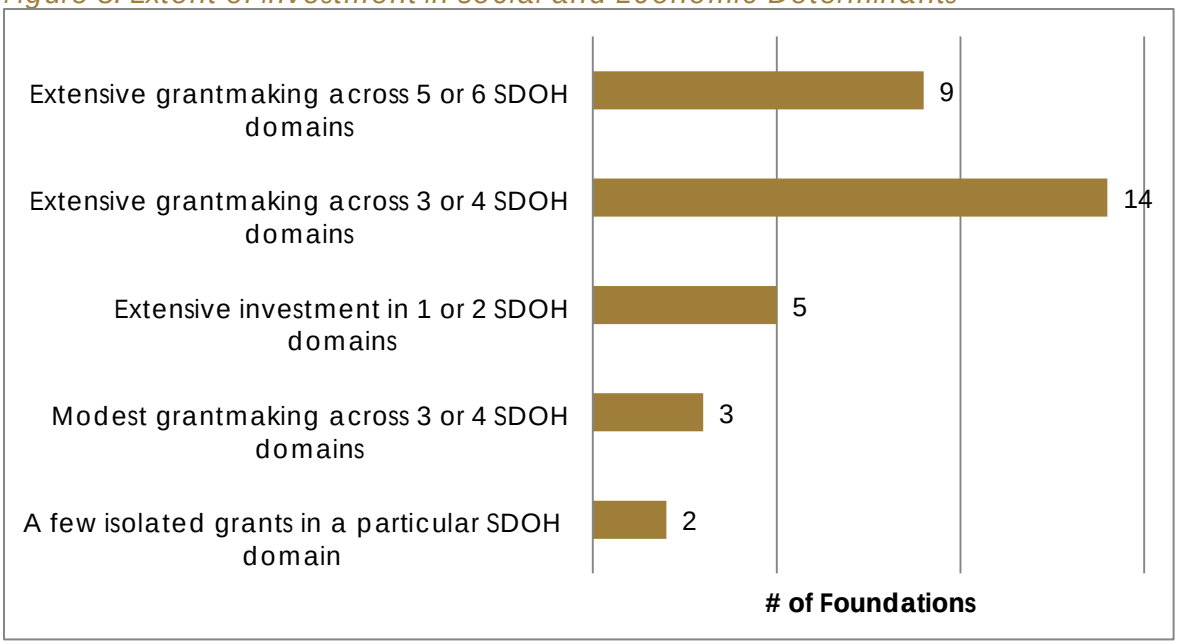
This analysis was used to determine which domains are receiving the most attention among our sample. The results are shown in Figure 7. The most popular SDOH domains for investment among our sample are **community building, K-12 education**, and **parenting and early childhood**. Approximately two thirds of the foundations in the sample are making at least some grants in these areas. The next tier includes: **economic well-being,** the **built environment** and **housing**. The two domains with the least investment are **community safety** and **transportation**. Only three foundations are investing in each of these two domains, but in each case two of the three are making what we regard to be "extensive" investments.

Figure 7. Prevalence of Funding in Different Social Determinant Areas



We also used this analysis of programmatic investment to determine how broadly or narrowly the foundations in the sample are investing in different domains. Those results are shown in Figure 8.

Figure 8. Extent of Investment in Social and Economic Determinants



Strategies

After exploring the why and the what of these foundations' SDOH work, we turn now to the question of how they are seeking to improve social and economic conditions such as those listed in Table 2. Given the diversity of outcomes that these 33 foundations are working to achieve, it is not surprising that there is also a rich mix of strategies. Appendix 2 lists examples under each of the eight SDOH domains.

One pattern apparent from Appendix 2 is the variation in grantmaking approach. Some foundations use open requests for proposals focused on specific SDOH issues, while others make grants for targeted projects developed by grantees that have a longstanding relationship with the foundation. And some funded projects are co-developed by the grantee and the foundation.

Grantmaking is a core element in most SDOH strategies, but it is certainly not the only element or even the primary element. Most of the foundations in the study go well beyond grantmaking and invest many other forms of philanthropic capital in order to catalyze change. These beyond-grantmaking strategies include:

- Publicizing and/or incentivizing the adoption of evidence-based programs;
- Establishing new organizations to fill a void;
- Convening coalitions, partnerships and problem-solving processes;
- Building organizational capacity;
- Leadership development training;
- Raising public awareness on critical issues;
- Conducting policy analysis;
- Overtly advocating for policy change; and
- Community organizing.

In order to present a clearer picture of what the 33 foundations are doing to improve social and economic conditions, we organized their strategies according to the following five *strategic pathways*:

1) Supporting program expansion and improvement
2) Building organizational capacity
3) Building higher-functioning inter-agency systems
4) Creating or changing policy
5) Stimulating broader and deeper social change

These are each described below.

Supporting Program Expansion and Improvement

The most natural and straightforward way for a foundation to improve a particular condition (regardless of whether it falls within a health domain or a SDOH domain) is to provide grants and other forms of support for programs and services that are designed to improve that condition.

In any given community, there will be nonprofits and government agencies that deliver programs and services addressing poverty, education, parenting, housing, transportation, and so forth. By making grants to these organizations, a foundation can make those programs and services more widely available. Virtually all of the foundations in our study made grants that allowed service providers to expand the reach of their existing programs and/or to add new programs. But these funders went well beyond grant making as a strategy to improve social and economic conditions.

Under the first strategic pathway, a foundation engages with key agencies, organizations and institutions in the community that have programs and services capable of influencing the target condition (e.g., poverty,

transportation, housing). Through grants, technical assistance and other philanthropic resources, the foundation supports those organizations in enhancing their programming. This might include expanding the number of clients the organization is able to serve, adding new services, incorporating evidence-based practices, making services more culturally relevant, or offering training opportunities to staff.

Most of the foundations in our sample have this intent of enhancing relevant services for many of their SDOH strategies (just as they do when seeking to improve the quality and availability of health services). This is often achieved by providing grant funding to key agencies to support the development, implementation and/or expansion of services and programs. Grants are not the only mechanism for doing this. **The Colorado Health Foundation** in Denver made a major program-related investment to the Colorado Coalition for the Homeless (CCH) to establish a revolving housing fund. This loan (at a favorable interest rate) allows CCH to finance affordable housing projects including the development of 500 units of permanent supportive housing for families and individuals by 2025.

Building Organizational Capacity

In addition to expanding the availability of critical programs and services, foundations often focus their attention on improving the quality of those programs and services. Organizational capacity building is a particularly important strategy for improving the design and delivery of programs. This work can focus on areas such as fundraising, technology, strategic planning, leadership development and succession planning.

Foundations can also intervene more directly to improve services and programs. **The Mary Black Foundation** in Spartanburg, South Carolina partnered with local agencies to develop a system to monitor and help childcare centers increase the quality of care they offer and provide information to families about their options. Elements of this monitoring and improvement system have been adopted by the state.

Capacity building is a particularly important strategy for improving the design and delivery of programs. **The Health Foundation for Western and Central New York**, based in Buffalo and Syracuse, established GetSET (Success in Extraordinary Times) to assist health and human service organizations in strengthening their strategy, operations and structures. Each organization formulates a capacity-building plan and then works on those issues through a process of training, consulting and peer learning (GetSET, 2015).

The REACH Health Foundation in Merriam, Kansas, has focused its capacity building specifically on cultural capacity. Under its Cultural Competency Initiative, health and human service organizations in the Kansas City region were provided with individualized technical assistance to improve their services to uninsured and underserved populations. Over time this program has evolved to emphasize peer learning and networking (Cultural Competency Initiative, 2015).

In developing its capacity-building approach, **The Rapides Foundation** in Alexandria, Louisiana, found that it needed to establish a new organization. Its strategy involves providing professional development opportunities for teachers as a means of increasing the readiness of pre-school children for kindergarten and the readiness of high school students for employment and post-secondary education. Because there were no organizations in the region with the capacity to provide this training, the foundation created a new entity, the Orchard Foundation, to administer the program.

Building Higher Functioning Multi-Agency Systems

The second strategic pathway extends beyond expanding and improving the services offered by individual organizations to focus on the larger systems within which those organizations operate. It is those larger systems

that determine how fully people's needs are met. For a system to be high-functioning, it needs to effectively deliver the services and resources that meet the needs of its clients. This requires having strong organizations that provide the necessary services, as well as alignment and coordination among those organizations. This in turn requires policies, connections and norms that promote effectiveness, responsiveness, collaboration, learning and adaptation (Foster-Fishman & Watson, 2012). Foundations are increasingly seeking to improve the functioning of existing systems and to foster new systems that address unmet needs. Typically this involves bringing together the leaders of organizations that are addressing a common issue and supporting the group in strategic analysis, planning, identifying promising models, creating and implementing shared strategies, evaluation and relationship-building.

One example of this approach is **HealthSpark Foundation** in Colmar, Pennsylvania, which convened and supported the Your Way Home coalition to reduce homelessness. The coalition developed and implemented a Homeless Prevention and Rapid Re-housing plan to end recurring and long-term homelessness in their community. The foundation's role included hiring a consultant to facilitate the process, researching best practices and forming a learning community. The coalition developed and implemented a Homeless Prevention and Rapid Re-housing plan to end recurring and long-term homelessness in their community.

Sisters of Charity Foundation of Cleveland initiated a similar process to address homelessness when an earlier initiative to help people get into permanent housing (Housing First) was started in Cleveland, OH in 2002. Following that and subsequent prevention efforts, the community is on track to end long-term homelessness by 2020.

Improving systems has been a core strategy of **The Health Foundation of Central Massachusetts** since 2001. Under its Synergy Initiative, the Foundation invites multi-agency groups to seek support for the development of collective strategies. The foundation provides multiyear financing, evaluation support, and a structured approach to planning. Foundation staff participate actively in the process. To date, this funder has supported sixteen Synergy projects in improving systems that provide services in areas such as criminal justice, child care, housing, and job readiness. The Together for Kids project focused on the problem of many children being suspended from preschool because of behavioral issues. With the foundation's help, Together for Kids designed and implemented a model of behavioral health consultation for educators and families. An independent evaluation found that this program significantly reduced the rate of suspensions. (Upshur, Wenz-Gross & Reed, 2009)

Creating or Changing Policies

Any condition that a foundation seeks to improve will inevitably be influenced to at least some degree by policy at the federal, state and/or local level. This includes both public policy (e.g., legislation) and the policies adopted by institutions that have influence over a particular issue (e.g., school districts, housing agencies, transportation districts, health systems, banks, employers). Foundations can influence policy through a number of pathways, some more direct than others. Depending on the tax status of the foundation, this work can include publicizing critical issues in which policy change is needed, supporting or carrying out studies that identify policy options, mobilizing public support for a particular policy, and disseminating model legislation or institutional policies.

Foundations with a 501(c)(4) social welfare organization status are able to advocate more directly for specific policies through communications campaigns and conversations with policy makers. This was the case for **The Health Foundation of Central Massachusetts** which has focused explicitly on policy change within its Synergy projects. Under the Together for Kids project described above, the Foundation's CEO, the evaluator and project

director all met with the state policy makers. As a result, the Massachusetts legislature included funding in the state budget to support the Together for Kids model across the state.

Many of the statewide and larger regional conversion foundations in our study (e.g., T**he California Endowment**, **The California Wellness Foundation**, **The Colorado Health Foundation**, **The Colorado Trust**, **Missouri Foundation for Health**) have well-developed strategies to influence state and local policy. Some of the work is carried out directly by foundation leaders and by staff members who specialize in policy analysis, policy making and public opinion research. In addition these foundations periodically enlist the support of research organizations, communications firms and groups that do advocacy and community organizing. **The California Endowment** has a strong policy-change component within its signature Building Healthy Communities initiative. Following the lead of students in the funded communities, The Endowment produced a marketing campaign to change school discipline policies in districts across the state. This has led to notable reductions in suspensions and expulsions.

It is not only large foundations that are engaged in policy-change work. The **Con Alma Health Foundation**, in Santa Fe, New Mexico, has an endowment of only $25 million, but policy change is a core element of its strategy. One of its efforts involved publicizing the detrimental effects of a proposal to downgrade New Mexico's water-quality standards, which would potentially affect people and wildlife, especially ranchers and a number of indigenous communities that depend on the Pecos and Rio Grande Rivers for drinking water. The foundation also funds Amigos Bravos to organize political participation within the affected communities (Amigos Bravos, 2014).

Stimulating Broader and Deeper Change

Some foundations have determined that their goals will be achieved only if there are more fundamental shifts in how institutions function, how societal problems are identified and solved, and who has the power to make key decisions. These foundations are interested in improving programs and systems, but with a particular focus on ensuring that those programs and systems are more inclusive, responsive and equitable. They seek this higher form of social change through strategies such as community organizing, developing leadership capacity among grassroots groups, building the political power of those groups and encouraging established institutions to change in ways that promote equity.

Northwest Health Foundation uses its position and reputation to enhance the influence of grassroots groups who are not yet connected to political structures. For example, the foundation hosted a high-profile dinner with the Speaker of the Oregon House of Representatives as a means of providing an audience for a grassroots organization that had previously been unable to gain attention on its policy priorities.

The Greater Rochester Health Foundation in upstate New York uses a community organizing strategy to improve the physical, social and economic environments of neighborhoods. 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), which focuses on resident-led efforts to improve the quality of life by drawing on the community's own assets.

The Colorado Trust uses a community organizing approach to advance health equity in communities across the state. The Trust hired community partners who organize local resident councils and facilitate the development of community-change strategies. The councils determine funding priorities for The Trust's grants to the community. A major component of The Trust's strategy is to build the political power of these councils, with the

expectation that this will cause local institutions to more fully incorporate the interests of traditionally-under-represented groups in decision making, priority setting, resource allocation and program delivery.

How Much Change?

The five strategic pathways described above reflect different types and different degrees of change to the organizations, systems and structures that define a community (or society more generally). Operating through either of the first three pathways (services, programs, organizations and systems) amounts to *improving existing institutions.* Operating on the next pathway (policy) involves *changing the context.* Operating through the fifth pathway implies that the foundation is in the business of *changing the fundamental structures* that underlie key institutions and that organize society more generally.

The conversion foundations in our sample are at different points in this "change spectrum." Some focus their attention on improving the programs and services that assist people in meeting their social and economic needs. Others are seeking to change how communities and society are organized, especially with regard to who has political and economic power. When introducing the Health Impact Pyramid in 2010, Thomas Frieden acknowledged that the need to work at this deeper level: "Addressing socioeconomic factors has the greatest potential to improve health … [However] achieving social and economic change might require fundamental societal transformation (p. 593-594)."

Not surprisingly, foundations that have incorporated "health equity" into their mission or identity (e.g., **Northwest Health Foundation**, **The Colorado Trust**, **Con Alma**) are much more likely to direct their strategies toward factors at the higher level of the change spectrum. These foundations are less focused on improving the overall health of a community or region than on increasing opportunity and seeking justice for groups that have been historically underserved, neglected or discriminated against, particularly communities of color. They are also the foundations that are particularly inclined to adopt the second SDOH paradigm, which focuses on the underlying determinants of health disparities rather than a more general orientation toward improving population health throughout a community or region.

Northwest Health Foundation is particularly explicit in articulating the need to focus on changing the fundamental structures and systems that define society. According to the foundation's website (https://www.northwesthealth.org/about/equity/):

> *Equity requires the intentional examination of systemic policies and practices that, even if they have the appearance of fairness, may, in effect, have the opposite result. Working toward equity requires an understanding of historical contexts and the active investment in social structures over time to ensure that all communities can experience their vision for health.*

Nichole Maher, the foundation's president provided the following description of what this perspective implies in terms of where and how they seek to catalyze change:

> *We have moved away from services and more to deep core capacity building, away from policy advocacy and more to power building and disrupting some of the systemic and structural barriers from those communities being included at all levels of government from boards and commissions to elected office.*

By focusing on the structural factors that are responsible for health disparities, health equity funders tend to adopt a more activist or disruptive role within their "community" (either local, regional or at a state level). This means that they are often challenging institutions to be more responsive to and inclusive of people who have historically not been well served because of their race, ethnicity, class or level of wealth. Likewise, health equity funders typically focus on changing public policy, employing strategies such as analyzing current policy,

developing policy alternatives, building public will around policy change, organizing coalitions and directly advocating with policy makers.

Beyond changing institutions and policy, some foundations are working toward more fundamental shifts in the culture of communities and society more generally. Changing a culture means changing the norms, beliefs and expectations that influence how people behave and interact with one another (Easterling and Millesen, 2015). The principles that define health equity have distinct implications for culture, especially with regard to respecting one another, ensuring that everyone has access to meaningful opportunities and focusing on the common good. Health equity funders are seeking to foster cultural norms that emphasize these principles.

It is important to point out that it is not only health equity funders who are striving for shifts in fundamental structures, systems and culture. **Danville Regional Foundation** is focusing specifically on changing the local culture as a core element of its strategy to transition the local economy beyond the dwindling textile and tobacco industries. Karl Stauber pointed specifically to the need to change the community's culture in his interview:

> *Creating a new economy is hard. Creating a new culture is even harder. We are talking about personal responsibility, talking about education is a key pathway to living wage jobs, talking about growing living wage jobs.*

Disrupting the prevailing community norms and expectations around personal responsibility and the importance of education can be just as radical as reforming institutions to be less racist.

Implications for Foundations

One of the most important takeaways is that focusing on the social determinants of health is not, in and of itself, a "strategic" move for a foundation. Although the foundation is indeed moving upstream and looking at the deeper causal factors behind poor health, these upstream factors may be even more difficult to influence than the availability, accessibility and quality of health care. Most social and economic determinants correspond to entrenched conditions, and as such are not easily changed. Government agencies, nonprofit organizations and non-health funders have been investing enormous resources in education, economics, housing, transportation and criminal justice for generations. Health foundations should not enter into SDOH work expecting to find some sort of "low hanging fruit" that has been previously overlooked. Just as with improving health care, improving social and economic conditions is complex, long-term, politicized work.

Think Strategically

The task of developing a truly impactful strategy is just as challenging when focusing on a social or economic condition as it is for a foundation that restricts its funding to the health domain. Health foundations have long recognized that improving the health system requires making wise use of many different forms of philanthropic capital they have available -- financial, human, social, political, reputational, intellectual, etc. Strategies need to be equally comprehensive and long-term when operating within SDOH domains.

In order to operate in a truly strategic fashion, the foundation needs to identify a few specific ways in which it can exert a significant influence over the social and economic determinants of health. This might be accomplished by focusing on one or two determinants that are major contributors to health and influence-able by the foundation. Alternatively, the foundation might develop a signature strategy that can be effectively applied across multiple issue areas. Either approach requires a sophisticated analysis of what influences health among the target population, as well as deep strategic thinking to identify how the foundation can best influence those factors.

Another reason for a health foundation to develop a strategic focus for SDOH work is to send a clear signal to grantseeking organizations. One of the most common concerns we heard in the interviews is the breadth of social and economic issues that potentially warrant the foundation's attention. When a foundation expands its grantmaking to move beyond programs that advance "health" (narrowly defined), there is a risk that the foundation will become a "go-to" funder for all nonprofit organizations and government agencies in a community. It is important for the funder to identify publicly the specific SDOH issues where it is focusing and to present its logic as to why these addressing these issues will contribute to the foundation's health goals.

Clarify the Level and Type of Change the Foundation is Seeking

Any foundation interested in pursuing an SDOH strategy would be advised to engage their board and staff in an exploration of the different SDOH paradigms we observed in our sample – social determinants of population health, social determinants of health disparities, and broad definition of health. Depending on the paradigm selected, going down the SDOH path can take the foundation into the role of social change agent. This isn't inevitable, but some SDOH paradigms call for reallocating political power and dismantling societal systems. As the foundation clarifies its SDOH-related beliefs and assumptions, it will also be deciding how disruptive a force it wants to be. It is crucial to be considering these alternatives explicitly and to communicate the decisions to the foundation's constituents.

Consider How the Organization Needs to Adapt

Once a foundation has set its strategic direction, identified the leverage points it will work through and decided how it will use its various resources, it is critical to test how well the selected SDOH strategies actually fit within the organization. Any given strategy will have distinct requirements for how staff members do their jobs, how grants are made, how grantees are supported, how partnerships are entered into, how the foundation shows up in various venues, etc. The foundation needs to have the right policies, procedures and organizational structure. And perhaps most importantly, the foundation's staff members need to have the competencies and orientation that the strategy demands.

One specific competency that many of our interviewees pointed to is the ability to do systems thinking and to analyze the often complex systems that are in place to ensure that there will be economic prosperity, high-quality education, efficient transportation, adequate and affordable housing, etc. This also means seeing the dynamic interactions between people and issues. Molly Talbot-Metz at the **Mary Black Foundation** in Spartanburg, South Carolina described how their staff came to be more oriented toward family systems.

> *We've really been focused on the child. So we've been talking more with our partners about the family system in which the child lives so if mom and dad are living in poverty or have other stressors that are impacting the health or health and success of that child then we should be looking at the systems in which that child is surrounded.*

Some of the foundations in the sample have moved in dramatically different directions that require a completely different skill set on the part of staff. As part of its commitment to advancing health equity with a community development approach, **The Colorado Trust** reinvented its approach to grantmaking. As part of this strategic shift, The Trust's leaders disbanded the program department, dismissed all of the program officers, and hired a cadre of Community Partners (Csuti & Barley, 2016). The Community Partners operate with a community-organizing orientation, focusing specifically on the factors that lead to disparities in health and the underlying inequities in resources and opportunity. In various communities around the state, the Community Partners recruit, organize and support teams of residents, with the expectation that each team will develop a locally relevant strategy to improve health and advance health equity. Grantmaking on the part of The Trust is guided – even directed -- by the resident team. The Trust's president, Ned Calonge, described how these changes were in some ways predetermined by the foundation's commitment to community-based social change.

> *Community ownership depends on us changing our decision model and pushing decision making power out to the groups we hope will make change.*

This example demonstrates that SDOH work can be disruptive both externally in the community and internally within the foundation. Antony Chiang, president of **Empire Health Foundation**, acknowledged the discomfort that can come with aligning the organization with its social-change strategy:

> *In all of our initiatives, we know that in order to move the needle we can't just convene or suggest disruptions or changes. We have to help catalyze or lead those changes or disruptions. It's a double edged sword. It feels uncomfortable for folks. It's uncomfortable for us sometimes*.

Invest for the Long Haul

Pat Baker, President of **The Connecticut Health Foundation**, stressed the importance of investing for the long haul, drawing on all the foundation's assets, and coordinating the foundation's strategy with the strategies of other players already operating in the area.

> *We come into this work knowing social determinants play a major role. Where can we add value is the question. One thing is you have to be present over time. That means that people can count on you. You*

> *never leave the table. It is about influence, relationships, bringing the R&D. It is about those strategic investments. Advocacy and leadership are critical. Leadership lasts longer than the money.*

SDOH strategies evolve over time. The **Mid-Iowa Foundation for Health** has been on this journey since its inception in 1984. The foundation's president, Suzanne Mineck, provided the following reflections on how the board and staff have come to recognize the role of social determinants and what that implies for the foundation:

> *Well before the term "social determinants of health" was in use, our board was looking at issues such as food insecurity and violence in the home. It was part of our culture to view health as being determined by far more than just your access to health care services. Our first guiding principle is good health is the balance of physical, social and emotional states.*
>
> *Today, as more and more research is available, it challenges us to dig deeper. Thirty years ago we knew intuitively that it's difficult to be healthy if you don't feel safe or if you are hungry. We are challenged now to understand the why behind those broader determinants of health. The more you ask those questions and the more you know the truth behind them, it pushes you to ask what is our role.*

This quote vividly illustrates that adopting the SDOH framework entails much more than simply making grants to a few organizations that work in the areas of education, job training, parenting, housing, transportation, etc. The SDOH framework raises the stakes for analysis and strategy-development, especially with regard to how the different social and economic factors relate to one another, why some people face conditions that undermine their health, and what the foundation can do to promote positive change in these conditions.

Concluding Thoughts

Although by no means a comprehensive review of what conversion foundations are doing with regard to the social determinants of health (and health disparities), this study provides the broadest portrait to date of how the field is evolving.

It is important to point out that the pattern shown in Figure 8 is not reflective of how the larger population of conversion foundations are investing in social and economic factors. We deliberately recruited foundations that were known to be making at least some grants in these "beyond health" areas. Most conversion foundations in the U.S. are currently investing little to none of their grant dollars in social and economic factors.

Correspondingly, the sample of foundations in this study is not representative of the overall population of conversion foundations with regard to a number of organizational characteristics (e.g., size, legal status). Based on censuses of the conversion foundation sector conducted by Niggel and Brandon (2014a) and GIH (2017), we know that our sample has proportionately more foundations with (a) statewide and multi-county funding regions, (b) assets over $100 million, and (c) private-foundation legal status. These "deviations" indicate what types of conversion foundations are most likely to be taking the lead in addressing social and economic determinants of health.

Collectively this sample of 33 conversion foundations is seeking to improve a wide array of social and economic conditions that are known to influence the health of people and communities, including educational attainment, economic well-being, housing, social fabric and civic engagement. Moreover, the majority of these foundations are making deep investments in one or more SDOH domains. They are bringing not only their grantmaking resources, but also their ability to convene, build capacity, set political agendas, change policy and organize communities. In short, most of the foundations in this sample have invested enough of themselves in SDOH work that it is hard to imagine them pulling back to a more traditional focus on health and health care.

One of the clearest patterns in our data is the variability in how deeply the foundation strives to change fundamental societal structures as a means of improving social and economic conditions. At one extreme are the health equity foundations that are explicitly seeking to disrupt and reorganize key institutions and systems. At the other end of the spectrum are foundations that are content to work with and within existing systems to improve the services and resources they provide. Both approaches can fit within a SDOH framework, but they aim at very different forms of change and require different work and different competencies on the part of the foundation.

It is crucial to reiterate that the patterns observed here pertain to a highly selective sub-sample of health conversion foundations – those that have a reputation for making grants to improve social and economic conditions. We do not assume that the larger field of conversion foundations is thinking and acting in the ways that we describe here. Even if they are well versed in the research literature showing the powerful effect of social and economic factors, the leaders of a health foundation may reasonably decide that they want to retain a narrower focus on health care and prevention. Indeed, one of the leaders we interviewed indicated that their foundation had decided not to adopt a large-scale SDOH strategy:

> *When it comes to poverty, racism, engagement in voting, crime, we do not engage in that. Our conclusion is that strategies to impact such social factors are not well established or we can't find them. Or they are highly political, not evidence-based approaches. We know there is a relationship between social factors and health. The question is where does the foundation place itself in the chain of events. Our job is to place ourselves a little more proximal to the health behavior and outcomes. I feel like we are really contributing by sticking with determinates, programs, and policy that are closer to health*

behaviors and disease. We stay away from emphasizing broad social factors, but keep them in mind as we do our work. Some foundations and organizations have steered toward the social determinants model, and those players have become less relevant to our work because of that.

Finally we end with the question of how much impact conversion foundations can have in improving social and economic conditions. The current study was designed to provide a survey of what conversion foundations have done in the SDOH and the thinking behind their strategies. We did not collect the type of data that would be required to assess the effectiveness of alternative strategies. That is the obvious next step in this line of research. In the meantime, we present the reflections of Daniel Zingale, Senior Vice President at **The California Endowment**:

Coming from the world of government and politics, if someone would have asked me 10 years ago to make a list of sectors who had influenced societal change, philanthropy probably wouldn't have made my top 20. [Now that I'm inside a foundation,] I've drunk the Kool-Aid a bit. I am convinced that philanthropy can be more influential when it takes more risks. The amazing thing about philanthropy is you don't have shareholders or voters or all the things that constrain a Governor and those other sectors. The philanthropic sector is amazingly free to act -- and remarkably risk averse given that. We actually can take risk, not just by funding but by having a point to make.

Appendix 1. Foundation Interviews

Foundation	Contacts	Interview Dates	State
Vitalyst Health Foundation	Suzanne Pfister	3/15/16	AZ
The California Endowment	Marion Standish, Jim Keddy, Daniel Zingale	5/9/16, 6/27/16, 7/18/16	CA
The California Wellness Foundation	Fatima Angeles	6/24/16	CA
The Colorado Health Foundation	Amy Latham, Khahn Nguyen	4/22/16, 5/3/16	CO
The Colorado Trust	Ned Calonge	6/28/16	CO
The Connecticut Health Foundation	Pat Baker	3/30/16	CT
Foundation for a Healthy St. Petersburg	Randall Russell	1/20/16	FL
Healthcare Georgia Foundation, Inc.	Gary Nelson	12/21/15	GA
Mid-Iowa Health Foundation	Suzanne Mineck and Denise Swartz	2/4/16	IA
Health Care Foundation of Greater Kansas City	Bridgett McCandless	7/21/16	KS, MO
REACH Healthcare Foundation	Brenda Sharpe	1/25/16	KS, MO
Foundation for a Healthy Kentucky	Susan Zepeda and Gabriela Alcalde	3/7/16	KY
Baptist Community Ministries	Charles Beasley, Luceia LeDoux, and Christy Ross	1/20/16	LA
The Rapides Foundation	Joseph Rosier	1/15/16	LA
The Health Foundation of Central Massachusetts, Inc.	Jan Yost	2/9/16	MA
Maine Health Access Foundation	Wendy Wolf and Barbara Leonard	2/3/16	ME
Missouri Foundation for Health	Bob Hughes, Ryan Barker, Kathleen Holmes	2/19/16, 2/24/16, 3/2/16	MO
Montana Healthcare Foundation	Aaron Wernham	1/11/16	MT
John Rex Endowment	Kate Shirah	3/2/16	NC
Endowment for Health	Yvonne Goldsberry	2/22/16	NH
Con Alma Health Foundation	Dolores Roybal	1/5/16	NM
Greater Rochester Health Foundation	John Urban and Barbara Zappia	12/22/15	NY
Health Foundation for Western and Central New York	Ann Monroe	2/5/16	NY
Interact for Health	James Schwab	2/22/16	OH, IN, KY
Saint Luke's Foundation	Anne Goodman and Heather Torok	1/21/16	OH
Sisters of Charity Foundation of Cleveland	Susanna Krey	5/11/16	OH
Northwest Health Foundation	Nichole June Maher and Suk Rhee	2/4/16	OR
HealthSpark Foundation	Russell Johnson	12/21/15	PA
Mary Black Foundation	Molly Talbot-Metz	12/17/15	SC
Paso del Norte Health Foundation	Michael Kelly, John Law	2/10/16, 2/11/16	TX, MX
The Alleghany Foundation	Mary Fant Donnan	7/20/15	VA
Danville Regional Foundation	Karl Stauber	6/21/16	VA
Empire Health Foundation	Antony Chiang and Kristen Fisher	2/19/16	WA

Appendix 2. Examples of Foundations Addressing Each SDOH Domain

Economic Well-being	**The Alleghany Foundation**	Building on local capacity, the foundation spearheaded an inclusive process called VISION 2025 to identify areas of community engagement that would be used as the focal points for an economic development plan. http://alleghanyfoundation.org/community-engagement/vision-2025/
	The California Wellness Foundation	Addressing financial security is the focus of the foundation's Promoting Employment and Asset-Building Opportunities initiative. The program uses a variety of strategies to help target populations obtain and retain employment and build financial assets. http://www.calwellness.org/grants_program/expanding_education_and_employment_pathways.php
	Danville Regional Foundation	The foundation sponsors a training series provided by the Duke University Nonprofit Management Program and has established a program called Middle Border Forward to strengthen the next generation of leaders in their community. http://www.drfonline.org/events/series/id/1/duke-university-continuing-studies https://www.middleborderforward.org/
Educational Success	**The California Endowment**	Following the lead of students in the Building Health communities, the foundation produced a successful marketing campaign to change school discipline policies across the state leading to a reduction in suspensions and expulsions. http://www.calendow.org/schools-priortize-prevention-not-incarceration/
	The Rapides Foundation	The foundation helped established a nonprofit agency, The Orchard Foundation, to administer their education programs for school districts in the area. Professional development for educators, mentoring for school systems and promoting kindergarten readiness are some of the main initiatives of the foundation. http://www.rapidesfoundation.org/OurWork/Education.aspx
	Northwest Health Foundation	The foundation's Oregon Active School program provides grants to elementary schools in Oregon for physical activity resources and to promote the Let's Move! Active Schools campaign. The foundation is targeting schools where more than 70% of students qualify for free or reduced-price lunch and less than 65% of students met 3rd grade reading benchmarks. https://www.northwesthealth.org/activeschools/
	Baptist Community Ministries	The foundation built on a successful pilot phase of the Youth Program Quality Initiative by recruiting partners and continuing funding for the program to improve the quality of out-of-school programs for youth in New Orleans, provide professional development and coaching, and establish self-assessment measures for programs. http://www.bcm.org/wp-content/uploads/2017/04/bcm-annual-report-2016-w.pdf
Parenting and Early Childhood	**Mary Black Foundation**	The foundation led a community effort to address teen pregnancy as a public health issue through programs in schools, access to contraception, programming in community based organizations and public awareness campaigns. http://www.maryblackfoundation.org/focus-areas/early-childhood-development/community-initiatives/
	The Health Foundation of Central Massachusetts	Through the Together for Kids model, the foundation addressed preschool suspensions, implementing a program of behavioral health consultations and ultimately leading the State to fund the implementation of the model statewide. http://www.hfcm.org/GrantsByInit/39
	Mid Iowa Health Foundation	The foundation helped launch an initiative, Connections Matter on the impact of toxic stress and opportunities to change the outcome. MIHF helped members of that group, including Prevent Child Abuse Iowa develop a common message. http://www.midiowahealth.org/images/downloads/16_Grants_List.pdf

Community Building	**The Colorado Trust**	Community Partnerships is the foundation's approach to funding the issues that are important to health equity in the community. The specific issues and approaches are defined by the community and supported with local and foundation resources. http://www.coloradotrust.org/strategy/community-partnerships
	Endowment for Health	Coordinating the efforts of four communities and a statewide coalition, the foundation is building Welcoming Communities for immigrants and refugees as part of their health equity priority area. http://www.endowmentforhealth.org/what-we-fund/advancing-health-equity-for-racial-ethnic-and-language-minorities/immigrant-integration-initiative
	Greater Rochester Health Foundation	The foundation's Neighborhood Health Status Improvement program uses an Asset-Based Community Development approach to train local leaders and work on the physical, social, and economic environments of the neighborhoods. http://www.thegrhf.org/funding/neighborhood-health/
Housing	**HealthSpark Foundation**	The foundation helped change the system of homeless services and affordable housing in their community through their Housing Fund and their partnership in the Your Way Home Montgomery County plan. https://healthspark.org/how-we-work/collaborative-projects/partnerships-about-specific-issues http://yourwayhome.org/
	Sisters of Charity Foundation of Cleveland	The foundation invests a significant portion of its funds in affordable housing for homeless individuals and families using a Housing First approach to addressing homelessness. http://socfcleveland.org/ending-homelessness/
	Mid-Iowa Health Foundation	The foundation helped start Healthy Homes Des Moines, an organization designed to help families with children suffering from asthma live in a healthy home. The community collaboration is one of seven programs nationwide to receive funding from the BUILD Health Challenge. http://www.healthyhomesdesmoines.org/
	The Colorado Health Foundation	The foundation used its program related investment funds to provide the basis for the Colorado Coalition for the Homeless (CCH) to establish a revolving housing fund. The below interest rate loan allows CCH to finance affordable housing projects including the development of 500 units of permanent supportive housing for families and individuals by 2025.
Built Environment	**Con Alma Health Foundation**	The foundation's Healthy People, Healthy Places program combined health, food access, and equity through built environment to support cultural assets and ensure equity-focused policies and environmental efforts. https://conalma.org/cahf-awards-grants-to-support-healthy-people-healthy-places-initiative/
	Greater Rochester Health Foundation	As part of the Neighborhood Health Status Improvement program, the foundation has given grants to neighborhood community groups for resident designed projects. The Project HOPE neighborhood reclaimed abandoned properties for playgrounds, community gardens, trails, and produce stands to revitalize the community. The initial grant led to additional funding from the RWJF, the City of Rochester, and others. http://www.thegrhf.org/funding/neighborhood-health/grantees/
	Mary Black Foundation	The foundation has been providing funding to Upstate Forever and Partners for Active Living to advance community planning that encourages healthy outdoor recreation and transportation opportunities. http://www.maryblackfoundation.org/focus-areas/healthy-eating-active-living/community-initiatives/

Transportation	**Northwest Health Foundation**	When selecting areas for advocacy work, the foundation learned from the community that the lack of drivers cards for undocumented people was one of the greatest barriers to accessing health care. The foundation used its resources to support a referendum that would have made driver's licenses available regardless of legal residence status. https://www.northwesthealth.org/2014-year-in-review/?rq=driver https://www.northwesthealth.org/news/archive/2014/9/13/why-does-nichole-support-the-oregon-driver-card?rq=driver
	Vitalyst Health Foundation	The foundation worked with the City of Phoenix to implement a Complete Streets approach to new and retrofitted streets. Complete Streets, designed for use by pedestrians, cyclists, motorists, and public transit riders, include welcoming entrances to businesses, shaded sidewalks, benches, landscaping, and more. http://vitalysthealth.org/advocating-for-complete-streets/
Community Safety	**Baptist Community Foundation**	Using a collective impact model, the foundation, behavioral health, public safety and community organizations formed the Opportunity Youth Initiative task force with the goal of creating more opportunities for disconnected youth. http://www.bcm.org/stories/transform-community-connect-youth-education-jobs/
	The California Wellness Foundation	The foundation's Promoting Violence Prevention program impacts juvenile justice through reforms to the juvenile and adult criminal justice system, leadership programs, research and public policy analysis on gun violence, helping to launch the Ceasefire Fund, and gang prevention and intervention activities. http://www.calwellness.org/grants_program/promoting_healthy_and_safe_neighborhoods.php

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