Taking Risks at a Critical Time

Conventional wisdom tells us that philanthropic dollars are the risk capital of society. But do foundations really live up to their bold, risk-taker self-image? Or, as one observer put it, do "foundations want to be bold, innovative, and at the cutting edge of world problems – just as long as the proposals served up to them are guaranteed" (Hooker 2001)? Tough times make risk taking difficult to contemplate. Yet, periods of uncertainty may call for unconventional thinking and action just as much as better times do – perhaps even more so. To remind foundations of their unique risk-taking potential, and of the reasons why they need to take those risks today, Grantmakers In Health chose *Taking Risks at a Critical Time* for its 2010 annual meeting theme.

This theme focuses directly on the challenges health funders are facing today when they have to balance fewer resources with greater internal and external needs. The economic crisis of the past year may have presented some opportunities, but it has also forced many foundations to make tough decisions about both their programs and internal operations. On one hand, there is less room for error. On the other hand, current circumstances call for bold action. Calculating risk in either case is not easy, but it is essential. The value of accepting calculated risks, and the downsides of not doing so, are the focus of this essay.

Be on the lookout for the following essays written specifically for the 2010 GIH annual meeting.

- "**Navigating Risk and Control in Creating Public Will to Eliminate Racial and Ethnic Disparities**" by Patricia Baker, President and CEO, Connecticut Health Foundation
- "**A Defining Moment for Health Philanthropy**" by Thomas David, Senior Strategist, Community Clinics Initiative, A Joint Project of Tides and The California Endowment
- "**Today's Risk Is Tomorrow's Convention**" by Karen Wolk Feinstein, President and CEO, Jewish Healthcare Foundation
- "**Taking Risks at a Critical Time: Partnering with Government to Improve Health**" by Phillip Gonzalez, Director of Grantmaking, Blue Cross Blue Shield of Massachusetts Foundation
- "**On Risk**" by Mark D. Smith, President and CEO, California HealthCare Foundation

PHILANTHROPY AND RISK TAKING: MADE FOR EACH OTHER?

Risk taking is more than simply taking on a challenge. Risks combine the uncertainty of challenges with the real possibility of loss. For organizations the loss could affect finances, such as a risky business venture; or reputation and community standing, like being associated with a high-profile failed project; or infrastructure, like the fallout from a board-CEO clash. Fear of the negative effect of losses drives most organizations to be risk averse.

Foundations are often idealistically viewed as being especially suited to take the risks that other organizations avoid. For instance, one author describes foundations as risk absorbers, investing where there is great uncertainty that an investment will yield a return and that actions will bring about intended benefits (Anheier 2009). Foundations are particularly seen as being better positioned to take risks than either government or business because of their independence from election politics and market considerations that make these sectors vulnerable, respectively. In fact, foundations are not immune from being hurt by risk taking, but risk taking plays out differently for philanthropy than it does for business and government. Understanding these differences both clarifies philanthropy's unique potential and underscores the importance of exercising it.

In business, risk taking is linked to rewards and is driven by the financial bottom line. Companies succeed by seeking risks, not by avoiding them, and companies that want large rewards have to be willing to expose themselves to risk. The most successful businesses of our time, from General Motors in the early part of the 20th century to the Microsofts, Walmarts, and Googles of today, have all risen to the top by finding particular risks that they are better at exploiting than their competitors are (Damodaran 2007).

Philanthropy, on the other hand, is driven not by profits or market share but by deeply embedded values, described by Susan Berresford (1999) as being generosity, experimentation, and respect for freedom. Being value-driven implies a much more complex relationship between organizational operating style and ultimate objectives than in the business world. Profit and loss, the best indicators of business performance, are generally absent in areas and fields where foundations operate (Anheier 2009). The bottom line does

not drive foundation decisionmaking or a foundation's assessment of an acceptable or unacceptable risk. Nor do foundations take risks in order to gain a competitive advantage over other organizations. Rather, the value of a risk to a foundation – at least in theory – derives from its relationship to the philanthropic goals the foundation wants to achieve.

Interestingly, being free from profit and loss considerations gives foundations more latitude than business to take risks, but foundations can also be more *risk averse* than business precisely because being successful does not require taking risks. A foundation can do the same thing year after year and consider itself to be successful, simply by defining success in conservative terms. This is a version of what has been termed "underperforming," by not taking substantial risks on behalf of change and innovation (Giloth and Gewirtz 2009). We will return to why this is a bad idea.

Compared to the public sector, foundations have the potential to take more risks because they are somewhat sheltered from political concerns. Elected officials who take chances that are not perceived as having a significant reward run the risk of being voted out of office. Other public officials are under scrutiny to show that they are spending tax money wisely, are eliminating wasteful and redundant programs, and are establishing clear accountability for government programs and agencies. Fiscal responsibility – which can quickly translate into risk avoidance – is considered a cornerstone of good governance.

Freed from government's vulnerability to external public pressure, philanthropy can work on complex problems that require sustained, highly targeted funding; that challenge the status quo; that strengthen essential but weak institutions; or that give voice to politically powerless communities (Lawry 2009). Foundations can fund issues that government cannot support or is reluctant to address, and can fund organizations that are not eligible for public funding. The organizational autonomy that foundations enjoy shelters them from the pressures of public accountability and the constraints of public financing. But this freedom, like being free from the pressure of making a profit, is a double-edged sword that can encourage risk taking but also lead to complacency. It can be tempting to focus on convening and consensus building – which can admittedly be challenging tasks – rather than being willing to take a stand and to exercise leadership in the face of vocal criticism.

ARE THERE GOOD REASONS FOR NOT TAKING RISKS?

The Chinese symbol for risk can be interpreted as being a combination of danger (crisis) and opportunity, representing both the downside and the upside of risk. The symbol suggests that any approach that focuses on minimizing risk exposure (or danger) will also reduce the potential for opportunity (Damodaran 2007). In other words, there is a risk to not taking risks. For foundations, not taking risks can spell missed opportunities to:

- tackle new or emerging problems,
- work with difficult or hard-to-reach populations,
- invest in new ways in communities and with community organizations,
- develop new relationships with other public and private funders,
- develop new organizational grantmaking strategies,
- increase foundation influence, and
- foster the ongoing education of trustees.

Missed opportunities matter because they are mechanisms by which foundations can evolve organizationally, address the root causes of community problems, leverage scarce funds, and improve on past programming. They are mechanisms for increasing effectiveness – both internally as a funding organization, and externally as a catalyst for social change.

There are several reasons why foundations are hesitant about taking risks:

- ***Focusing on Short-Term Measurable Impact Rather than Taking the Long View*** – Short-term projects of a year or two seem safe because they limit the foundation's financial investment. Moreover, grantees may reassuringly predict dramatic results within this short timeframe (Lawry 2009). But in reality – especially in the health arena – few problems turn around in the short term, and a foundation that expects measurable, positive results in just a year or two is destined to be disappointed. Long-term investments in health improvement are essential. Avoiding them because they are higher risk than short-term interventions simply denies the reality that health problems develop over years and have complex origins that relate to community conditions, individual behavior, and health care service delivery. Tackling the causes of ill health requires long-term support, even if grantmaking focuses on just one of the factors that contribute to the problem.
- ***Misinterpreting Failure*** – Because risky opportunities are untested, they are likely to have a higher rate of failure than conventional approaches. But is that a bad thing? Many observers of philanthropy assert that if a foundation's role is to invest in exploring new territory, then it must also be expected to fail. Indeed, some assert that unless a foundation grant portfolio includes a healthy proportion of failures, the foundation has not taken enough risks. It is simply substituting philanthropic money for government or market money and hence is not fulfilling

its societal role (Raymond 2002).

For some, failure goes hand-in-hand with taking risks and pursuing difficult tasks. If philanthropy never fails, it means no risks have been taken. If no risks have been taken, then the chance to produce high levels of social impact is off the table (Stannard-Stockton 2008). In the words of Warren Buffett, "You can bat a thousand in this game if you want to by doing nothing important. Or you'll bat something less than that if you take on the really tough problems" (Gates 2010).

Failure informed by self-reflection and evaluation can open the door to new insights and program strategies:

> Given the challenging social problems that foundations and our grantees try to solve, we should expect that we will often fail to achieve our shared aspirations. When this happens, we should seize the opportunity to understand the causes in order to improve our own performance and benefit others working in the field (Brest 2007).

Another writer observes, "While it may not have accomplished what was originally intended, [a] project may well have succeeded in accomplishing something wholly desirable even if unintended or unanticipated" (Hooker 2001).

- ***Over Reliance on Best Practices*** – It is understandable that foundations want to promote best practices and reproduce effective programs. Doing so reflects the assumption that social problems are common across diverse communities and that it is far more cost effective to systematically reproduce an effective solution to these problems than to continually reinvent the wheel. As an organizational strategy it is certainly preferable to uncritically questing after the latest thing and succumbing to fads.

  Even best practices and model programs have their pitfalls, however. The main one is that a practice or model that comes from the outside and was not developed by the local communities in which it is being replicated may not work out even if the prototype was successful. The conditions in which the program took shape can be quite different from those of the superficially similar community into which it is being introduced. Because replication is a complex task and "one size fits all" does not apply, successful efforts to bring social programs to scale have actually been limited (Summerville and Raley 2009).

  Thus, under the best of conditions, best practices and program replications have their limitations. But even if their success rate was high, it would be legitimate to ask how foundations will learn about other approaches that work if their only investment is in best practices and known program models (Pickett 2009). If risk is totally avoided in the search for guaranteed results, who will thoughtfully fund the "blasphemers, the innovators, the revolutionaries" (Raymond 2002)?

- ***Anxiety about the Regulatory Environment*** – Concerns about engaging in advocacy make many foundations gun shy about supporting certain organizations or issues. They may be worried about legal restrictions or about the political consequences of taking a side on an issue. In fact, while some legal restrictions exist, health funders have great flexibility to engage in the public policy process. Different rules apply to public charities (501(c)(3) organizations that meet certain requirements such as broad public funding support), private foundations (501(c)(3) with limited funding sources), and social welfare organizations (501(c)(4) organizations). In general, health funders may legally engage in a wide variety of activities related to advocacy and public policy (GIH 2009).

EXAMPLES OF RISK TAKING IN ACTION

The following examples illustrate successful risk taking at the local, regional, and state level to improve health. The Mabel Louise Riley Foundation's goal was the revitalization of the Dudley Street neighborhood in Boston, while The Dorothy Rider Pool Health Care Trust (Pool Trust) wanted to create a regional health authority in the Lehigh Valley of Pennsylvania, and the Blue Cross Blue Shield of Massachusetts Foundation wanted statewide health care reform. Risks they faced included loss of reputation, trustee fatigue, and the appearance of money going down the drain. All three foundations exhibited strong, sustained leadership; patience; and a willingness to use a variety of strategies to achieve their goals. Their stories demonstrate the value of taking the long view, learning from mistakes, and getting involved in public policy.

- ***Fostering Community Change*** – Community change, especially when it involves disrupting the status quo in support of residents, neighborhood leaders, organizations, and networks that need and deserve access to better chances and resources, is a high-risk enterprise. One of the most successful community development projects in the nation is the result of a foundation making the high-risk decision to not be in control. In 1984 the trustees of the Boston-based Mabel Louise Riley Foundation partnered with a few key nonprofit organizations to develop a plan to revitalize the Dudley Street neighborhood in a racially mixed section of Boston devastated by arson, disinvestment, neglect, and redlining practices.

  When the newly formed Dudley Street Neighborhood Initiative (DSNI) presented its plan at a public meeting the process fell apart. Neighborhood residents protested and balked at participating in the plan. They were upset that they had not been consulted during the development phase, and they demanded to know how many of the

foundation and nonprofit leaders lived in, and could therefore speak for, the community.

In response, the Riley Foundation's trustees discarded their original idea and began again, involving residents in every phase of the rebuilding plan. DSNI set up a new governing structure that gave residents a majority on the board, and the redevelopment process began with a $50,000 grant from the foundation.

One of DSNI's first successful community health projects was the *Don't Dump on Us* campaign. Recognizing the disproportionate impact of pollution and trash on poor communities, residents asked the U.S. Environmental Protection Agency to test soil samples in areas where refuse was being illegally dumped. They ultimately succeeded in getting the city to haul away trash and abandoned cars throughout the area. They were also able to get two illegal trash transfer sites closed. That process and the redevelopment work that followed required residents and community leaders to develop skills in organizing, policy development, fundraising, strategic planning, and coalition building. The foundation came to see itself as a resource for the community, not a leader of the initiative (GIH 2006). It has since contributed more than $10 million to projects in the Dudley neighborhood, continuing to the present day.

- ***Improving Regional Health*** – For the Pool Trust, risk taking was supporting the creation of the first regional health board in Pennsylvania, a state characterized by fragmented services and the dominance of local government. Achieving this goal meant sticking with the project for nine years, dipping into the muddy waters of local and state politics, investing more than ever before, and demonstrating boundless resourcefulness. To paraphrase one of the Pool Trust's program officers:

  > It was constantly kind of going into the toolbox, and okay, what are we pulling out today? Are we pulling out convening? Facilitating? Public policy work? Grantmaking? Leveraging? Partnering? Innovation? So we're constantly kind of going back to our little toolbox trying to pull little things out to keep this thing going….Once you get involved with this, there's just no walking away from it. They just keep pulling you back in (Dendas 2008).

  The long process began in 2000, with a feasibility study that the Pool Trust funded at the urging of the mayor of the city of Bethlehem. Through many ups and downs in the years that followed, the Pool Trust maintained its commitment to the project and worked creatively with local lawmakers, service providers, and nonprofit organizations to bring it to fruition. Challenges along the way included skepticism about the feasibility of a regional board, concerns about costs, and public health law. The Pool Trust's involvement included supporting service model studies, working with local legislators to revise an antiquated public health statute that had a "one in a million chance" of changing, and funding a local nonprofit to support community organizing and a campaign to build citizen support.

  After investing about $150,000 over the years for feasibility studies, business models, and outside consultants, the Pool Trust confronted a final, enormous financial hurdle. First, so that the new regional board could draw down more state funds and use less local funding, the Pool Trust developed a new funding model involving local hospitals that intertwined hospital charitable care and public health funds. Then, to seal the deal, the Pool Trust offered a $1-million challenge grant if Lehigh and Northampton counties could pass ordinances creating the regional board of health by December 31, 2007 (GIH 2008). The challenge was successful, and the new regional board held its first meeting in January 2009. Now, in partnership with the Two Rivers Health & Wellness Foundation, the Pool Trust has given the regional board a $1-million grant to support startup of the regional board. This funding will allow elected officials to move ahead with the project without drawing on severely limited public funds (Pool Trust 2009).

  The Pool Trust's extraordinary role in the Lehigh Valley story was recently recognized by the National Association of Local Boards of Health, which presented its 2009 President's Award to the foundation in recognition of its leadership in creating new partnerships between and among local governmental entities, community hospitals, businesses, civic organizations, and public health advocates (Pool Trust 2009).

- ***Health Care Reform in Massachusetts*** – All told, reform to expand health insurance coverage in Massachusetts was a 25-year process. The Blue Cross Blue Shield of Massachusetts Foundation (BCBSMA Foundation) was among many funders that supported the work of health care advocates to move health reform to the front of the state's agenda. Established in 2001 with the single purpose of expanding access to health care, BCBSMA Foundation's strategy from the start included grantmaking that would promote programmatic change while simultaneously advancing public policy (Community Catalyst 2009).

  Health reform in Massachusetts had its origins in the early 1980s when there was no consumer voice in the health policymaking process. In this period, the Villers Foundation and The Boston Foundation were among the pioneering funders that supported coalition building to give consumers a voice in health care. This funding resulted in the formation of new consumer advocacy organizations that utilized tactics such as policy advocacy, direct action, and grassroots organizing to win a seat at the

table in health care negotiations.

In 1988 Massachusetts passed its milestone Universal Health Care Law. This achievement was followed, however, by a severe economic downturn and the abandonment of support for health reform by political leaders and hospitals. The Nathan Cummings, Public Welfare, and Boston Globe foundations were among those that sustained momentum during this difficult period and through the 1990s.

In 2004, leveraging the work of these earlier funders, BCBSMA Foundation developed a three-year initiative called the Roadmap to Coverage to significantly expand health insurance coverage in Massachusetts. The initiative involved BCBSMA Foundation in meetings with members of the state legislature, and community and health care leadership, and included the commissioning of a series of reports. Using the report findings, an extensive and strategic process of engaging policymakers, stakeholders, and the media moved the policy debate forward. At the same time, the foundation made a significant and sustained investment in community organizing and advocacy (Community Catalyst 2009).

In 2006, after intense negotiations, Massachusetts passed comprehensive health reform legislation to provide affordable coverage for uninsured residents. Following this, BCBSMA Foundation commissioned polls and surveys on the effects of health care reform to inform the general public and policymakers about residents' concerns. This information proved to be so helpful that the state subsequently assumed responsibility for collecting it.

In recent years, BCBSMA Foundation has focused its funding efforts on policy analysis and grantmaking to ensure that policymakers, stakeholders, and the general public understand the challenges of implementation, which implementation projects are working, and where they need to be strengthened. Currently the foundation's primary policy initiative is Care Beyond Coverage, which focuses on identifying barriers to access beyond health insurance coverage and suggesting evidence-based policy solutions.

CONCLUSION: RISK, TRUST, AND HONESTY

An important lesson from these examples is that taking risks means trusting communities and community organizations. As one author puts it:

> We need to trust that they can identify and describe the issues and problems facing them and that they have much to contribute to the design of solutions. This, traditionally, has been a very hard trust for grantmakers to have, sometimes for very good reasons. There have been cases where it hasn't worked out very well…What are often needed are a good collaborative method and a lot of capacity building (Broadbent 2006).

Honesty is a critical element of trust. If funders are more honest about the risks they perceive in a project, it may encourage grantees to be more honest in turn about possible pitfalls ahead. More often, both sides downplay risk, hoping to convince their respective decisionmakers that the project is a sure bet. "Because they fear program officers and feel they must seduce them with beauty while concealing their flaws, grant seekers do not pursue a relationship with program officers built on trust" (Hooker 2001).

To take risks strategically and intentionally, and to learn from the experience, foundations must embrace transparency, accountability, and the philosophy that the lessons learned make risk taking worthwhile. For philanthropy, mistakes are part of the reward of grantmaking. Along with successes, they are an important opportunity to improve the design and implementation of social investments (Giloth and Gewirtz 2009).

Giloth and Gewirtz's "Philanthropy and Mistakes: An Untapped Resource" (2009) offers key points that underscore the value of risk taking, even when the originally desired outcome is not achieved:

- Sharing and leveraging lessons learned from mistakes can improve philanthropic investments and nonprofit performance.
- Philanthropic mistakes can be used to examine questions of mission, role, investment strategies, and implementation.
- By distinguishing between "constructive" and "nonconstructive" mistakes, attention can be focused on the factors that shape the outcomes for even the most well-designed investments.
- Sharing and reflecting upon mistakes can improve philanthropic capacities for anticipation, learning, and adaptation.

In conclusion, it is worthwhile to consider the challenge issued in Somerville and Setterberg's *Grassroots Philanthropy*. Drawing on one of philanthropy's grand goals – to achieve greatness – Somerville and Setterberg (2009) assert:

> The thought of failure terrifies most funders. With almost nothing to lose, grantmakers persistently embrace safe and predictable projects instead of untested, but promising, new ideas. They confuse bold action with recklessness. Imagine if this attitude prevailed in other aspects of American life. There would be no cell phones, no computers, no man on the moon, no *Declaration of Independence*, and perhaps no Columbus sailing across the perilous seas. Great achievements almost always involve calculated risks.

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Navigating Risk and Control in Creating Public Will to Eliminate Racial and Ethnic Health Disparities

PATRICIA BAKER, *President and CEO, Connecticut Health Foundation*

Connecticut is one of the wealthiest states in the country, but there are two Connecticuts, and in many African-American and Latino neighborhoods, poverty is high and health is poor. One goal of the Connecticut Health Foundation's (CT Health) 10-year strategic plan is to improve racial and ethnic health outcomes in these low-income communities.

In 2006 CT Health's strategic planning committee met to take a hard look at several disparities initiatives – workforce diversity, cultural competency, and community-based health promotion – in which the foundation had invested. Had they made a difference? Were racial and ethnic health outcomes likely to improve in coming years? The hard answer, especially to the latter question, was "No."

True, the foundation had funded good programs. There were pearls in its portfolio; staff and board had learned from the experience, and individuals had benefited. Still, as worthy as these efforts had been, because they were limited in scope and reach or were simply limited in their effectiveness, they had not substantially advanced the foundation's goal of reducing racial and ethnic health disparities.

So what *would* achieve that goal? After much thought and discussion, the strategic planning committee realized that the foundation needed to be more systematic and take the step of initiating a high-risk process in which it did not control the agenda, goals, or objectives.

The committee's conversation frequently returned to CT Health's Policy Panel on Racial and Ethnic Health Disparity, a 12-member group of state leaders from the public, private, and nonprofit sectors created in December 2003. The panel's 2005 report opened the door with policymakers, and what CT Health had found behind that door was instructive. While some of the state's greatest champions of the cause embraced the panel's recommendations for developing sound policy, they spoke of difficulty pursuing them, since many in elective office and power saw any discussion of health disparities as one that could polarize the legislature rather than bring it together.

The foundation needed to be more systematic and take the step of initiating a high-risk process in which it did not control the agenda, goals, or objectives.

If the champions were saying this, how much could CT Health really accomplish? It was a sobering thought that challenged the strategic planning committee's thinking regarding change – and the foundation's role as a change agent.

SHIFTING PUBLIC WILL

Committee members understood that without a shift in what was acceptable regarding health outcomes, racial and ethnic health disparities in Connecticut would persist and could grow even more disparate. They wanted racial and ethnic health disparities to be unacceptable, not only to CT Health and its grantees, but also to a critical mass of Connecticut residents and decisionmakers. They asked themselves, "If the results are to change, what conditions must exist and who has the power to affect change?" They knew that the shift required more than a neat program or a quick policy fix. The complexity of the issues demanded much more.

Ultimately, the bleary-eyed strategic planning committee concluded that sustainable, measurable change could occur only by shifting public attitudes and will, and by engaging a critical mass that demanded action.

It agreed that the effort should be led not by the foundation, but by the people who were most affected. The committee was willing to risk not being in control because of the importance of the moment. It reasoned that if the foundation did not seize the opportunity, Connecticut residents might not be willing to conduct a conversation about racial and ethnic health disparities until some time many years in the future.

DEFINING PUBLIC WILL

Once it took on the challenge of fostering public will to understand racial and ethnic health disparities and act to ameliorate them, the strategic planning committee was challenged with defining public will, defining success, and determining what to measure and where to start as a baseline. It defined public will as the expression of public sentiment or opinion through a set of efforts to educate, inform, or influence a particular segment of the public about racial and ethnic health disparities. The intent is having them support actions (or oppose actions that would have a detrimental effect on reducing disparities) at the programmatic, systemic, or policy level.

With the decision made to focus on building public will, CT Health now needed to outline a grantmaking strategy. It started with a baseline assessment, conducted by The Opportunity Agenda, that included a media content analysis, a telephone survey, focus groups, and legal research. The foundation also conducted one-on-one interviews and completed a social network map. The findings included the following:

➤ ***Media Coverage***

The assessment analyzed news coverage of racial and ethnic health disparities from 2002-2007 in the *Hartford Courant*, *Connecticut Post*, *Boston Globe*, *The New York Times*, and *Associated Press*. The analysis revealed little coverage of the topic. When there was coverage:

- 62 percent of articles cited health care costs and access as the cause of racial and ethnic health disparities. Many saw it as lack of health insurance.
- Other media stories attributed the issue to patient behavior or, as we often hear, "Why won't they take better care of themselves?"

When the media discussed solutions to health disparities:

- 64 percent cited health care as the source of the solution.
- 20 percent cited increased awareness.
- Only 15 percent cited systems change.

➤ ***Telephone Survey***

The telephone survey contacted 785 Connecticut respondents over age 18, with an oversampling of African Americans and Latinos. The survey found that:

- 85 percent of respondents saw health care costs as the greatest problem.
- 70 percent believed that disparity resulted from the poor being in worse health, which they attributed to lack of access.
- 52 percent believed that racial and ethnic minorities have equal opportunity for quality health care.
- 90 percent believed that everyone has a right to health care.

The findings from the media and telephone surveys reflect the public perception of racial and ethnic health disparities that CT Health continues to battle: disparities are seen as a poor person's problem. People of color even blame themselves for their health problems (I should eat better, take better care of myself, follow doctor's orders, etc.).

➤ ***Focus Groups***

The survey results identified specific groups to which efforts to build public will could be targeted,

including Latino voters, ages 25-34; politically moderate/independent white women, ages 25-34; and politically progressive white men, ages 21-34. These results were affirmed by the focus groups. Key findings from the focus groups included:

- identification of lacking or inadequate health insurance as the most important Connecticut health issue;
- uncertainty about the definition of health disparities (when asked about health equity, focus groups associated it with health savings accounts);
- skepticism among white respondents about the existence of disparities and concern about undocumented immigrants overburdening the health care system – individuals they saw as "undeserving"; and
- agreement among participants that the Internet was the most important channel of information on health issues, while providers, family, and friends were seen as the most trusted information source.

➤ ***Personal Interviews***

It is difficult to measure what individuals think and feel about racial and ethnic health disparities because how people feel about sensitive issues can be very different from what they articulate. Nonetheless, knowing that building public will boils down to fighting for the hearts and minds of the public, CT Health conducted numerous personal interviews. From them the foundation learned that a successful movement to build public will would have to:

- put a human face on the issue of disparities,
- tap into people's values, and
- deliver a unifying message with a clear agenda that could be acted on at both the local and state level.

➤ ***Social Network Mapping***

CT Health's social network mapping showed that the state lacked a hub of influence or specific focus of power, such as a group of leaders who could move public opinion or organize strong constituencies to affect change.

➤ ***From Prescriptive to Organic Solutions***

The overall message of the baseline assessment was that people in Connecticut did not understand racial and ethnic health disparities. This, coupled with the issue's complexity, showed the foundation that a multifactoral approach would be required – not a simple fix or simple "ask." For its initiative to be successful, CT Health knew it would have to support the development of clear messages that resonated with multiple populations, and that the approach would have to be inclusive, with multiple partners and constituencies.

To implement this strategy, CT Health recognized that it would have to move from the prescriptive (solutions from outside the group) to the organic (solutions from those most affected). Going beyond the comfort of discreet objectives (such as increasing the diversity of the health workforce) was unfamiliar territory, but the foundation was committed to shifting its approach in order to bring about systemic change.

Data collection is a key element of the public will initiative. Recent actions include:

- a grant to the Connecticut Department of Public Health to standardize over 27 databases, and include race and ethnicity in them, which will allow constituencies to track efforts;
- a foundation-initiated Community Health Data Scan for Connecticut that provides timely, accessible, accurate data (the scan has identified the metabolic syndrome as the emerging issue for everyone in the state, but clearly impacting African Americans, Latinos, and Native Americans at ever-growing rates);

- support for the NAACP to complete a report card on African-American health, which couples data with the public voice of those most affected; and
- seed funding for the Health Equity Index, which gives communities an in-depth assessment of their health, with a specific examination of equity.

In addition:

- CT Health's policy research on establishing Medicaid reimbursement for medical interpretation and funding of the medical interpretation coalition has provided a "win" and a glimpse of the possible.
- Investment in the documentary *The Deadliest Disease in America* gives a face to health disparities.
- Funding the Greater Hartford Interfaith Coalition for Equity and Justice strengthens the alignment of the faith community and the issue.

LEADERSHIP AND ORGANIZATION

Data collection is just one element of CT Health's initiative to build public will. The foundation recognizes that investments in communities to determine their destiny are the basis of an organic movement. Therefore, it is making major investments into leadership and organizing through support of a Health Leadership Fellows program and a leadership council.

When CT Health's fifth fellows class graduates in June 2010, a total of 100 midlevel professionals will have completed a 10-month program designed to improve and enhance their leadership skills and sharpen their focus on racial and ethnic health disparities. In effect, the state will have 100 new agents of change.

Meanwhile, the leadership council is just beginning with a 2009 grant to the Connecticut Conference of Churches that supports convening diverse opinion leaders from across the state and sectors, guiding them on ways to frame the issue and identifying an agenda for change.

Anger and frustration fuel passion, but to work consistently over time requires an aspiration, a dream, and belief of what is possible. Accordingly, the leadership council is charged with helping define the values that will rally critical numbers of people to achieve health justice. With support from the foundation, this frame and the agenda flowing from it will provide the blueprint for local communities to organize. The council will direct implementation of the agenda at the local level.

CT Health cannot predict what the rallying point for organizing will be. Nor can the foundation define the agenda, for it cannot be CT Health's agenda. Rather, the communities most affected will determine the agenda. The foundation, however, must participate, understanding that movement-building is a long-term investment. It is this movement that offers the promise of significant change.

A NEW VIEW OF COMMUNITY

As CT Health planned investments in local communities throughout Connecticut, the foundation had to acknowledge that the definition of community was shifting from hometowns and local geography to professional and social networks. This changing reality was reflected in both the findings of the foundation's social network mapping and in sentiments expressed in the individual interviews that were part of the baseline assessment.

Originally the foundation envisioned creating a central website to which grantees would steer readers and commenters. We now believe the most effective approach is to infiltrate media such as Facebook and Twitter. In a way, it is the basic tenet of organizing: go where the people are.

Using social media to increase awareness and action about health disparities will be challenging. This complex issue, unlike a political transaction, does not lend itself to a simple "ask." However, the foundation's hypothesis is that these communities represent an innovative, untapped, "can't-miss" – but high-risk – opportunity to foster change.

LETTING GO

With time, CT Health has learned that the Web functions as a true community, not just as a means of providing and obtaining basic information. It turns out that the questions to be addressed are similar to those in grassroots organizing:

- How will we get information and foster conversation about racial and ethnic health disparities?
- What are the issues to face and resolve when entertaining this virtual community?
- How do we plant the seeds to spark conversation, raise awareness, and move participants to action?

But there are important differences from community organizing as well, particularly because of the on-line medium's rapid-fire pace and atmosphere of anonymous free speech. With this aspect of the public will initiative, CT Health moved again into territory that required relinquishing control. Because the foundation would not be able to control on-line content, its reputation could suffer. Risks involved included:

- handling outrageous comments,
- ensuring that the conversation reflected the foundation's values, and
- deciding whether or not to engage if racist statements were posted.

The decision was made to accept the challenge. In the third quarter of 2009, CT Health awarded the Society for New Communications Research (SNCR) of San Jose, California, and its collaborating partner CRT/Tanaka, headquartered in Richmond, Virginia, a 15-month, $200,000 grant to create and implement a social media strategy to eliminate racial and ethnic health disparities in Connecticut.

SNCR is a global nonprofit research and education foundation and think tank. CRT/Tanaka is a public relations and marketing firm with extensive on-line, nonprofit, and health care expertise. The strategy will focus on inspiring participants to engage in on-line conversations related to health disparities elimination. We encourage other foundations to join us in developing this virtual community.

TAKING GREAT STRIDES

Since the strategic planning committee members first struggled with the concept of public will, CT Health and its partners have made significant strides. There are positive signs and opportunities for change. For example:

- The Connecticut NAACP, using a CT Health-funded report and working with others, has created a Connecticut Health Equity Commission.
- Health reform efforts – whether Connecticut's Health First Authority (created by the legislature in 2007 to study ways all state residents can access health care and health insurance coverage) or the present reform effort, SustiNet (passed into law in July 2009 to provide affordable health care coverage to 98 percent of Connecticut residents by 2014) – make reducing health disparities a primary objective.
- There is recognition of the need for medical interpretation to eliminate language barriers to effective health care and the responsibility of government and systems to provide this service.

The environment has changed and now many political leaders are willing to give public support to the debate regarding health disparities. This is an opportunity that cannot be lost. The public will effort must continue to build the critical mass of individuals who collectively declare health inequities unacceptable and who demand action. CT Health believes that over the next 10 years this public demand will lead to public actions, which will lead to health disparities reduction and ultimately improved health outcomes for populations of color.

Do we know the first action to be taken or indicator to be addressed? No. Neither can we blueprint this to outline the architecture or outcomes of the initiative. Yet the return – and the potential for real and lasting change – is too great not to pursue.

And the greatest return will be realized if we accept the risk of letting go.

A Defining Moment for Health Philanthropy

Thomas David, *Senior Strategist, Community Clinics Initiative*

We are living in extraordinary times. The events of the past 18 months are familiar to anyone who has not been lost on a remote island in the Pacific, but it is worth briefly enumerating some of the "highlights." We are mired in a recession unprecedented in scale and scope since the Great Depression. Nationally, unemployment is at 10 percent, not including those who remain uncounted as having dropped out of the labor force. Waves of foreclosures are displacing millions who thought they had achieved the American Dream of home ownership. State and local governments are facing record deficits, with the largest states particularly hard hit. California alone is currently facing a budget deficit of $20 billion for the coming fiscal year, which is anticipated to result in another round of painful cuts to frontline health care providers.

And while the stock market had a terrific year in 2009, most nonprofit organizations are bracing for worse times yet to come. The Nonprofit Finance Fund's survey of 1,000 nonprofit leaders in the first quarter of 2009 revealed that 93 percent of organizations serving vulnerable populations had seen increased demand for their services (up over 87 percent in 2008). Only 12 percent of those surveyed expected to operate in the black in 2009; just 16 percent anticipated being able to cover their expenses in 2009-2010. To cope, 48 percent were freezing hiring and salaries, 41 percent were reducing staff or salaries, and 43 percent were dipping into reserve funds. In addition to decreased foundation and government funding, 49 percent had also experienced reduced individual donations.

> ***The greatest danger in times of turbulence is not the turbulence; it is to act with yesterday's logic.***
>
> ***– Peter Drucker***

But not all is bleak. To forestall a global financial meltdown and jumpstart the economy, we have witnessed the rapid commitment of hundreds of billions of dollars by the federal government to bail out banks and other major financial institutions, as well as additional billions in "stimulus" funds to preserve and create jobs across the country. Federally Qualified Health Centers, for example, have received substantial stimulus checks, with significant additional funding yet to come for health information technology and capital expansion. No matter what one's political persuasion, that is risk taking on a massive scale. There is no guarantee that it will work as hoped, but the potential consequences of inaction were simply too terrible to contemplate.

Meanwhile, after years of inertia and political stalemate, there has been growing recognition nationwide that reforming the health care system is an essential element of our long-term national economic recovery and industrial competitiveness. Even if partisan politics succeeds in derailing national health insurance reform (up in the air at this writing), that will leave it to the states to craft their own local solutions because inaction is not a viable option. There will be implications for every corner of the system, with much left to be done to significantly improve quality while "bending the cost curve." It will also be a major undertaking to simply help the American people understand how any new legislation – whether national or local – will affect them.

For most health foundations, whose missions tend to focus on issues of access and improving health outcomes, I contend that this is exactly the moment for which they were created. It is unlikely that anyone's strategic plan had 2010 pegged as *the* year for decisive action, but here we are anyway. The context for our work has been neither so dire nor so promising in the lifetimes of most of our organizations. The way we choose to act will define us for years to come.

HOW WILL WE RESPOND?

Will we rise to this historic challenge and act boldly and decisively even though (*or precisely because*) the risks are great?

Or will we choose to hunker down, cut our grantmaking, trim staff and operating expenses, and focus on regrowing our endowments? After all, is it not the fiduciary responsibility of staff and trustees to protect the assets of the foundation?

I would argue that the latter course of action seems prudent, proper, and reasonable only if you have been watching the news with the sound turned off. But I also predict that is the way many health foundations are likely to act. We like to think of ourselves as underwriters of innovation and catalysts for change, but it is moments like this that reveal just how risk averse we really are.

Foundations like to think of themselves as unique entities. We all smile in knowing agreement when someone quips "when you've seen one foundation, you've seen one foundation." But we are remarkably similar under the skin when it comes to the most important characteristic of all: how we define and approach the stewardship of our assets.

It has been fascinating to hear how frequently boxing metaphors have been employed to describe the toll that the stock market has taken on foundation assets. It is common to hear foundation staff use phrases like "we took a hit," "we got our heads handed to us," and "we took a beating." It is as if foundations had been engaged in a disastrous titanic cage match with the forces of chaos, and our only sensible course of action is now to withdraw to the temple of healing for restoration of our powers.

It is at times like this that nonprofits, who like to think of foundations as allies in their struggles, have learned not to count on their friends when they need them most. You can sense the frustration in their voices as they describe the strain their organizations and communities are experiencing, and we actually feel justified responding with our boxing metaphors so that they will understand that foundations are hurting as well.

Of course, there is a valid rationale for that response. The magnitude of government cuts (a reported $30 million for developmental services in Maryland alone) simply cannot be addressed by foundations. All of the health foundations in California could spend down all their assets this coming year, and we would still barely make a dent in our state's projected deficit.

But there is also an unchallenged (at least not openly challenged) assumption underlying that response that tacitly pleads our special status. Should not the priority be to preserve foundation assets for future needs rather than to squander them on the crisis du jour? Even if we cut back our travel and do not get raises, it is seen more as symbolism than real sacrifice. And let us be honest, we are buffered from the worst of what is happening. There is no point in apologizing or feeling guilty for a privileged status that is obvious to all. Instead, I would like to see health foundations respond by taking on some real risks to put ourselves on the line in ways that might tangibly, rather than symbolically, benefit our nonprofit allies in their time of greatest need.

TAKING THE LONG VIEW

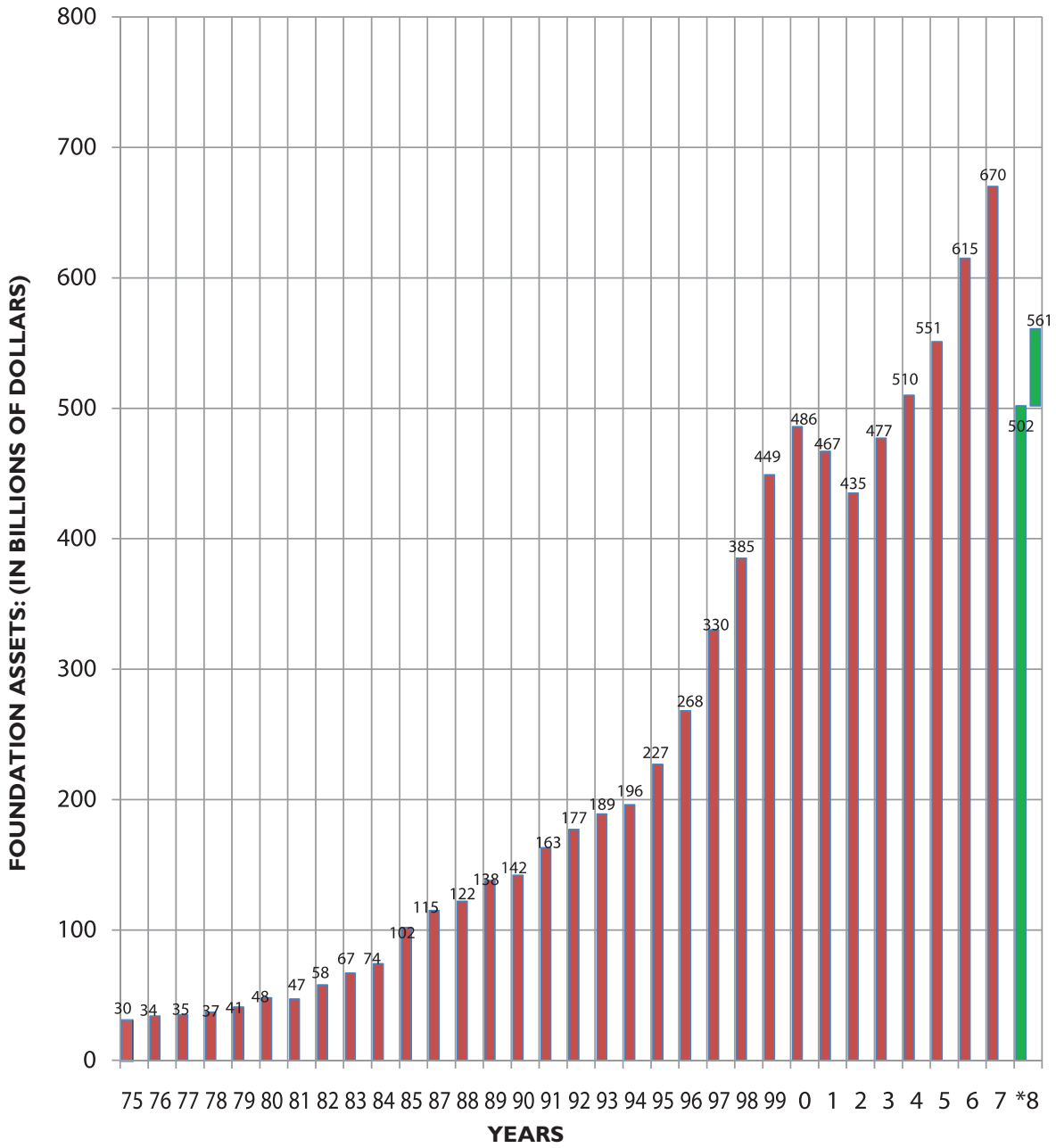
If there was ever evidence of the position of privilege that foundations occupy, it is that we could choose to put the narrow self-interest of our own financial replenishment ahead of the crisis in which nonprofits find themselves and the historic challenge this moment presents. Boards and their advisors rationalize such (in)action by the traditional stance that "we must take the long view and not be distracted by short-term events." I have sat through many discussions of long-term investment strategy over the years and am quite familiar with the argument (or should I say article of faith) that foundations must stick with a minimum 5 percent payout and not act rashly if they want to preserve their corpus in perpetuity. But I believe the time has come to challenge that thinking.

There is another way to take the long view, as illustrated in Figure 1. First, it is important to acknowledge the amazing growth in foundation assets that paralleled the great bull market of 1982-2000 (which

witnessed an average annual return for the S&P 500 of 19.5 percent). Certainly there were some downturns along the way, notably in 1987 and when the tech bubble burst in 2001-2002, but the overall trend has been inexorably upward. Even with the significant market decline in 2007-2008, foundation assets are more than four times greater now than they were just 20 years ago. I do not have comparable figures for just health foundations, but given the number of new health foundations created since the 1980s, I would expect the assets devoted to health philanthropy to have shown an even greater percentage increase in magnitude.

FIGURE1: FOUNDATION ASSETS 1975-2007

** Source: Lawrence and Mukai 2009*



** While final data is not yet available for 2008, The Commonwealth Fund provides two estimates of decreasing assets.*

** 2008 foundation estimates high and low projections.*

Perhaps that growth in assets has subtly altered our perspective in ways we do not even realize. It may be that instead of emboldening us, our relative wealth has actually made us even more risk averse. I had just accepted my first job in philanthropy shortly before the stock market crash in 1987. I had not yet reported for duty, and I nervously called my new boss to see if I still had a job. After all, the foundation's assets had just been diminished by 25 - 30 percent in the course of a couple of weeks. Surely that would affect their plans for the coming year. I cannot describe my relief when he told me, "We take the long view of these things. Sure, our assets are reduced on paper, but there's a still lot of work to be done, and we need you to help us do it." I wonder how many foundation CEOs would respond that way today?

Instead of fixating on how much they had "lost," foundations in those days looked back at the bleak stagflation years of the 1970s when their assets had barely appreciated for a decade. Their subsequent growth helped them put the events of 1987 in perspective. They used a different baseline for their calculation of the assets they felt they needed to preserve in order to do their work. As foundations have grown larger and larger, we seem to have adopted a "sliding" baseline more akin to a corporation's profit margin to gauge the adequacy of our assets. Viewed from the perspective of our colleagues of just 20 years ago, we have become financial institutions who have been stockpiling capital for an opportunity just like the one in which we find ourselves. Does our baseline keep moving up? Or do we look at our accumulated assets as providing a pool of dollars for risk taking at moments such as this?

EXAMINING FOUNDATION CULTURE

A true long-term perspective recognizes and acts on a historic moment such as this when it occurs. Before we can act, however, we need to confront our true feelings about risk. Most foundations do not think of themselves as risk averse. Indeed, we have historically justified our privileged tax status and minimal government regulation by arguing that we exist to stimulate creative solutions to social problems, that is to take risks that government cannot or will not take and at a scale at which most individual donors could not engage.

But if you talk with any randomly selected group of nonprofit executives "off the record," they quickly dispel the notion that most foundations are risk takers. In fact, they tend to use words like "stodgy," "overly bureaucratic," and "slow to act" to describe their foundation partners. That is unless we are talking about a project invented by the foundation itself. Then a different set of rules seems to apply.

What accounts for this disparity in perception? Foundations are circumscribed by a culture of their own creation that can provide a powerful distortion of reality as others see it. To paraphrase Marshall McLuhan's observation on the pervasive influence of culture, "The one thing fish know nothing about is water." Those of us who work in foundations swim in a very comfortable fishbowl that provides a clear but protected view of the world around us. The "water" in which we swim is rarely examined, at least by those of us who dwell in it. It is only when one of us has the opportunity (voluntarily or involuntarily) to jump outside the bowl that we can begin to objectively analyze its contents.

Periodic broadsides from critics of foundation practices typically bounce harmlessly off our bowls like foam Nerf pellets. Even significant challenges to foundation dogma like those represented by new "spend-down" donors may cause some significant ripples on the surface but ultimately few vibrations in the depths…or cracks in the glass.

I have been asked numerous times over the years about why foundations are the way they are, and I have also spent a good deal of time trying to reflect on that question with my colleagues. Others have written at length on this topic, but I would like to offer a couple of observations about foundation culture that I believe are pertinent to the challenge of stimulating more risk taking.

In my view, foundations have evolved an institutional culture that combines aspects of banks and universities (one might argue some of the less sanguine aspects of both). The similarities to banks are obvious and logical since some foundations actually had their origins as funds administered by bank trustees. Both institutions steward large amounts of money that others outside the organization are striving to access. Both have highly developed policies and procedures to minimize risk and maximize reward. And, at least until

their misguided adventures in subprime lending were revealed in the recent financial crisis, banks were once viewed as the pinnacle of probity and prudent financial management. The common foundation terminology of "program officer, " "due diligence," and "docket" are all reminiscent of the role of "loan officer" and the process of loan approval in a financial institution.

Since many foundation presidents and staff have come from universities, they have also grafted onto banking culture a number of key cultural features of their institutions of origin. Chief among these is the now infamous "siloization" of the foundation by discipline and program area, akin to academic departments, with all the resultant competition for resources and attention…and lack of meaningful cross-silo communication and collaboration. Also central to academic culture is the refinement of written communications and the imperviousness to feedback from sources other than valued peers. Many foundations have implemented elaborate internal peer review processes to vet grant applications, and that requirement typically trumps any effort to move quickly on an opportunity. Foundations, like universities, are more likely to commission a study (or multiple studies) to inform their decisions rather than act in a way that might be perceived as precipitous.

There are also obviously positive cultural attributes that come from these institutional roots, such as commitment to high ethical and professional standards, thoroughness, and dedication to mission. But the culture that has evolved in the vast majority of foundations is also remarkably risk averse. While newcomers to the board or organization might notice it initially, it is amazing how quickly they can become socialized to the dominant culture. Of course, that has a lot to do with the kinds of people who are selected for positions on the board and staff. In my experience, those who have felt the most at odds with foundation institutional culture are people of color and others whose social class background is different from the upper-middle class values and style of the institution. These outsider-insiders can offer valuable insights into the self-limiting aspects of foundation culture, but that kind of feedback is rarely taken too seriously in my experience, despite most foundations' professed commitment to diversity.

THE SHADOW SIDE OF FOUNDATION CULTURE

There is also a darker side to serving as the steward of large sums of money. To borrow an analogy from J.R.R. Tolkien, it is almost as if a foundation CEO carries an invisible Ring of Power on a chain around her neck. It is a heavy but seductive burden, and even the pure of heart are not immune to its pull. Even though we are clear that it is not *our* money, the longer one bears the Ring, the power it exerts has an inexorable effect on one's thought processes. Over time, it is easy to become increasingly impervious to negative feedback and dismissive, perhaps even suspicious, of those who might question the Ring Bearer's judgment.

The influence wielded by investment committees of the board also reinforces the tendency to focus on *growing* the assets of the foundation. The competitive dynamic invoked by the desire to "beat the benchmarks" and "outperform our peers" subtly (and in some cases not so subtly) influences institutional policy to limit the dollars made available for grantmaking so as not to diminish the endowment. Particularly in times like these, when the book value of our investments has "taken a hit," there is a natural tendency to pull back and regrow what has been lost. If we equate power and prestige with the size of our assets, then the preservation of those assets becomes the priority…and helps reinforce a risk-averse corporate culture, at least on the program side. The power of the Ring has the ability to dull the senses to the larger charitable purposes of the organization and to blind us to opportunities such as the ones that now lie before us.

As John Craig, Jr., executive vice president and COO of The Commonwealth Fund, observes in his excellent essay on "New Financial Realities" (2008), even while foundations have taken a conservative approach to spending in their grantmaking, they have been taking increasing risks on the investment side.

> …Drawing on the success of such major university endowments as that of Harvard, Yale and Princeton, sizable foundations have successively dialed down the once-traditional 60:40 allocation between equities and fixed income: first to 70:30 (1980s), and then to 80:20 or lower (1990s). In doing this, they substituted riskier holdings like venture capital, real estate, emerging-markets equities, energy, commodities, private equity, and hedge funds for conventional stocks and bonds –

> in the end, leaving barebones fixed-income allocations to ensure liquidity and bolster returns in the event of deflation. This model worked well through the second quarter of 2008 but faltered in the fall 2008 market collapse….

Craig goes on to list several pertinent lessons for foundation investment policies, which I do not have the space to enumerate here, but I highly recommend reading the entire piece.

This may be truer of big foundations than smaller foundations, but I suspect that the tacit pressure to grow the endowment has similar proportional consequences, no matter what the scale of the organization. And, to be fair, many foundations have responded to the run-up of their assets in recent years by increasing their grantmaking. According to the Council on Foundations, the average giving rate for U.S. foundations in 2007 (excluding most intramural spending) was 6.4 percent. But it remains to be seen how many will maintain that rate of giving over the next few critical years.

SEIZING THE OPPORTUNITY

Just as savvy investors always see opportunity, even in a down market, this is an ideal time for health foundations to seize the opportunities that lie before them on the grantmaking side. This is not a time for excessive caution; it is a moment that calls for bold, countercyclical thinking. I am not suggesting that health foundations should suddenly back away from current grant commitments in order to engage in large-scale inappropriate risk taking. But this is a propitious time to question those aspects of our organizational cultures that cause us to be so slow moving and risk averse, even at such a critical moment.

We should all ask ourselves why the largest single grant for advocacy on health reform ($10 million to the Health Care for America Now coalition) was made by a foundation (The Atlantic Philanthropies) that until recently was not even a U.S. health funder. What helped them see a historic opportunity and act so decisively? They are in spend-down mode, and that certainly may make them more prone to take risks. But even foundations that are committed to existing in perpetuity can take inspiration from their courage.

Not many health foundations have the resources to make a $10 million grant, but there are actions that each can take to examine our heretofore unchallenged beliefs about risk taking. Some might be uncomfortable with these suggestions, but they are offered in the spirit of respect for this field and its potential. Here are eight ways in which health foundations might transcend their traditional aversion to risk and lead in this time of turbulence:

- **Initiate an institution-wide conversation about risk.** Given the privileged status foundations enjoy among nonprofit organizations, one could argue that it is not only our prerogative, but also our obligation to take risks, particularly at a time like this, to advance our mission. What is getting in our way? Have we been willing to take risks on the investment side that we have not given our program staff license to take as well? What is an appropriate level of risk for an organization of our size and scope? If you want to really take the next step, share those thoughts with your grantees and colleagues and ask for their honest feedback and suggestions.
- **Recalibrate your endowment baseline**. Rather than constantly increasing your institutional definition of perpetuity to match your appreciating portfolio, look instead at the assets your organization began with. Then ask, what is an appropriate baseline for your endowment that allows your program staff the latitude to propose bold and decisive actions at moments of historic opportunity? Take an enlightened perspective on "the long view" to not only allow for, but encourage, such risk taking when warranted. Promote a broadened view of fiduciary responsibility that looks not only at perpetuity, but also to creative and effective pursuit of mission as equally important charges for board and staff.
- **Increase your grantmaking this year.** Even if you are one of those foundations already exceeding 6 percent in your grantmaking, this is not the time to cut back. Indeed, there is no more important message you could send to the field than you are increasing your grantmaking in this time of economic crisis. Frontline nonprofits are facing tough times over the next few years as state and local government funds contract and caseloads expand. Foundations may not be able to fill the gap, but they can keep from adding to the problem.

- **Ease up on control of your grantees.** One of the most disturbing trends in recent years is the increase in highly prescriptive grant agreements, onerous paperwork requirements, and other efforts by foundations to exert more control over the work of their grantees. Some of these actions skirt the boundaries of illegality. But at this time in particular, an important way foundations can demonstrate support for the plight of their grantees is to cut back on reporting requirements and even offer to renegotiate active grants to give organizations more flexibility to meet their short-term survival needs. It also hardly needs repeating that the most valued funding by any nonprofit is unrestricted core operating support. In my experience, it is the raw material out of which extraordinary things are spun.
- **Make some big bets.** Every foundation is funding some extraordinary leaders and organizations that have the potential to really make a difference if they had more resources at their disposal and could devote less of their time to the minutiae of fundraising. What if every year we made a few large bets on groups like that rather than continuing our usual practice of funding them repeatedly for relatively modest projects? What kind of creativity could be unleashed? I would wager that it is exactly these kinds of risks – investing big in proven leaders and performers – that will take you further toward fulfillment of your mission than any precisely crafted grants program you could invent in-house.
- **Get serious about mission-related investing.** This is a prime area where the academic side of our culture gets expressed. How many studies and consultants have been commissioned to advise foundations on this topic? How many committees have studied and stewed about options for years without ever putting more than a token amount of the foundation's assets on the line to really test this seemingly common sense notion? If I were a trustee, I would be far more willing to risk a subpar return on an investment that is attempting to save or create jobs or promote the general health of the community in which I live. Why is it considered so risky to use the foundation's endowment to complement its grantmaking? Certainly the kinds of high-priced investment advisors who nudge foundations to invest in derivatives or real estate investment trusts would not recommend this course of action. It is not in their self-interest to do so. But is this not exactly the kind of risk that foundations *should* be taking with their endowments? From what I hear, some "socially responsible" investments actually did quite well in the most recent market downturn.
- **Invest in advocacy.** If there was one single strategy to effectively represent consumer interests in the current health reform maelstrom, it is through significant support for advocacy. Vast sums are being expended by special interests to shape the pending (and one could argue overly complex) federal legislation to their ends. By comparison, the voice of underserved communities is a relative whisper. Yet when appropriately mobilized, consumers can significantly influence the actions of policymakers at every level of government. In my view, every health funder should support advocacy as part of its portfolio. There is a new generation of politically active and astute young people who would love to do consumer advocacy as their life's work if they could only find a job that pays them to do so. Meanwhile, health advocacy organizations are typically undercapitalized and produce results far in excess of the funding they receive. For boards interested in "bang for the buck" and maximum leverage for their limited grant dollars, I can think of no wiser programmatic investment.
- **Share what you are learning and thinking.** This may seem oddly out of place in a list of suggestions for risk taking by foundations, but I could not resist including it. Too many health foundations devote very little staff time or money to learning from their work and sharing those lessons both internally and with the field. Yes, there is a risk that someone might point at an unsuccessful foundation-funded venture and call its judgment into question. But I would much rather take that kind of risk than pass up on important opportunities to capitalize on the practical knowledge being created daily by foundations and their grantees. It takes an intentional effort to prioritize learning and to have a thick enough skin to publicly share results even when they do not live up to our initial expectations. How else can we expect our field to advance?

This list could be longer, but it offers an ample set of opportunities for health foundations to expand their comfort zone and become a bit less risk averse. Most of all, it is important that foundations resist the temptation to pull their heads and legs back into their shells like giant tortoises until they have fully recouped their paper losses in the recent market turbulence. Any single one of these actions would be a valuable step

in the direction of more appropriate risk taking; in combination they would demonstrate real leadership by health foundations at a time when it is most needed. As final words of encouragement, let me share these thoughts from two individuals who understood a bit about the importance of decisive action in turbulent times:

Now is the accepted time, not tomorrow,
not some more convenient season.
It is today that our best work can be done
and not some future day or future year…
– W.E.B. Du Bois

No matter how insignificant
what you do may seem,
it is important that you do it.
– Gandhi

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Today's Risk is Tomorrow's Convention

Karen Wolk Feinstein, Ph.D., *President and CEO, Jewish Healthcare Foundation*

As I reflect on risks taken at the Jewish Healthcare Foundation (JHF), I am struck with the timeliness of risk. Risk is of the moment; sometimes it is hard to translate into current reality the extent of risk taken at some previous date. That said, JHF was born of risk: we evolved from the sale of Pittsburgh's Jewish hospital becoming one of the first (poorly named) "conversion foundations," the assets of a beloved hospital converted into a foundation's endowment. Knowing not what "Jewish health" meant, we were free to draw on the tabula rasa.

The anguish, and sometimes outright anger, at the sale of the hospital by the Jewish community cannot be understood in contemporary terms. So many hospitals have been subsequently sold and the assets positively diverted. Somehow, our early staff team knew that we had to create something bold, energetic, and prescient to replace the cherished institution from whence we sprang. Embracing risk did not seem optional; it was adopted as a tribute to our origins in an innovative institution.

Born into turbulence, JHF has a taste for risk. We regard all times as worthy of addressing the unmet need, the controversial issue, the frontier thinking, and the hot topic. We regard this as any foundation's prerogative and, indeed, its mission. Blessed with a trusting and supportive governing board we have taken on large scale policy change; leveraged five dollars for every dollar spent; staffed up in expectation of major developments, hoping that funding would follow; challenged the medical status quo; and turned ourselves into a start-up, developing a bold new product to transform health care delivery. To draw attention to a worthy cause, I have personally dressed up as a tomato and a silent nun, spent time in a jail cell, walked four U.S. Senators through an intensive care unit, and appeared on talk shows with right-wing zealots.

Embracing risk did not seem optional; it was adopted as a tribute to our origins in an innovative institution.

Eschewing the traditional foundation models of the time, we aspired to be a "think, do, teach, and give" tank. We wanted to be all things: a center of research, program management, and education/training, while pursuing unconventional grantmaking. Our eclectic staff includes physicians, nurses, lab techs, health information technology experts, researchers and epidemiologists, data analysts, labor force economists, educators and trainers, a venture capitalist, former Capitol Hill staffers, and event planners.

We started off with signature initiatives. The first round of grants in 1991 included a massive measles-immunization campaign called KidShot. The intent was to immunize all children before school started in September. Eleven children had died of measles in Philadelphia in the spring, and Pittsburgh wanted to move fast. We enlisted Rotary, the county health department, and local hospitals as partners and set off for malls, community centers, and places where children gather to get the job done. We took out extra insurance to protect our assets! This was risk at a critical time.

The same first round of grants moved us to fund school-based health centers, a controversial action but most worthy. We also established a program with our local PBS station called *The Breast Test* to create public sentiment and advocacy among women for better funding of breast cancer research, better treatment, and more informed and collaborative decisionmaking. Most controversial was the publication of a guide to accredited mammography – some of our most prestigious institutions had equipment that did not pass inspection.

So, you get the picture. We wanted to establish that this was not a hands-off foundation. Remember, the year was 1991. The HIV/AIDS virus terrorized the public. We became the state's fiscal agent for AIDS funding in our region, developed a strategic plan for regional action to contain the virus, and made several grants to develop new organizations to manage the disease and support its victims. We have been leaders in AIDS funding, research, treatment, and program development to this day – and we remain the Pennsylvania's fiscal agent.

To make a lasting gift to the Jewish community, the home base of the hospital that created our endowment, we invested $35 million in a state-of-the-art continuum of care for seniors – a nursing village, assisted living center, hospice, meals on wheels, adult daycare, information central, and more. We supported new projects such as a Jewish residential center for mentally impaired adults, a kosher food pantry, and a new health center. Many of our investments were informed by a JHF-led community needs assessment project, the Healthy Jewish Community Project. All of these projects have been highly successful – worthy of our serious investment. Recently we have been exploring ways in which the Israeli health system, which is very advanced in primary care, can inform American reform.

Adding a component of patient empowerment, we built a consumer health movement in Pittsburgh by founding the Consumer Health Coalition and the western office of the Pennsylvania Health Law Project. We knew that these organizations had to be free to represent the consumer as vigorously as possible, so they were established as independent entities.

Within the foundation, we built our agenda to improve patient care and safety. Perhaps the biggest risk we have ever taken began in 1997. We focused on the serious system failures in health care: waste, errors, inefficiencies, and bad practices. Most importantly, we realized the enormous damage and pain caused as a consequence. Bringing to the public our awareness of the extent of harm (100,000+ preventable deaths, multiples in preventable injury) was risky; explaining the widespread culpability of all stakeholders in this tragedy even more so. The work began before the influential Institute of Medicine report *To Err is Human*. That established us as the Jeremiah of health care.

All times are alive with possibility for major transformative and positive change. It is up to us to seize the opportunity and embrace risk.

We understood that nothing less than a revolution, a health reform movement of extraordinary magnitude, would deliver the right care to every patient, every time, reliably. In 1998, with the blessing and sponsorship of our local corporate leadership, we formed the Pittsburgh Regional Health Initiative (PRHI), one of the world's first regional multistakeholder health care improvement organizations. We developed our own improvement process, Perfecting Patient Care. We established our own "four-day university" to teach this method, and set up numerous "champion" programs for nurses, doctors, pharmacists, graduate students, and others to test the method in practice. Controversial as our message was, our actions – teaching, coaching, researching, and testing – were intended to be scientifically rigorous and objective.

Stepping out ahead of the pack, taking on so monumental a set of problems, energized the foundation like nothing we had done before. It cemented partnerships that have withstood the test of time with our regional medical and hospital associations and local health leadership who have been at our side through the days of controversy to the present – when our message is accepted by every responsible person connected with health care. But, alas, that was not the case in the early days. It took courage to be a quality leader and to demonstrate to one's peers, and the broader community, how much potential existed to perfect our systems of care.

Our reward: numerous books, articles, television features, and media coverage heralding the wisdom of our early perceptions and solutions. Of course, the biggest reward is lives saved and pain averted. And perhaps the biggest tribute of all, the current national health reform debates. The question now is not: Is our health care system fundamentally flawed? It is: How do we fix a fundamentally flawed health care system

prone to error, waste, and bad practices routinely? How do we save lives and money by reforming payment and delivery? To that end, we have established a Center for Healthcare Quality and Payment Reform whose website has already been visited by tens of thousands of viewers.

Clearly, we were among the first, if not the first, foundation to devote so much time, money, and staff to perfecting patient care. We were the first foundation to experiment with the introduction of industrial systems improvement methods into health care settings. We championed the use of information technology in health care before the Office of the National Coordinator for Health Information Technology existed, and believe me, this was not popular. As an award, the Centers for Medicare and Medicaid Services did grant us one of their prized electronic health record demonstration grants that might bring $40 million to local, small independent primary care practitioners. We have traveled abroad to witness the frontiers of medically appropriate health information technology systems.

We established internally a program called Health Careers Futures to address the many workforce challenges facing health care: recruitment, education, retention, and promotion. We had no idea, initially, that creating a Summit on the Health Workforce of Tomorrow would lead to long-term engagement and leadership in this issue. But our homework for the summit disclosed the serious challenges ahead in assembling the highest quality workforce in sufficient quantity to meet demand. We help with retention in the volatile nursing home industry; we even have a Pathways project in partnership with the United Way to prepare and attract "marginal" high school students to health careers.

JHF's passion for improving the quality of health care has led us in interesting directions, some more controversial than others. Let us consider our long-term commitment to improve end-of-life care. We have activated all of our areas of endeavor to advance more humane, patient-centered care at end of life: funding a Chair at the University of Pittsburgh Medical School, establishing community conversational groupings around the topic, training graduate students in the health professions, and engaging in policy advocacy. When we knew that there was no hope of buying back our hospital and running it according to our Perfecting Patient Care standards, we applied for and received funds to start our own unique federally qualified health center (FQHC).

An interest in public health has taken us deep into women's heart health (Working Hearts initiative), breast cancer (*The Breast Test*); end of life (Closure); and eating disorders (The Problem with Food). These are outreach, education, and policy advocacy initiatives that we run ourselves. We attempt to move where the puck is going. We have engaged local providers in an accountable care network demonstration, and we are a regional coordinating center for FQHCs. Our longstanding love affair with FQHCs stems from a conviction that the model is simply the best way to deliver comprehensive, integrated care to populations with special health needs.

As you might guess, the atmosphere at JHF is one of a start-up company. In spite of our comfortable quarters, we like to think we are working out of a garage, attempting to create the next new thing – that magic lever that will change behavior, policy, and knowledge. Our current excitement is a web-based tool for health organization executives to transform the delivery of care. We are keen on bringing rapid corrective action to the problems and system failures that plague health care and cost us many lives and wasted resources. Over time, we have altered our focus, our staffing, and our arena for action to meet the current "crisis." Yes, yesterday's crisis is today's established issue. But all times are alive with possibility for major transformative and positive change. It is up to us to seize the opportunity and embrace risk.

Taking Risks at a Critical Time:
Partnering with Government to Improve Health

PHILLIP GONZALEZ, *Director of Grantmaking, Blue Cross Blue Shield of Massachusetts Foundation*

This is a critical time for health care and philanthropy. In the last year, Congress, consumer advocates, business interests, and others have sparred over how to reform our health care system so that many of the 42 million Americans without insurance can get coverage. As health foundations, we have a stake in how this debate is resolved. If reform is enacted, some of us will be funding implementation work and monitoring the impact of the new law. If no bill passes, or if the legislation is extremely limited in scope, health care reform will recede into the background, most likely overtaken by efforts to deal with the economy. Our work to improve the health of our communities will become even more difficult than it already is.

It is striking to note the one constant to the myriad responses to the health care debate: a deep skepticism that government exists to serve our collective interests. As the U.S. House of Representatives debated a health care reform bill last August, the public was gripped with the idea that the bill would establish "death panels" that would be charged with deciding who among the sickest would get to live. The "death panels" rumor persisted despite clear, factual evidence to the contrary. Much contributed to bringing this rumor to life (and is traced in an August 13, 2009 *New York Times* article titled "False 'Death Panel' Rumor Has Some Familiar Roots"), but surely public sentiment against "government control" that runs strong in all parts of the nation played a role.

While many of us are troubled by these fantastic pictures of government, we do not believe it is our problem to address. Or is it? At this critical time, we must ask ourselves: At what point does public mistrust of government – resulting in predictable calls for "less government"– begin to impede *our* work?

> ***At what point does public mistrust of government – resulting in predictable calls for "less government"– begin to impede our work?***

Think for a moment about the approach many of us take when we fund efforts to improve health care. A common tactic is to support an innovative effort that holds the potential to have great impact in solving a pressing problem. We then document the model and promote its sustainability through additional funding sources, replication, and system change in support of its adoption. Hopefully you are nodding as you read this over-simplified "theory of change," because it is the process you have more or less followed for many of the grants you have made over the years. This approach has had many notable successes over the years, as foundation initiatives like public libraries and the 911 emergency response system became part of our national infrastructure. But what happens to this approach if government is not nimble enough to embrace new ideas? Does the capacity to sustain wide-spread adoption of new models exist anywhere else? If we are honest, we have to admit that it does not.

So what *do* we need from government as a partner in implementing successful innovations in care delivery and improving health outcomes? What do individuals and organizations need from government to make our communities healthier? And how much information does the community have and need from government to do its work most effectively? All of us in philanthropy should be asking these questions, and the answers will vary greatly among health foundations. Requirements based on geography, multiple organizational missions and cultures, and a mix of strategic priorities mean that our relationship to government and all the other entities comprising the public sector is complex and dependent on local circumstances. And, of course, there is the policy advocacy variable: some foundations support policy work and are much more comfortable

with an overt focus on creating change within the public sector. Many others do not engage in such work and do not see themselves as engaging much with the public sector.

Regardless of where your foundation falls on this spectrum, there is much we all can do to improve the chances that the public sector will be the resource we need. The Blue Cross Blue Shield of Massachusetts Foundation, where I work, is considered to be very policy oriented. When the foundation was established in 2001, its mission – which continues to this day – was to expand access to health care. The foundation's board included several individuals who had served in government, and at their first meeting the board immediately recognized the limits of the foundation's resources when contrasted with the state's $3.5 billion Medicaid budget. They instinctively knew that to maximize the foundation's impact, it needed to leverage additional resources by focusing on public policy.

Many of you may know the work of our foundation from the role we played leading up to passage of Massachusetts' health care reform in 2006. We sponsored research that helped inform the debate over what measures should be included in the law. Our health care "summits" were seminal events for learning about and discussing key aspects of reform. We funded consumer advocates who brought the voices of low-income and vulnerable state residents to the policymaking table. Since the passage of the state's health care reform law, we have continued to sponsor research, convene key players, and promote advocacy in monitoring the implementation of the law.

Collectively, foundations are a link between vulnerable populations and key decisionmakers in our communities.

While we are an example of a foundation with a strong focus on policy and advocacy, there is more we can do to foster constructive relationships between decisionmakers and the community. For example, our most recent round of health care disparities grants supports coalitions comprised of community organizations and health care providers. As these coalitions have planned their projects, they have defined the changes coalition members can make to help reduce disparities. They have also begun to define some changes that require action by decisionmakers in the public sector. Despite our knowledge of policy change and advocacy, we must now learn how to build the capacity of these coalitions to engage the public sector so they can achieve maximum impact.

Then there are foundations that do no policy work or do not see themselves as having strong relationships with the public sector. Regardless of why that is, these foundations can still help themselves without having to adopt a formal, strategic policy agenda. Say there is a foundation working to increase the number of children who have access to dental care in a specific community. This kind of effort does not require a focus on policy change to have a positive impact. However, the foundation's staff members probably communicate regularly with school officials, clergy, business leaders, health care providers, and the heads of other local organizations. With these kinds of connections the foundation likely has the relationships to bring decisionmakers and community members together to discuss their roles and common interest in better access to dental care. It may not be necessary to do this for the immediate success of the project, but over the long term this kind of convening can serve many purposes. It can provide an opportunity to build positive relationships between the community and decisionmakers, as well as helping define expectations about the project's sustainability.

Collectively, foundations are a link between vulnerable populations and key decisionmakers in our communities. There are many ways in which we serve as this bridge. It is critical that we make the most of our opportunities to enhance the impact of our work. Most states are now facing massive budget problems and structural deficits. Health care costs continue to rise and provider shortages promise to limit access to health care in all parts of the nation. Whatever your preferred solution to these and many other problems, the public sector must play a role in devising those solutions. And government's ability to address these issues, and embrace the solutions we are testing and proving with our grants, is jeopardized by massive budget deficits and a lack of trust from the general public. If we need government to assist with public and private sector adoption of our grant-funded innovations, then we must rethink how we – and our

communities – relate to government.

Fostering positive relationships between community members, providers, business leaders, community organizers, and public officials is essential for improving government's ability to build community health. The following examples from the Blue Cross Blue Shield of Massachusetts Foundation show what such work can look like.

- During site visits and other meetings with grantees, foundation staff regularly discuss the status of health reform implementation. The conversation incorporates research sponsored by the foundation, insights gained at meetings and conferences the foundation staff attend, and from the frontline perspective of the grantees. The goals of these discussions are to understand what has been accomplished to date, to identify the upcoming challenges of reform, and to discuss how it could be improved. An essential part of this conversation is avoiding the assignment of blame and focusing on how the common interests of the foundation, the government agencies involved, and grantees can best address the needs in the community.
- As a new health insurer was beginning to provide a more limited version of subsidized coverage to legal immigrants at the end of 2009, we convened a meeting among grantees who work with legal immigrants, key public officials, and the head of the new insurer for a daylong meeting. The purpose of the meeting was to give those working with legal immigrants an opportunity to better understand the new coverage plan and provide them with an opportunity to directly ask questions of the new insurer and public officials responsible for implementing the plan. While the session had significant moments of tension among participants, those who attended gave it high marks. In the evaluation form filled out by attendees, one wrote: "Communication between the decisionmakers and the people affected by those decisions is critical if we are really working toward preventive care." Another noted, "Learning about the legislative part of this decision made it clearer to me."
- In 2006 we funded a community advocacy group that wanted to measure how much low-income residents could afford to spend on health care. Although much policy work had been done in this area, it looked at families from the 30,000-foot level. By contrast, our grantee met with individuals in their homes and collected detailed information about family budgets: how much was spent on basics like food, rent, utilities, and transportation to work. The resulting data gave a concrete picture of what families realistically could – and could not – afford on health care premiums and prescription drug coverage. The process helped those families understand why and how the government was working to define the "affordability" of health coverage. The data was eventually shared with policymakers working on affordability standards for health plan cost sharing.

As readily witnessed in the debates over issues such as national health reform, many in our nation mistrust government or are unwilling to bear the cost of having a well-resourced and proactive government. And while each one of us may have reasons to be skeptical of government, we in philanthropy cannot sit idly while others clamor to limit and diminish government. Rather, we need government to have the capacity to embrace and adopt good ideas. Whether or not you fund direct policy advocacy, all health foundations need to consider the role government can play in achieving their goals.

On Risk

Mark D. Smith, M.D., M.B.A., *President and CEO, California HealthCare Foundation*

As part of their overall strategic deliberations, all foundations must at some point tackle a fundamental question: How much risk are we willing to take? (Here I mean *programmatic*, not investment, risk: How prepared are we to make a grant with a significant chance of not achieving its main objectives?)

The answer depends on many things. Each foundation has the obligation to decide for itself what strategy will best serve the public good. Some of the factors involved are outside the foundation's control: the organization's mission, donor intent, manner of formation, asset size, geographic focus, environment, existence of other philanthropic organizations, among others. Others are variables the foundation itself can influence: principally the size, skill set, and expertise of its staff and the composition of its board. One foundation may decide that its role is to sustain the not-for-profit organizations in its community; another may fund cutting-edge biomedical research. Appetite for risk is both an element in making such decisions and a consequence of them.

In the case of the California HealthCare Foundation (CHCF), we were born in 1996 as the smaller of two foundations created from the conversion of Blue Cross of California. Our first task was to monetize the stock of WellPoint Health Networks (the for-profit company created from the conversion) and to transfer 80 percent of the proceeds to our sister foundation, The California Endowment. The endowment signaled early that it intended to take a broad view of health care and focus on local communities throughout the state. Given its size and orientation, our founding board encouraged CHCF to take on at least some grants that were riskier than we might have liked had we been operating alone. This fact – that the organization has grown up along with, and in the shadow of, The California Endowment – has continued to play an important role in the consideration of our appetite for risk.

The composition of our early board also influenced its approach to risk. Many of the members had management and governance experience in the corporate world. After the debacle of Enron and the institution of Sarbanes-Oxley, corporate boards were being required to estimate their risks systematically. CHCF's board similarly urged us to develop a systematic characterization and estimation of the "risks" in our grantmaking. It was an expansion of the way we thought about our grants, but one we believed prudent and necessary in

FIGURE 1: ELEMENTS OF RISK

Definition of Risk: probability of failure to achieve desired outcomes

- ***Execution Risk***: How likely is the project to achieve its objectives?
  - Complexity
  - Challenges
  - Strength of project management and operations capabilities
- ***Environmental Risk***: How great is dependence on features of the environment that are out of the direct control of the team?
  - Political instability or lack of political will among policymakers
  - Major changes in law or policy that may affect the project
  - Dependence on the success of related projects, events, or grants
- ***Reputational Risk***: Could the project endanger CHCF's reputation as neutral, objective, and nonpartisan?
  - Controversial topic or project
  - Implications of grantee failure for CHCF's ability to achieve its objectives

the aftermath of the meltdown of companies whose risks clearly had not been well understood or managed. Our objective in making risk an explicit dimension of our grantmaking was not to minimize it; rather, we concluded that risk needed to be assessed, mitigated, and learned from.

RISK ASSESSMENT

> *A ship in harbor is safe – but that is not what ships are for.*
>
> *– John A. Shedd*

We realized early on in this endeavor that we could not generate an overall estimate of the foundation's risk taking without a more explicit definition of what we *meant* by risk and some way to assign values to individual projects and initiatives in order to develop a more systematic view. In the fall of 2007, a three-dimensional risk assessment framework was developed and incorporated into our peer review and board approval processes. The framework included a separate assessment for environmental, execution, and reputational risk elements. Each grantmaking project above $150,000 received an overall risk designation. The current version of this framework and their definitions are displayed in Figure 1.

As an illustration, consider a recent grant made by CHCF to the Annenberg School for Communication & Journalism at the University of Southern California. The grant created the California Healthcare Foundation Center for Health Journalism. Its purpose is to support the publication of in-depth reporting on state-focused health care issues. Its approach is to forge partnerships with traditional and emerging media and temporarily augment their staff with journalists who are experts in health care reporting. The project has already produced some striking results[1,2,3]. A four-page write-up presenting the proposal to the board concluded with an assessment of the risks associated with the grant (Figure 2).

FIGURE 2: RISK RATING / ISSUES FOR DISCUSSION

The overall risk of this project is medium.

Risk Rating	*Low*	*Medium*	*High*
Execution		***X***	
Environmental		***X***	
Reputational			***X***

- ***Execution Risk:*** The news business is in a state of turmoil and transition. Where in the past many journalists would likely not accept the notion of working with a foundation-funded effort, some are now open to it given the decline in resources. CHCF is particularly well-placed for this effort because its nonpartisan approach in many ways mirrors the way journalists see their role in society. However, as newspapers are focused on survival, many may be focused on the core business and too distracted to engage. Also, reductions in ad revenue translates into less space for stories, which could make placement more difficult.
- ***Environmental Risk:*** Traditional means of news distribution are being disrupted. Newspapers have served as an agenda-setting mechanism for most other media, including TV, radio, and on-line news. It would be important for the center to pay close attention to the shifting landscape and work with all players in the media space to assure its content has wide impact, as well as build its own hosting and dissemination abilities on-line.
- ***Reputational Risk:*** The industry is in survival mode and philanthropy is seen by some as a life raft. Yet it is entirely possible there could be a backlash against this kind of activity. Also, there is the potential the center could produce work critical of a CHCF grantee, partner, government official, or agency with which CHCF is working. That could harm CHCF's ability to work with those organizations. An advisory panel comprised largely of distinguished journalists would support the independence of the center and mitigate the risk of backlash against the foundation for the center's reporting, and also mitigate the potential risk of charges that CHCF was unduly interfering with the editorial decisions on the center.

FIGURE 3: DISTRIBUTION OF APPROVED FUNDS BY RISK

FY 2008-09 Board-Approved Projects ($26.3M in 25 projects)

	Program Area*			
RISK	**IFTU**	**BCDC**	**MPM**	**Total**
Low	0%	0%	17%	**17%**
Medium	9%	31%	4%	**44%**
High	33%	1%	5%	**39%**
Total	**43%**	**32%**	**26%**	**100%**

* **IFTU** = Innovations for the Underserved
BCDC = Better Chronic Disease Care
MPM = Market and Policy Monitor

At our board's annual retreat, it reviews grantmaking for the previous year and provides guidance for the year ahead. As part of that review the board considers staff reports on the grants devoted to each of our program areas and other efforts such as research and evaluation. Part of that review also considers the overall risk assessment of the grants, which it has approved. An example of this roll-up can be found in Figure 3.

RISK MITIGATION

> ***It's tough to make predictions, especially about the future.***
>
> ***– Yogi Berra***

We recognize that our risk assessments are far from scientific and necessarily somewhat subjective. But during our peer-review discussions of each major grant, the risk assessment focuses considerable attention and debate on this issue. It has become a useful way to identify what could go wrong with a grant and how we would attempt to limit the risks.

Accomplishing this requires not only advanced planning, but often *flexibility* as well because of our inability to predict the future.

Some foundations' strategies are based on long-term deep involvement with local communities and decades-long efforts such as economic development or the transformation of community infrastructure; ours is not. We focus almost entirely on the health care system and its financing, organization, and policy oversight. And our experience has been that economic and policy developments in this domain are extraordinarily difficult to predict beyond a year or two. Community health centers and hospitals are, for instance, subject to staff turnover, changes in reimbursement rates, new laws and regulations from every level of government, economic downturns and upticks, among others. As a result, we tend not to fund many long-term academic studies of interventions, especially when the study design involves comparing "intervention" and "control" groups that remain uncontaminated.

Of course, there is no one "right" number for foundations when considering their risk profile. A Major League Baseball player who gets a hit one-third of the time is headed to the Hall of Fame; a venture capitalist who hits it big one-fifth of the time will likely make a lot of money for his or her investors. As for CHCF, we would not be happy with a batting average of .340, let alone .200. But given our approach we would not be happy batting 1.000 either – that would probably mean that we were only investing in "sure things," and that is not consistent with how we see our role.

But if higher risks mean a higher chance of "failure," how do we make those failures productive? We think that we have three responsibilities in assessing our failures along with our successes: lessons for staff, lessons for the board, and the dissemination of lessons to the field.

STAFF LESSONS

> *Results! Why, man, I have gotten a lot of results. I know several thousand things that won't work.*
> *– Thomas Edison*

In 2008 CHCF began to convene internal sessions aimed at capturing and distilling key findings from foundation grantmaking – both successes and failures – in order to improve performance. We dedicated the first session to the question: What does it take to maximize the spread of best practices?

We are deeply involved with the health care delivery system in California. But our limited resources mean that our grants cannot directly touch more than a few provider settings. Therefore, much of our strategy relies on identifying promising interventions, implementing them on a small scale, and then facilitating their adoption or spread in new sites or populations. Evaluation staff compiled background materials summarizing the results of past projects, and the entire program staff met for three hours in small, cross-program workgroups to share experiences and grapple with issues related to spread. This session produced a number of guidelines for consideration by program staff developing projects targeting spread, including careful attention to the value proposition of the intervention from the perspective of the target audience, the role of "champions" and leaders at all levels (from line staff to executive), and the critical importance of peer-to-peer learning in those efforts. The session findings were documented in writing and have become a source of institutional knowledge for program staff. Subsequent sessions have focused on translating policy recommendations into action, working in partnership with the state, and sustainability models.

A number of risky grants whose outcomes were disappointing taught us to test out big, new ideas on a small scale first. For example, the Center for Health Journalism went through a 6-month pilot "proof of concept" phase before our board considered a major multiyear commitment.

Another result of our self-assessments is a commitment to do more frequent midcourse check-ins with grantees and encourage redirection and modification as appropriate. This approach is a bit at odds with many traditional evaluation methods, but we think it is more likely to produce success in the real world.

BOARD LESSONS

From the foundation's beginning we reported on closed-out grants to our board. Over time, as our grantmaking experience and portfolio grew, our staff and board decided to formalize this process to better inform the board's discussions of foundation strategy. In the spring of 2007, we began to complete what we call Results Reports for all board-approved projects when all related grants have closed. These reports are short summaries (no more than four pages) of accomplishments, challenges, evidence of impact, and lessons learned, and they ask program staff to compare the actual results of the project to results expected at the time of project approval. Our board has consistently told us that they find them extremely valuable.

In the spring of 2009, we conducted a review and synthesis of the 46 Results Reports completed to date, covering $49 million in foundation investments. A few key themes emerged from that review – hard-won lessons learned that cross content areas and program teams. For example, staff reported that initiatives were sometimes unrealistic in their scope and timeline, failing to allow sufficient time and flexibility to adjust to changing circumstances. Instead, the suggestion repeatedly emerged, we should adopt a phased approach to large and complex projects that would allow (some might say force) us to "pause and reflect" on progress to date and on the need for a midcourse correction. We shared this and other themes with the board at our annual retreat in 2009, resulting in an animated discussion.

We grappled, though, with how to involve the board in oversight of risky projects, especially since most of our board does not have deep personal expertise in health care. Eventually we developed and presented to each board member an "oversight tool" (Figure 4) that translated the themes into questions, and explicitly invited them to challenge staff to address these issues during the approval process – with the objective of engaging them as full partners in our effort to identify and mitigate risks.

FIGURE 4: BOARD OVERSIGHT TOOL

If the project...	Then ask us...
Is large, complex, and long-term	Has the project been separated into phases to learn from work to date and make midcourse adjustments
Depends on county government action	About incentives or levers to stimulate county action, e.g., executive champion or Board of Supervisors' commitment
Involves large-scale data analysis using untested data sets	How have the uncertainty and potential delays in obtaining, reformatting, and analyzing the data been addressed
Attempts to spread an intervention and encourage adoption	• Whether the value of the intervention has been considered from the perspective of leadership and staff, including incentives and barriers to adoption • About the role of peer learning in the project • Who would provide leadership at all levels – from organization to frontline staff • Whether widespread adoption of the proposed intervention is truly feasible, and what approaches we are taking to lower adoption cost (establishing standards, creating a "toolkit") • If timeline and outcomes are realistic
Targets policy change	• To define the specific policy outcomes • How results of the stakeholder analysis support the project's approach • How stakeholders would be engaged in identifying policy solutions

Even if a board of directors supports taking risks, it can be a test of fortitude for staff to respond. Staff may ask, "Is the board really serious?" or "Does the risk-taking appetite of one or two board members truly reflect the sentiment of the entire board?" These issues can only be tested by reporting both successes and failures to the board for its reaction. As our board chair has said, "Unless the board urges risks, it is harder for the staff to take them, no matter what they might say on the subject. Most institutions, and most people, tend to be risk averse. So it is important for a board to be quite specific about the need for a staff to take risks – and to repeat that admonition." He also points out that a board may have different appetites for taking different kinds of risk; the consequences of funding a project that does not produce high value results may be more easily tolerated by the board – or some members of the board – than reputational risks.

DISSEMINATION TO THE FIELD

It is emotionally difficult and professionally humbling to acknowledge failures – let alone broadcast them. And there are political dangers here, too. Given the tremendous demands for resources for health and social services, foundations understandably face criticism for "wasting" money when concrete immediate needs go unmet. One of the strengths of philanthropy, and one of the privileges working in this field, is the ability to try new things and to fail without being turned out of office, going bankrupt, failing to get tenure, or any of a number of negative consequences in other lines of work. But if taking philanthropic risk leads inevitably to some level of failure, we should be sure to make them productive failures. The privilege of grantmaking is

accompanied by a reciprocal responsibility to extract every possible lesson from our efforts so that we and others can benefit from them.

This is easier said than done. It is often intellectually challenging to understand *why* something did not work; doing so successfully usually requires careful planning *before* a project starts. Complex controlled experimental designs are rarely practical (or affordable) for us, so creativity is required. There are a number of foundations whose efforts to scrupulously report strengths and weaknesses of their major investments are particularly noteworthy – The California Wellness Foundation, for instance, and its Reflections series come to mind[4]. We, too, have tried to make our failures productive ones. Perhaps the best example is our investment in the Santa Barbara Care Data Exchange, a multimillion dollar investment in a then-new form of technological interconnection allowing local health care providers to share patient information across various care settings. Indeed, it was the first example of what has come to be known as regional health information organizations. Although the effort was ultimately unsuccessful, it revealed for the first time a number of significant lessons about the political, business, and operational challenges of exchanging patient data in the real world. CHCF commissioned several research papers, which we disseminated widely, and supported a special section in the journal *Health Affairs*, which reviewed the history of this effort and included an independent evaluation, commentaries by participants and experts in the field, and a foundation perspective on the experience – warts and all[5,6,7,8]. Even though the local project did not succeed, it helped put the concept of using technology to share health information on the map. The leader of that project, Dr. David Brailer, went on to become the first National Health Information Technology Coordinator.

All organizations, whether they choose to admit it or not, suffer losses at some point in their existence. In the investment world, risk is directly related to potential return – in theory. In practice, as we have seen in recent years, that is not necessarily the case. Nevertheless the economic risk/reward relationship holds broadly true – indeed, most foundations' investment committees acknowledge it in their asset allocation. But like smart businesspeople and smart politicians, smart foundation leaders can learn from failures though we do not seek them. In philanthropy, our work is rarely binary– win/lose or success/failure. By assessing the risks of a grant or initiative, mitigating them where possible, and sharing misfires with the wider community, the public is best served. In this way the failure of one philanthropic effort contributes a building block for future successes.

FOOTNOTES

1 http://www.fresnobee.com/diabetes/

2 http://www.santacruzsentinel.com/ci_14252716?IADID=Search-www.santacruzsentinel.com-www.santacruzsentinel.com

3 http://www.mercedsunstar.com/115/story/1282751.html?story_link=email_msg

4 http://www.calwellness.org/publications/reflections.htm

5 Miller, Robert H., and Bradley S. Miller, "The Santa Barbara County Care Data Exchange: What Happened?," *Health Affairs* 26(5):w568-w580, September/October 2007.

6 Brailer, David J., "From Santa Barbara To Washington: A Person's And A Nation's Journey Toward Portable Health Information," *Health Affairs* 26(5):w581-w588, September/October 2007.

7 Frohlich, Jonah, Sam Karp, Mark D. Smith, and Walter Sujansky, "Retrospective: Lessons Learned From The Santa Barbara Project And Their Implications For Health Information Exchange," *Health Affairs* 26(5):w589-w59, September/October 2007.

8 Holmquest, Donald L., "Another Lesson From Santa Barbara," *Health Affairs* 26(5):w592-w594, September/October 2007.