GRANT MAKERS IN HEALTH

Decisive Grantmaking in Dynamic Times: How to Build a Balanced Grantmaking Portfolio of Big Ideas to Improve Health in Our Communities

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Often in envisioning big ideas in response to dynamic times, innovative approaches or frameworks can be crafted by considering and integrating knowledge from other sectors. The invitation to provide an essay for this year's Grantmakers In Health annual meeting gave me a welcomed opportunity to reflect on how we at The Colorado Trust are crafting our grant strategies as we strive for additional focus within our existing "access to health for all Coloradans" vision. Pulling from two strategic paradigms, from the worlds of foundation investment and preventive medicine, we are building our grantmaking priorities to achieve a balanced grantmaking portfolio.

The public health sector is well-versed in grantmaking, grant writing, logic models, program design, program implementation, and program evaluation. However, ideas like theory of change, attribution vs. contribution, strategic philanthropy, shared funding, and collective impact have not made their way into the public health or health care vernacular. I have faced a significant learning curve in my journey from public health to philanthropy, using ideas and terms like these to discuss our work through the lens of foundation strategy. I have also become a student of foundation investment philosophy, which has its own language and wisdom. I have found useful similarities with how we think strategically in grantmaking and how we think strategically in investing. The "balanced portfolio" approach in particular is a useful way to consider decisions around a decisive and responsive grantmaking strategy to address health improvement in our dynamic times.

Our investment committee and fund management consultants work to maintain an investment strategy to assure earnings over time that allow us to fund grants to advance our foundation mission. We work to balance our investment portfolio to accept a degree of higher-risk investments with the opportunity for greater returns, less-risky investments with more predictable growth and income potential, and investments designed to hedge against inflation and unanticipated market losses. In addition, we consider a balance of long-term investments, as well as more liquid investments, that support the maintenance of our endowment "in perpetuity" while allowing us to generate income to expend on grant activity now. A similar diversified approach that balances long-term, higher-risk grant strategies with shorter-term, more direct grant strategies can similarly support our success advancing our foundation's vision.

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In the health care sector, preventive medicine uses a paradigm that also may be considered in crafting a balanced grantmaking strategy to respond to dynamic times. This paradigm describes the "prevention spectrum," which looks at patient health along a continuum from no biologic disease, to presymptomatic disease, to symptomatic disease, to disease with complications. There are health care interventions for each part of the spectrum from disease prevention through disease treatment. The model has expected outcomes all along the spectrum, and presents an intuitive, problem-focused linear model that informs care service design and delivery for the health care system. Over time, a successfully implemented preventive services program shifts the profile of a given disease in a population away from the disease end of the spectrum toward the disease-free end. For example, a good weight management program should decrease the prevalence of type 2 diabetes in a target population.

In describing the prevention spectrum, I use the story about the town folk from a community at the mouth of a river noticing that there are people floating down the river and drowning. The town folk develop an increasingly effective, efficient (and expensive) system for pulling victims out of the water, but never think to head upstream to figure out why people were falling into the river in the first place.

There is more than one lesson here. Indeed, it is critical to consider upstream prevention efforts in order to best address the problem. But there are risks associated with focusing only upstream. You could lose a significant number of drowning victims downstream while you work to understand the upstream issues, design an intervention, test the effectiveness, and implement a full-scale program.

Considering both the investment and prevention paradigms makes sense to create a grantmaking portfolio that balances upstream (prevention) with downstream (treatment) strategies; higher risk/higher reward with lower risk/steady reward strategies; and long-term, "slow burn" with short-term, immediate-need strategies.

This integrated paradigm is guiding our work at The Colorado Trust as we craft grant strategies aimed at focusing our access to health work on advancing health equity through addressing health disparities, striving to achieve an effective, diverse, and balanced portfolio.

Our current internal work in health policy provides an example at one end of the investment spectrum. Policy, broadly defined, is one key to addressing upstream determinants of disparities in health. Many of the social determinants of health, such as education, income, and opportunity, have aspects that could be addressed through policy changes, although the root causes of the inequities here are often a product of our history and the social fabric of our country. Creating and enacting policies, however, can have an enduring effect on downstream health disparities.

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In policy work, we begin developing accurate, credible, and unbiased information that defines the scope and extent of the issue the policy will address. This information serves to educate and raise the awareness and interest of stakeholders and other members of the public and to use public will-building strategies to create a commitment to change. Public will fuels advocacy efforts, supporting the development of political will and, ultimately, policy change.

We can consider categorizing "big P" policies, created at the state and national level, and "small p" policies, which can be implemented much more locally, such as at the organizational or facility level. An example of policy development at the "small p" level could be making Spanish translation services available at a community clinic. Data on the number of clinic clients who are monolingual Spanish would describe the extent of the problem, while reviewing existing literature on the negative impact on the efficacy of health care services provided without professional, quality translation services defines the scope of the impact on health. This information would activate stakeholders and others to approach clinic administrators and advocate for developing translation services. Clinic administrators would balance the costs of services with the potential health benefits, and advocacy could come to bear in promoting the political will to implement a policy that all monolingual-Spanish patients would have access to professional translation services and seek solutions to creating a sustainable program.

What about a "big P" change? Medicaid expansion is a timely example. A structure approach to investing to address this policy goal would start with gathering information on the scope and extent of the problem. One source of information is the Colorado Health Access Survey (CHAS), funded by The Colorado Trust. The CHAS is a telephonic survey covering 10,000 households and more than 26,000 people in our state, asking questions about health insurance status and health care seeking behavior. Key findings from the 2011 survey include that an estimated 829,000 Coloradans do not have health insurance, that the major reason is cost, that uninsurance impacts people of color and those with low incomes disproportionately compared with others, and that being uninsured translates to not getting needed health care services (Colorado Health Institute 2011).

There are national research data that indicate Medicaid expansion significantly decreases mortality at the state level (Sommers et al. 2012). These data can raise awareness in the general population and are being used by health care advocates to support the decision to expand Medicaid under the provisions of the Affordable Care Act. Public will has shifted in Colorado such that for at least the next two years, the majority of both the House and Senate of the state legislature supports increases in health care coverage. Nonprofit agencies that have advocacy activity and have general operating funds from The Colorado Trust or are part of our Public Will-Building grant strategy are using data from the CHAS to promote expansion and build public and political will, and the governor has announced that he will seek

Medicaid expansion in the 2013 session. Assuming a successful bill, this work will result in a policy that addresses access to care and will reduce health disparities in Colorado.

This example presents an opportunity to discuss important caveats for grant strategies to promote policy change, which are caveats for nearly all "upstream" grant strategies. Policy change is complex and involves a great number of interrelated grant strategies and other moving parts that are unassociated with funding from The Colorado Trust. Pursuing policy change requires dedication and perseverance. Foundations and their boards need to be content with contributing to the goal (contribution), rather than having results directly attributed to their investment (attribution). Funding the CHAS, public will-building, and advocacy will not create the policy change by itself, but we believe these strategies will support a successful outcome. We can never know whether the policy would have been created without our investments, nor to what extent the grants contributed to the final outcome. We cannot know that funding these strategies at a lower amount would have had the same degree of contribution, and if with a lower commitment of resources, the outcome would be the same. Similarly, if the expansion bill were to fail, we cannot know whether a larger investment would have succeeded. These are the realities of funding to change policy. Thus, policy investments represent a high-risk strategy. The potential return of policy change, however, is significant and enduring.

There will be similar issues with any upstream grant strategy targeting a complex health issue. For example, investing in community grants to address physical activity and nutrition in order to decrease obesity will require a comfort with contribution and an unknown absolute impact, or a reliable estimate of return on investment, as any improvements in the targeted outcome will be multifactorial. Grants such as scholarships to increase the racial and ethnic diversity of students enrolling in health professional programs will certainly take time to affect the diversity of the health care workforce, and the impact on health disparities may be difficult to measure. Upstream strategies are, in general, more innovative, with a higher risk profile coupled with a higher opportunity for significant return, similar to what we experience in endowment investments. But in order to achieve bold, important visions, such high risk investments must be part of the grant portfolio.

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There is a downside to investing only in upstream strategies, however, and not dedicating any resources to disease treatment—or saving people already in the river. The problem with an upstream-only grant investment strategy is that it ignores the tyranny of today, the pressing need to address current health problems. The loss of health capital from ignoring the immediate needs of a community can be simply too great. By way of analogy, what if the health care system chose to provide only for smoking cessation and stopped providing services for smoking-related heart disease, cancer, and lung disease?

Assuming Medicaid expansion is implemented in Colorado, it will take time to go into effect and perhaps even longer to address the immediate health care needs of a currently ill patient. As important as having coverage is, it does not guarantee access to care. To address the vision of reducing health disparities, there will need to be additional grant investments in short-term strategies, even the support of direct health care service delivery.

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Some foundations seem uncomfortable with funding direct services. It is a logical concern: none of us has the resources to provide all the needed health care, and if we focused only on direct services we would never address the upstream determinants of health. And resources are consumed as the care is provided. Care delivered to a person in need, however, can have an immediate, profound impact on the health of the care recipient, and such benefit should not be discounted. Even when providing direct services, grant funding can be strategic and can lead to sustainable change. For example, funding the expansion of care services to uninsured patients is essential to the success of a clinic working to become a federally qualified health center. Grants that lead to sustainable increases in capacity, organizational resilience, or achieve

a tipping point are all strategic approaches to downstream services that can have an enduring impact on advancing the foundation's vision.

Finally, a balanced portfolio means filling in along the continuum between upstream and downstream strategies. I think of leadership development as this type of lower-risk, reliable-return initiative that bridges the gap between long-term, high-risk strategies and downstream service delivery projects. Leadership development to support health equity would be a logical strategy to consider. Many of these investments have a strong evidence base and track record of success. We should not shy away from funding strategies that have been found effective in other settings. In the investment analogy, these could represent fixed income investments, less risk for a known outcome. An example would be funding nurse home visitor programs for low-income Medicaid mothers; these programs have a good evidence base of positive health impact and cost savings. Balancing innovation and risk with evidence-based strategies with a high likelihood of success rounds out the investment portfolio and can improve advancing the work of a foundation.

Meeting the financial goals of a foundation through a balanced endowment investment strategy is essential for advancing the foundation's vision. Similarly, balancing the foundation's grantmaking portfolio between long-term, upstream, high-risk/return projects with downstream, more direct, lower-risk projects and other strategies with intermediate risk/return profiles can improve the ability to make meaningful impact on community health. We are looking for this balance as we consider our grantmaking strategies for the future. We still need to build our big idea strategies cognizant of the continuous changes facing us today with the dynamic health care environment. The challenges of becoming agile, nimble, and responsive to change while we pursue long-term strategies, such as policy change, represent yet another area of balance. Knowing how to build these dynamic grant programs will require ongoing scanning of the environment, close partnerships with our community grantees, strategies where our involvement continues substantially after the grants are awarded, and a commitment to ongoing strategic learning with a willingness to consider significant course corrections in the middle of a multiyear strategy. A balanced grantmaking portfolio should provide a strong basis for these challenges and opportunity for success.

SUGGESTED READING

Colorado Health Access Survey Reports: www.cohealthaccesssurvey.org/reports/

Invest in Results: The Story of The Colorado Trust's Nurse-Family Partnership & Invest in Kids Initiative: bit.ly/XXWgKE

The Colorado Trust's *Project Health Colorado* Campaign: bit.ly/WTSWAQ

REFERENCES

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Sommers, Benjamin D., Katherine Baicker, and Arnold M. Epstein, "Mortality and Access to Care among Adults after State Medicaid Expansions," *The New England Journal of Medicine* 367:1025-1034, September 13, 2012.