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Becoming Strategic: Finding Leverage Over the Social and Economic Determinants of Health

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Introduction

The defining legal feature of a foundation is that it expends its resources on charitable purposes. Most foundations, however, have an orientation that transcends charity. Steve Gunderson (2006), former president of the Council on Foundations, provided the following distinction between charity and philanthropy:

> Charity tends to be a short-term, emotional, immediate response, focused primarily on rescue and relief, whereas philanthropy is much more long-term, more strategic, focused on rebuilding. One of my colleagues says there is charity, which is good, and then there is problem-solving charity, which is called philanthropy, and I think that's the distinction I have tried to make. (para. 28)

More and more, the concept of philanthropy is associated with solving problems and with changing social conditions in ways that improve the well-being of people and communities. Along the same lines, foundations have become increasingly focused on generating measurable impact with their grantmaking. They are also taking fuller advantage of the nonfinancial assets available to them (e.g., knowledge, experience, reputational capital, influence over decision makers) in order to move into lines of work that lead more directly to change. This includes bringing public and political attention to critical problems, convening interagency groups to address complex challenges, providing education on policy issues, and building the capacity of organizations and people who are in a position to solve particular issues (Hamilton, Parzen, & Brown, 2004; Bernholz, Fulton, & Kasper, 2005; Easterling, 2011).

Key Points

- While a number of observers have offered advice to foundations on how to be more effective with the implementation, evaluation, and adaptation of their strategies, there is little guidance on how foundations should go about designing their strategies.
- This study fills that gap by analyzing the strategic thinking of health conversion foundations when they determined how they would address various social determinants of health. Based on interviews conducted with the leaders of 33 foundations across the U.S., we identified four strategic pathways: expanding and improving relevant services, creating more effective systems, changing policy, and encouraging more equitable power structures.
- In choosing a strategic pathway, a foundation is determining the type and degree of social change it wants to achieve. This choice should be aligned with the foundation's mission, values, philosophy, resources, and sphere of influence.

When a foundation shifts its orientation from making grants to generating impact, it may discover that it has entered a whole new world (Brown, 2012). The thinking and activity that are required to generate impact are strategic in nature, rather than transactional. Paul Brest (2015) contends that a foundation that adopts an outcomes orientation is by definition entering into the realm of strategic philanthropy.

Unpacking the Concept of Strategic Philanthropy

Drawing on the various definitions that exist in the literature (e.g., Porter & Kramer, 1999; Brest, 2012, 2015; Buteau, Buchanan, & Brock, 2009; Kramer, 2009; Patrizi & Heid Thompson, 2011; Kania, Kramer, & Russell, 2014; Easterling & Metz, 2016), we believe that a foundation needs to meet eight conditions in order to be considered "strategic":

1. Resources and effort are focused on a small number of issue areas and goals.
2. The foundation publicly commits itself to achieving these goals.
3. The goals are defined in measurable terms, so that it's possible to determine whether or not the goal has been achieved.
4. The foundation uses evidence and strategic analysis to develop a strategy that is capable of achieving its goals.
5. The strategy is clearly operationalized and fully implemented.
6. Mechanisms are put in place to evaluate how well the strategy has been implemented and the degree to which it is achieving its expectations, including the intended outcomes.
7. Drawing on those evaluation findings, the foundation reaches an informed assessment of where the strategy is and is not effective.
8. The strategy is adapted in light of evaluation and learning.

Becoming strategic requires time, commitment, in-depth analysis, hard choices, focused action, a host of complex skills, the ability to learn, and the willingness to let go of approaches that aren't working. A number of authors have described how foundations have come up short in carrying out the necessary tasks (e.g., Patrizi & Heid Thompson, 2011; Patrizi, Heid Thompson, Coffman, & Beer, 2013; Coffman, Beer, Patrizi, & Heid Thompson, 2013; Kania, Kramer, & Russell, 2014; Snow, Lynn, & Beer, 2015). Metz and Easterling (2016) present a summary of what too often does not happen:

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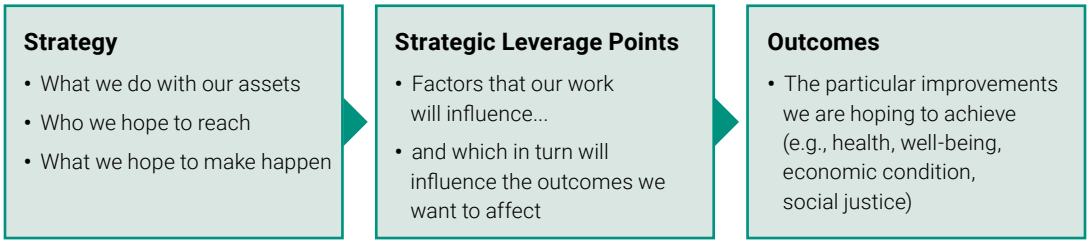
- The strategy is based on a weak or naïve theory of what is required for the intended outcomes to occur,
- The strategy fails to appreciate what the strategy requires with regard to new and different work on the part of the foundation,
- The foundation is overly confident in the willingness and ability of grantees and partner organizations to accomplish what the strategy expects of them,
- The foundation fails to carry out the work that the strategy requires, and
- The foundation fails to put in place procedures and systems that promote learning and the adaptation of the strategy.

The various authors cited above have coupled their critiques with a host of remedies designed to help foundations become more effective with

FIGURE 1 The General Form of a Strategic Pathway



the implementation, evaluation, and adaptation of their strategies. Our review of this literature, however, finds that little guidance is available to foundations on how they should go about designing a strategy that has the potential to achieve their goals. This article is intended to help fill that gap.

Our overarching recommendation with regard to strategy development is that staff and board need to conduct a more thoughtful, realistic, and research-informed analysis of what it will take for the foundation to achieve its goals. Such an analysis would pay particular attention to three strategic questions:

1. What are the factors that significantly influence the conditions we are hoping to improve?

2. Given our resources, experience, competencies, reputation, etc., which of these factors are we potentially in a position to influence?

3. What would we need to do in order to actually exert this influence?

These three questions guide the foundation in determining where and how it has strategic leverage over the issue it is attempting to influence. By intelligently and honestly answering these questions, the foundation will be in a position to develop a compelling theory of change and to determine exactly which resources and actions to bring into its strategy.

In answering these three questions a foundation is mapping out the strategic pathway through which the work it does can produce the outcomes it is seeking. (See Figure 1.) This figure emphasizes the role of strategic leverage points in determining the focus of strategy. A strategic leverage point is a factor that (1) exerts influence over the conditions that the foundation wants to change, and (2) is within the scope of the foundation's influence.

Foundations differ in terms of asset size, experience with grantmaking, skill sets of staff, and reputation and leadership profile within the community(ies) they serve. As a result, each foundation will have its own strategic pathways with leverage points that are specifically appropriate to the foundation. Finding those leverage points requires the foundation to embark on a journey to define who it is, what it wants to accomplish, and what it is willing and able to do in order to get there. To a great extent, the questions required to identify strategic leverage points are the same questions that Patton, Foote, and Radner (2015) pose in their methodology for developing a foundation's "theory of philanthropy."

Although every foundation needs to engage in its own exploratory process to determine its leverage points, there is much to be learned from other foundations that have taken the time to develop thoughtful strategies. This article presents examples of the strategic thinking that health conversion foundations engaged in when they determined how they would address various social determinants of health. Through interviews with the leaders of 33 foundations across the United States, we gained an understanding of the thinking that led to the decision to focus on social determinants of health, as well as the development of specific strategies. We found that these foundations are operating through a multitude of strategic pathways, but these pathways generally fall into four

categories: (1) expanding and improving relevant services, (2) creating more effective systems, (3) changing policy, and (4) encouraging more equitable power structures. Some strategic pathways involve incremental improvements in services and systems, while others involve more radical disruptions in how institutions operate and how society is structured. In the final sections of this article, we consider the question of how a foundation can develop a strategic pathway that fits with its mission, values, philosophy, resources, and sphere of influence.

Strategic Leverage for Health Conversion Foundations

The drive for outcomes is particularly pronounced among health conversion foundations (sometimes referred to as "health legacy foundations"). These foundations are created when a nonprofit health organization (e.g., hospital system, physician practice, health insurance plan) is involved in a sale, acquisition, merger, conversion, or other transaction that generates proceeds that need to remain in the nonprofit sector (Standish, 1998; Frost, 2001; Grantmakers in Health, 2005, 2017; Niggel & Brandon, 2014). The two most common scenarios are the conversion of a health plan (e.g., Blue Cross Blue Shield) from nonprofit to for-profit status and the sale of a nonprofit hospital or health system to a for-profit firm that is seeking to expand into a new market. When these sorts of transactions occur, the proceeds are typically used to create a new foundation that maintains the general mission of the nonprofit entity that was sold (i.e., improving or advancing the health of the population served by the entity).[1]

According to a recent census by Grantmakers in Health (GIH), there are at least 242 conversion foundations in the U.S. (GIH, 2017).[2] These foundations vary tremendously in their size and reach. At the high end are The California Endowment, the Colorado Health Foundation, Missouri Foundation for Health, Episcopal Foundation for Health in Texas, and Group Health Community Foundation in Washington state, each of which hold more than $1 billion in assets. While these large conversion foundations have attracted a great deal of public and political attention in recent years, it is important to recognize the resources and influence of small and medium-size conversion foundations, many of which are the dominant funder in their respective community.

More than family foundations and community foundations, conversion foundations tend toward strategic philanthropy. They specifically seek to achieve measurable improvements in health care, health status, and/or health equity.

More than family foundations and community foundations, conversion foundations tend toward strategic philanthropy. They specifically seek to achieve measurable improvements in health care, health status, and/or health equity. This strategic inclination is due to a variety of factors, including the specific nature of most conversion foundations' mission statements (focusing on the health of a particular region or population), the

[1] Another option is for the proceeds to be transferred to an existing foundation that serves the population served by the health organization that was sold or converted (e.g., a community foundation based in the same region as the health organization). A more complicated approach to handling the transaction is for the nonprofit health entity to stay in business but change its mission from delivering health care to making grants (i.e., disbursing funds derived from the sale or conversion).

[2] The Bridgespan Group produced a somewhat lower figure of 228 (Hussein & Collins, 2017), but Niggel and Brandon (2014) counted 306 conversion foundations as of 2010. The discrepancies reflect different search methods and differences in the criteria for counting a transaction. For example, there are differences of opinion as to whether an existing foundation that receives the proceeds from the sale of a nonprofit health organization should be viewed as a conversion foundation. Likewise, there is disagreement as to whether a "conversion" occurs when a nonprofit health organization is acquired by another nonprofit entity.

large degree of discretion that board and staff have over allocating grant funds (as opposed to community foundations with donor-advised funds), and the fact that most conversion foundations have been established at a time when there is an emphasis on strategic philanthropy.

On the other hand, it would be erroneous to assume that all conversion foundations operate with a strategic orientation. Some conversion foundations are more oriented toward serving as a local resource than an agent of change. This is especially true when the board is directly involved in individual grant decisions and its members bring in their own personal interests and perspectives. As in any other subsector of philanthropy, conversion foundations differ in terms of how much they aspire to be strategic.

Likewise, among those conversion foundations that do operate from a strategic orientation, there are different patterns as to when they became strategic. Because of who is on the board and/or who is hired as the first CEO, some conversion foundations begin with a strategic orientation. Others start out with a more open-ended approach to their grantmaking, but then move in a more strategic direction.

Easterling and Main (2016) describe how The Colorado Trust, one of the oldest conversion foundations, shifted to a more strategic orientation five years after embarking on a fairly scattershot approach to supporting health-oriented nonprofit organizations in the Denver region. The impetus for this shift came from the board, which consisted primarily of physicians and successful business leaders. In what turned out to be a seminal board retreat in 1990, one of the board members raised the clarion call of outcome-oriented philanthropy, namely, "How do we know we are making any difference with our money?" (Easterling & Main, 2016, p. 88). This question triggered a conversation that eventually led The Trust to make grants through multi-site initiatives with foundation-specified objectives and to invest significantly in evaluation.

The Colorado Trust's initiatives were developed in response to an environmental scan that pointed to a small number of strategic leverage points — factors that diminished the health of Coloradans and that the foundation was in a position to influence because of its resources, reputation, and expertise. A critical leverage point identified by the scan was a sense of disenfranchisement among residents throughout the state. Residents felt that they were not able to participate in critical decisions involving policy, resource allocation, and the design of programs and projects intended to improve health. According to the scan, this led to a perceived lack of control and a mismatch between the programs available in a community versus what local residents needed and valued (Colorado Trust, 1992). The foundation sought to change this situation — and in the process to improve health across the state — through a variety of community-based initiatives that created venues for local problem-solving and offered opportunities to build individual, organizational, and collective capacity (Easterling & Main, 2016). The most prominent of these was the Colorado Healthy Communities Initiative, which engaged broadly representative stakeholders in a 15-month process of visioning, assessment, planning, and consensus formation (Conner & Easterling, 2009).

Conversion foundations throughout the United States have similarly taken intentional steps to set a strategic direction that takes into account their resources, position, and values, as well as the needs and interests of the community that the foundation is serving. One of the specific ways in which they are demonstrating their strategic thinking is by turning their attention upstream to address the social determinants of health (SDOH). An ever-increasing body of research demonstrates that factors such as income, employment, housing, education, neighborhood conditions, political power, and social standing exert a powerful impact on one's health status and life expectancy (e.g., Williams & Collins, 1995; Pickett & Pearl, 2001; Wilkinson & Marmot, 2003; Braveman & Egerter, 2008; Braveman, Egerter, & Williams, 2011).

Conversion foundations are increasingly appreciating the critical role that social and economic conditions play in influencing the health of

individuals and communities, and in response are developing strategies to improve these conditions. This trend was highlighted by GIH in its September 2017 *GIH Bulletin*. Drawing on a recent survey of GIH's current and former board members, most of whom are either the CEO or vice president of a health conversion foundation, GIH President and CEO Faith Mitchell (2017) reported that several survey respondents "identified the social determinants of health as a primary challenge — now and in the future — for health philanthropy" (para. 3).

Many of the country's large statewide conversion foundations (e.g., The California Endowment, California Wellness Foundation, Colorado Health Foundation, Missouri Foundation for Health, Connecticut Health Foundation) are devoting major portions of their grantmaking portfolio to addressing upstream determinants of health, including poverty, education, and discrimination. The California Wellness Foundation (2018) presents the following rationale on its website:

> The Foundation's grantmaking is grounded in the social determinants of health research that states that where people live and work, their race and ethnicity, and their income can impact their health and wellness. It's the Foundation's desire to help "level the playing field" so that everyone has access to good-paying jobs, safe neighborhoods, and quality health care services. (para. 3)

Smaller health conversion foundations are also allocating more of their attention and resources toward improving social and economic conditions (Niggel, 2014). Conversion foundations with a local or regional service area are especially well suited to address social and economic determinants. They can tailor their grantmaking and other philanthropic resources to community-specific issues, conditions, and systems. In addition, locally and regionally oriented conversion foundations are often the dominant philanthropic institution in their communities. These foundations take advantage of their visibility and influence to stimulate new work and new ways of thinking that lead to improved community health, including more deliberate and strategic action on the social and economic determinants of health.

Conversion foundations with a local or regional service area are especially well suited to address social and economic determinants. They can tailor their grantmaking and other philanthropic resources to community-specific issues, conditions, and systems. In addition, locally and regionally oriented conversion foundations are often the dominant philanthropic institution in their communities.

By moving upstream and focusing on social and economic determinants, these foundations are operating from a more "strategic" vantage point. They are seeking to influence the factors that are at the root of poor health and health disparities. But deciding to focus resources and attention on a particular upstream determinant of health does not in itself constitute a strategic orientation. There remains the hard work of determining how to intervene effectively on those factors. Most social and economic determinants correspond to entrenched conditions, and as such are not easily changed. In order to be truly strategic and impactful, these foundations need to find and take advantage of specific opportunities to impact conditions such as poverty, unaffordable housing, poor-quality education, and unsafe neighborhoods.

Study of Health Conversion Foundations

In order to understand how foundations find this sort of leverage, we interviewed the leaders of 33 health conversion foundations that have a reputation for being strategic, especially with regard to the social determinants of health. These interviews asked about the strategic thinking that led to the decision to focus on social determinants, as well as how and why specific strategies were developed. We paid special attention to the question of what the foundation was seeking to make happen and the logic as to how this would pay off with regard to the outcomes it was seeking.

Our sampling frame for the study was health conversion foundations that were known to be investing in improving social and economic conditions through some combination of grantmaking, convening, advocacy and leadership work. Based on conversations with longtime observers of health philanthropy at GIH, the Robert Wood Johnson Foundation (RWJF), and other leading health foundations, we estimated that 40 to 50 conversion foundations across the country were intentionally focusing resources on SDOH at the time we initiated the study in September 2015, with many additional conversion foundations exploring the possibility of moving into this space. The study was intended to explore the approaches of a representative sample of the subset of conversion foundations that were focusing at least some of their resources on SDOH (as opposed to a representative sample of all conversion foundations).

In collaboration with the program officers at RWJF who oversaw this project, we determined that the study would seek a sample size of 25 to 30 conversion foundations. We also defined a set of stratification factors to take into account when selecting the sample. In particular, the sample needed to include foundations with funding regions of different scales (e.g., statewide, regional, local), with different levels of financial assets, and from different regions of the country. We also wanted to be sure to include those conversion foundations that were widely recognized as national leaders in developing ambitious and/or innovative SDOH strategies. Through a series of email exchanges, phone calls, and meetings with informants at RWJF, GIH, and the Kate B. Reynolds Charitable Trust, we were able to assemble a diverse list of 38 conversion foundations from across the country. All 38 were known to have made at least some grants to improve social and economic conditions.

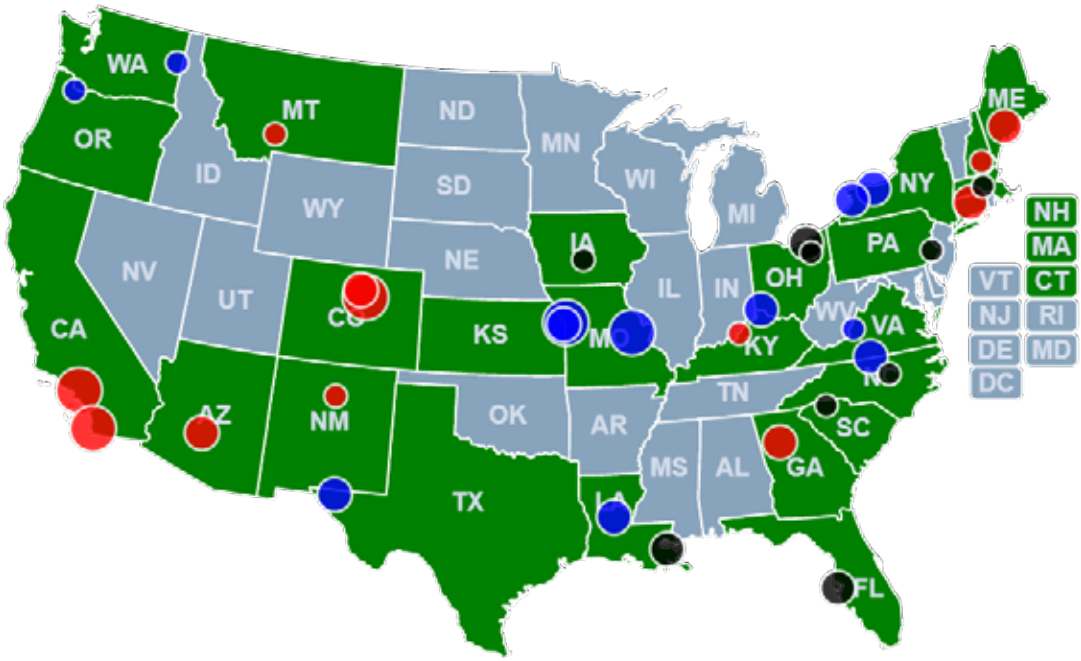
To each of these foundations, we emailed an invitation to participate to either the CEO or another foundation leader who was known to be central to the social-determinants work. If we did not hear back following our initial email, we followed up with additional emails and phone calls. Of the 38 foundations invited to participate, we were able to schedule interviews with leaders from 33 (an 87 percent participation rate). (See Appendix.)

For 21 of the 33 foundations in the study, we conducted a single interview with a single representative of the foundation. For eight of the foundations, we conducted a single interview with multiple representatives. And for the remaining four foundations, we conducted multiple interviews with different representatives. Altogether, we conducted 39 interviews and talked with 48 representatives. The CEO was interviewed for 27 of the foundations.

The 33 foundations are located in 25 states in all regions of the country. (See Figure 2.) Four of the foundations have funding regions that cross into multiple states, and one (the Paso del Norte Health Foundation) makes grants in both the U.S. and Juarez, Mexico.

The sample is diverse on a number of attributes beyond location. (See Table 1.) We included a mix of statewide foundations (12) and foundations that make grants within either a single county (nine) or a multicounty region (12). Looking at the level of assets, 13 of the foundations had less than $100 million, 15 had between $100 million and $500 million, and five had more than $500 million. The smallest foundation is the Con Alma Health Foundation, in New Mexico, with $25 million, while the largest is The California Endowment, with $3.7 billion. In terms of the foundations' tax status, most (23) were private foundations, with the remainder split between public charities (six) and social welfare

FIGURE 2 Geographic Distribution of Participating Foundations



Key

Black = Local
Blue = Multicounty
Red = Statewide

Small circle = Assets up to $100 million
Medium circle = Assets between $100 million and $500 million
Large circle = Assets over $500 million

organizations (four). The vast majority of the sample (28 of 33) were established between 1990 and 2009.

It is important to point out that our sample has a different profile than the overall population of health conversion foundations. Grantmakers in Health (2017) and Niggel and Brandon (2014) conducted separate censuses of the sector and reported how conversion foundations distribute on various characteristics. Based on those studies, we can conclude that our sample has proportionately more foundations with (1) statewide and multicounty funding regions, (2) assets over $100 million, and (3) private-foundation legal status. These "deviations" indicate what types of conversion foundations are most likely to be taking the lead in addressing social and economic determinants of health.

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

Interviews with foundation leaders were conducted between December 2015 and July 2016. These provided a fuller view of the nature of each foundation's strategy, how strategies were developed, what they were seeking to achieve, the underlying logic, and outcomes to date. We

TABLE 1 Characteristics of Participating Foundations

Characteristic	Number of Foundations	Percentage of Sample
Service Area		
Statewide	12	36.4%
Multicounty	12	36.3%
Single county	9	27.3%
Asset Size		
Less than $50 million	3	9.1%
$50 million to $100 million	10	30.3%
$100 million to $200 million	8	24.2%
$200 million to $500 million	7	21.2%
$500 million to $1 billion	2	6.1%
Over $1 billion	3	9.1%
Legal Entity		
501(c)(3) private foundation	23	69.7%
501(c)(3) public charity	6	18.2%
501(c)(4) social welfare organization	4	12.1%
Date Established		
Before 1990	3	9.1%
1990–1999	17	51.5%
2000–2009	11	33.3%
2010–2015	2	6.1%

elicited this information with an interview protocol that covered the following topics:

- the foundation's origins, history, mission;
- the interviewee's history with the foundation;
- how and why the foundation decided to focus on social determinants of health;
- which social and economic conditions the foundation is seeking to improve;
- strategic frameworks that guide the foundation's work;
- exemplar initiatives — intent, approach, results, lessons;
- observations and reflections on the foundation's larger body of work; and
- future directions for the foundation and for the larger field.

Interviews were transcribed and analyzed to characterize each foundation's strategic orientation, priority issues, and approach to achieving impact. We extracted quotes that reflect the foundation's orientation and strategies. These data were used to develop conceptual frameworks and typologies that depict the variation in approach we observed across foundations, particularly

with regard to strategic pathways and leverage points. Those frameworks and typologies were vetted with interviewees through follow-up email exchanges, as well as with participants at a breakout session at the 2017 annual GIH conference. The frameworks underwent significant revision and refinement based on the feedback from interviewees and conference participants.

Strategic Considerations in Pursuing an SDOH Approach

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

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

Regardless of whether the foundation was investing extensively in SDOH, the foundations in the study had all devoted considerable attention to the question of whether it was an appropriate strategic direction to pursue. The argument in favor of this approach is that social and economic factors are major drivers of health status — possibly even more influential than the availability, accessibility, and quality of health care.

For example, the Rapides Foundation, in Alexandria, Louisiana, contracted with Tulane University to conduct a community health assessment shortly after its founding in 1994. Based on that assessment, the board adopted a set of priorities that included not only health issues (health care access and health behaviors), but also social issues (education, economic development, and community development). The foundation has continued to focus on this mix of issues. According to Rapides' president, Joe Rosier, the foundation is currently allocating 40 percent of its grant funds to health care access and health behaviors, 40 percent to education (prekindergarten through grade 12) with an emphasis on increasing high school graduation rates, and 20 percent to community development in order to increase median income and civic engagement.

The Danville Regional Foundation (DRF), in Danville, Virginia, likewise chose from the outset to focus much of its grantmaking and community leadership work on education and economic development. From its beginning in 2005, DRF has emphasized the social context within which health is attained and maintained. This approach is reflected in the foundation's vision statement: DRF "envisions a thriving Dan River Region that works well for everyone" (Danville Regional Foundation, n.d., para.1). A large portion of the foundation's resources are focused on increasing educational attainment throughout the region. The foundation's president, Karl Stauber, told us: "Our original charter talks about economic development, health, education, workforce, and community capacity rather than simply a pure health orientation. We're trying to simultaneously create a new economy and new culture."

Our interviews showed that in addition to Rapides and DRF, a handful of other foundations (e.g., the Health Foundation of Central Massachusetts, the Mid-Iowa Health Foundation) honed in on social and economic determinants of health in developing their initial organizational strategies. Most of the foundations in the sample, however, adopted their SDOH approaches at a later stage of organizational development and learning. Amy Latham, vice president of philanthropy at the Colorado Health Foundation, described the evolution toward an SDOH approach:

> We learned from [our earlier place-based initiative] that we have to have a social-determinants lens

With health equity, the goal is not so much to improve the average health of a population, but rather to reduce the disparities in health that exist between different racial groups, different ethnic groups, different levels of wealth, and different geographic regions. Moreover, the intent is not so much to improve social and economic conditions throughout their region as it is to change the underlying structures in ways that create more opportunity for people who have historically been disenfranchised — and whose health has suffered as a consequence.

> when we approach any kind of community work. We learned that you can't influence the health of a community without talking about all the ways that the environment influences health, that poverty influences health, that civic engagement influences health.

Foundations that are committed to advancing health equity have an even stronger rationale for focusing on social and economic factors. With health equity, the goal is not so much to improve the average health of a population, but rather to reduce the disparities in health that exist between different racial groups, different ethnic groups, different levels of wealth, and different geographic regions (World Health Organization, 2010). For health-equity funders such as the Northwest Health Foundation, Con Alma, The Colorado Trust, and the Connecticut Health Foundation, operating on social and economic factors is essential. Moreover, the intent is not so much to improve social and economic conditions throughout their region as it is to change the underlying structures in ways that create more opportunity for people who have historically been disenfranchised — and whose health has suffered as a consequence. This work is inherently broad in scope, extending well beyond health and health care.

While the vast majority of the foundations in our study found ample justification to invest at least some of their philanthropic resources in improving social and economic conditions, it would be erroneous to conclude that this was an easy or straightforward decision. One of the most common concerns we heard in the interviews has to do with the breadth of social and economic issues that potentially warrant the foundation's attention. When a foundation expands its grantmaking to move beyond programs that advance "health" (narrowly defined), there is a risk that the foundation will become a go-to funder for all nonprofit organizations and government agencies in a community. More generally, moving into the arena of SDOH opens up the foundation to funding a much broader range of issues, which raises obvious challenges with regard to finding and maintaining a strategic focus. In order to operate in a truly strategic fashion, the foundation needs to define a limited number of specific SDOH issues where it will make a difference.

Another countervailing factor that discourages conversion foundations from investing in SDOH is the difficulty of influencing social and economic conditions. Most social and economic determinants correspond to entrenched conditions, and as such are not easily changed. Health foundations find it challenging enough to improve the availability, accessibility, and quality of health care. It can be even more daunting to improve job opportunities, the quality of schools, the fairness of the justice system, family

TABLE 2 Targets of Foundation Work on Social Determinants of Health

Domain	What conditions are foundations seeking to improve?
Community building	Increased civic engagement, improved sense of connectedness and trust, collective efficacy and ability to set communitywide goals
Educational success	Increased educational attainment and graduation rates, more educational opportunities, increased access to quality education
Parenting and early childhood	Parenting skills, healthy family environment, increased access to quality child care
Economic well-being	Increased job opportunities and workforce development; a growing, thriving economy that is enticing to business and entrepreneurs; increased homeownership and financial literacy
Built environment	Promotion of walkways, parks, trails, and exercise routes; conversion of former rail lines to exercise paths; more public spaces to encourage social interaction and healthy activity
Housing	More affordable and transitional housing, more independent living for seniors, reduced homelessness
Community safety	Violence prevention, criminal justice reform, better opportunities for re-entry among ex-offenders
Transportation	Transit-oriented urban development, expansion of transportation options to promote healthy activities and reduce traffic, increased availability of public transportation in underserved communities

circumstances, neighborhood conditions, housing options, transportation options, etc. One of our interviewees pointed to the difficulty of impacting these conditions as a rationale for not pursuing a SDOH approach:

> Our conclusion is that strategies to impact such social factors and their direct impact on health are not well established, or we can't find them. Or they are highly political, not evidence-based approaches. We know there is a relationship between social factors and health. The question is where does the foundation place itself in the chain of events.

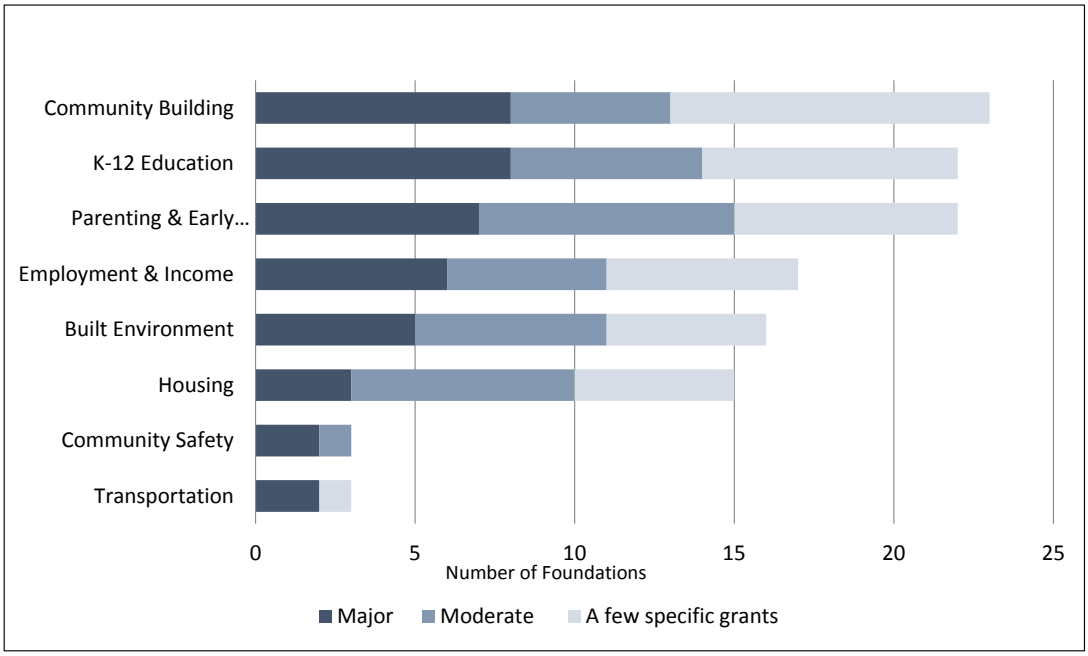
Which Changes in Social and Economic Conditions to Pursue

If a health foundation decides to adopt a SDOH approach, one of the first hard choices it faces is which social and economic factors are appropriate places to focus. While health is influenced by a broad array of social determinants, many of these are deeply rooted in historical, political, economic, and cultural contexts, and thus are difficult for foundations to influence. Health foundations face the added challenge that they often haven't established strong working relationships with the government and nonprofit organizations that focus on such SDOH issues as housing, transportation, economic development, civic engagement, and criminal justice.

Despite these challenges, the conversion foundations in our sample have in fact staked out specific SDOH issues where they believe they can stimulate positive change. These include increasing civic engagement, increasing high school graduation rates, reducing out-of-school suspensions, improving opportunities for job training, increasing access to quality child care, creating more transitional housing for the homeless, and making it easier for ex-offenders to re-enter their communities. (See Table 2.)

The foundations in our sample are trying to influence social and economic conditions in various ways; each is focusing on its own particular subset of issues. We assessed each foundation's SDOH portfolio by reviewing the grants and initiatives listed on the foundation's website and their work in eight domains. (See Figure 3.) We

FIGURE 3 Prevalence of Funding in Different Social-Determinant Areas



classified each foundation into one of the following categories: (1) no work in the domain, (2) a few isolated grants, (3) a "moderate" level of grantmaking (in terms of size and number), or (4) a "major" area of investment (either with multiple grants or a focused initiative).

Among our sample, the most popular domains for investment are community building, K-12 education, and parenting and early childhood; approximately two-thirds of the foundations in the sample are making at least some grants in these areas. The next tier contains economic well-being, the built environment, and housing. The two domains with the least investment are community safety and transportation. Only three foundations are investing in each of last two domains, but in each case two of the three are making what we regard to be "major" investments.

Strategic Pathways

By focusing philanthropic resources on social and economic conditions that are upstream of health, one might say that these health foundations in our sample are acting in a "strategic" fashion. To be truly strategic, however, the foundations also need to use their resources in ways that are capable of producing the SDOH-related outcomes they are seeking. This requires identifying and operating on factors that offer strategic leverage over the conditions they are trying to change. In other words, what can a health foundation do that will lead to the changes listed in Table 2?

In our interviews, we asked foundation leaders to describe key SDOH strategies with regard to (1) what the foundation was trying to accomplish, (2) the specific grantmaking and beyond-grantmaking approaches it was employing, and (3) the strategic pathways through which the foundation's resources and activities would generate the desired outcomes. Interviewees were generally able to answer all these questions in fairly specific terms. Nearly half of the foundations in the sample provided us with a logic model or theory of change that mapped out the foundation's assumptions of how change would occur.

While each foundation strategy has its own distinct pathway from inputs to impact, those pathways fall naturally into a smaller number of categories. For the foundations in our sample, the vast majority of strategies had pathways that fit into the following four categories (and sometimes into more than one category):

1. *Expand and/or improve programs and services.* Within this pathway, the foundation engages with key agencies, organizations, and institutions in the community that have programs and services capable of influencing the target condition (e.g., poverty, transportation, housing). Through grants, technical assistance, and other philanthropic resources, the foundation supports those organizations in enhancing their programming. This might include expanding the number of clients the organization is able to serve, adding new services, incorporating evidence-based practices, making services more culturally relevant, or offering training opportunities to staff. At a more macro level, the foundation might support organizational capacity building in areas such as fundraising, technology, strategic planning, leadership development, and succession planning. The foundation might also act proactively to establish a new organization that fills a void in the services available within the community.

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

3. *Create or change policies.* Any condition that a foundation seeks to improve will inevitably be influenced to at least some degree by policy at the federal, state, and/or local level. This includes both public policy (e.g., legislation) and the policies adopted by institutions (e.g., school districts, housing agencies, transportation districts, health systems, banks, employers) that have influence over a particular issue. Foundations can influence policy through a number of pathways, some more direct than others. This can include publicizing critical issues where policy change is needed, supporting

By focusing philanthropic resources on social and economic conditions that are upstream of health, one might say that these health foundations in our sample are acting in a "strategic" fashion. To be truly strategic, however, the foundations also need to use their resources in ways that are capable of producing the social determinants of health-related outcomes they are seeking.

Sector

TABLE 3 Foundation Initiatives That Illustrate the 4 Strategic Pathways

Strategic Pathway	Examples
Expand and improve relevant programs and services	*The Mary Black Foundation,* in Spartanburg, South Carolina, partnered with local agencies to develop a system to monitor and help child care centers increase the quality of care they offer and provide information to families about their options. Elements of this monitoring and improvement system have been adopted by the state.
	The Rapides Foundation, in Alexandria, Louisiana, is seeking to increase the readiness of preschool children for kindergarten and of high school students for employment and post-secondary education. A major focus is to increase professional development opportunities for teachers. Because there were no organizations in the region with the capacity to provide this training, the foundation created a new entity, the Orchard Foundation, to administer the training program.
	The Colorado Health Foundation, in Denver, made a major program-related investment to the Colorado Coalition for the Homeless to establish a revolving housing fund. This loan, at a favorable interest rate, allows the coalition to finance affordable housing projects, including the development of 500 units of permanent supportive housing for families and individuals by 2025.
	*The Health Foundation for Western & Central New York (*2015), based in Buffalo and Syracuse, established GetSET (Success in Extraordinary Times) to assist health and human service organizations in strengthening their strategies, operations, and structures. Each organization formulates a capacity-building plan and addresses key issues with training, consulting, and peer learning.
	The REACH Health Foundation, in Merriam, Kansas, introduced a Cultural Competency Initiative in 2009, which provided health and human service organizations in the Kansas City region with individualized technical assistance to improve their services to uninsured and underserved populations. This assistance included organizational assessment, coaching, policy development, change management, and peer learning. More than 60 organizations participate in a learning community (Cultural Competency Initiative, 2015).
Create higher functioning multiagency systems	*The HealthSpark Foundation,* in Colmar, Pennsylvania, convened and supported the Your Way Home coalition to reduce homelessness. The coalition developed and implemented a Homeless Prevention and Rapid Rehousing plan to end recurring and long-term homelessness in the community. The foundation's role included hiring a consultant to facilitate the process, researching best practices, and forming a learning community.
	The Health Foundation of Central Massachusetts, through its Synergy Initiative, provides financial resources, evaluation support, and structured planning to agencies that come together to solve a shared problem. The Together for Kids project focused on children being suspended from preschool because of behavioral issues. With the foundation's funding and active engagement, the group designed and implemented a program that significantly reduced suspensions. The foundation also supported policy analyses and advocacy work that were instrumental in persuading Massachusetts policymakers to fund the model statewide.
Create or change policies	*The Foundation for a Healthy Kentucky* supports policy change at both the state level, through advising legislators and leaders of government agencies, and the local level, through the dissemination of model legislation. This strategy includes research, education, coalition building, training community members in local advocacy, and statewide conferences and trainings to highlight issues and strengthen coalitions.
	The Con Alma Health Foundation, in Santa Fe, New Mexico, has publicized the detrimental effects of a proposal to downgrade the state's water quality standards, which would potentially affect wildlife, ranchers, and a number of indigenous communities that depend on the Pecos and Rio Grande rivers for drinking water. In addition to its own role in raising public awareness, the foundation funds Amigos Bravos (Con Alma Health Foundation, 2014) to organize political participation within the affected communities.
	The California Endowment, following the lead of students in the Building Health communities, created a multi-pronged awareness-raising and advocacy campaign to change school discipline policies in districts across the state. This has led to notable reductions in suspensions and expulsions.
Create more inclusive and responsive societal structures and institutions	*The Greater Rochester Health Foundation,* in upstate New York, uses a community-organizing strategy to improve the physical, social, and economic environments of neighborhoods. With its Neighborhood Health Status Improvement initiative, the foundation funded a community organizer position in 10 neighborhoods and rural communities throughout the region. The organizers are trained in the Asset-Based Community Development paradigm of Kretzman and McKnight (1993), which focuses on resident-led efforts to improve the quality of life by drawing on a community's own assets.
	The Northwest Health Foundation, based in Portland, Oregon, uses its position and reputation to enhance the influence of grassroots groups that are not yet connected to political structures. For example, the foundation hosted a high-profile dinner with the speaker of the Oregon House of Representatives as a means of providing an audience for a grassroots organization that had been unable to draw attention to its policy priorities.
	The Colorado Trust, based in Denver, uses a community-organizing approach to advanced health equity in communities across the state. The Trust hired community partners who organize local resident councils and facilitate the development of community-change strategies. The councils determine funding priorities for The Trust's grants to the community.

or carrying out studies that identify policy options, mobilizing public support for a particular policy, and disseminating model legislation or institutional policies. Foundations with a 501(c)(4) social welfare organization status are able to advocate more directly for specific policies through communications campaigns and conversations with policymakers.

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

We observed strong examples of all four of these strategic pathways within our sample of conversion foundations. (See Table 3.) One way to interpret this is that there are multiple subpathways within each of the four major pathways.

How Much Change Is the Foundation Seeking?

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

The conversion foundations in our sample are at different points in this "change spectrum." Some focus their attention on improving the programs and services that assist people in meeting their social and economic needs. Others are seeking to change how communities and society are organized, especially with regard to who has political and economic power. This latter group includes the foundations in the sample that have incorporated "health equity" into their mission or identity (e.g., Northwest Health, The Colorado Trust, Con Alma). These foundations are less focused on improving the overall health of a community or region than on increasing opportunity and seeking justice for groups that have been historically underserved, neglected, or discriminated against — particularly communities of color.

The Northwest Health Foundation is explicit in articulating the need to focus on changing the fundamental structures and systems that define society:

> Equity requires the intentional examination of systemic policies and practices that, even if they have the appearance of fairness, may, in effect, have the opposite result. Working toward equity requires an understanding of historical contexts and the active investment in social structures over time to ensure that all communities can experience their vision for health. (n.d., para. 3)

During our interview, Nichole Maher, the foundation's president, described what this perspective implies in terms of where and how they seek to catalyze change:

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

Any given strategy will have distinct requirements for how staff members do their jobs, how grants are made, how grantees are supported, how partnerships are entered into, how the foundation shows up in various venues, etc. The foundation needs to have the right policies, procedures, and organizational structure. And, perhaps most importantly, the foundation's staff members need to have the competencies and orientation that the strategy demands

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

Beyond changing institutions and policy, some foundations are working toward more fundamental shifts in the culture of communities and society more generally. Changing a culture means changing the norms, beliefs, and expectations that influence how people behave and interact with one another (Easterling & Millesen, 2015).

It is important to point out that it is not only health-equity funders who are striving for shifts in fundamental structures, systems, and culture. The Danville Regional Foundation is focusing specifically on changing the local culture as a core element of its strategy to transition the local economy beyond the dwindling textile and tobacco industries. Karl Stauber pointed specifically to the need to change the community's culture: "Creating a new economy is hard. Creating a new culture is even harder. We are talking about personal responsibility, talking about education as a key pathway to living-wage jobs, talking about growing living-wage jobs."

Implications for Foundations

This study provides foundations with guidance for strategic thinking, including answering the three strategy-design questions posed at the outset of this article. While the study examined a specific subset of foundations (conversion foundations that are addressing SDOH), we believe that many of the findings apply more generally to foundations seeking to become more strategic. The four strategic pathways identified here are relevant for generating philanthropic impact in virtually any domain.

Nearly all foundations are in a position to improve and expand existing services, but the demands are much higher when it comes to developing better functioning systems, changing community conditions, and, especially, changing fundamental social structures. Operating on these leverage points requires the foundation to have considerable influence over institutions and to play a disruptive role.

Once a foundation has set its strategic direction, identified the leverage points it will work through, and decided how it will use its various resources, it is critical to test how well the selected SDOH strategies actually fit within the organization. Any given strategy will have distinct requirements for how staff members do their jobs, how grants are made, how grantees

are supported, how partnerships are entered into, how the foundation shows up in various venues, etc. The foundation needs to have the right policies, procedures, and organizational structure. And, perhaps most importantly, the foundation's staff members need to have the competencies and orientation that the strategy demands (Easterling & Metz, 2016).

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

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

Some of the foundations in the sample have moved in dramatically different directions that require a completely different skill set on the part of staff. As part of its commitment to advancing health equity with a community development approach, The Colorado Trust reinvented its approach to grantmaking. This included disbanding the program department, dismissing all of the program officers, and hiring a cadre of "community partners" (Csuti & Barley, 2016). The partners operate with a community-organizing orientation, focusing specifically on the factors that lead to disparities in health and the underlying inequities in resources and opportunity. In various communities around the state, the partners recruit, organize, and support teams of residents, with the expectation that each team will develop a locally relevant strategy to improve health and advance health equity. Grantmaking on the part of The Trust is guided — even directed — by the resident team. During our interview, The Trust's president, Ned Calonge, indicated that these changes were in some ways predetermined by the foundation's commitment to community-based social change: "Community ownership depends on us changing our decision model and pushing decision making power out to the groups we hope will make change."

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

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

Conclusion

Becoming strategic is a challenging journey replete with complex tasks, existential questions, and awkward uncertainty. One of the most underappreciated tasks is to determine where the foundation is best positioned to generate impact. For the foundation to act in a strategic manner, it needs to thoughtfully apply its resources to factors that (1) exert influence over the outcomes that the foundation is hoping to achieve and (2) are within the scope of influence of the foundation. This is a high bar — more challenging than has been acknowledged in most writing on foundation strategy.

In exploring potential leverage points, it is important to recognize that the leverage points available to foundations are different from the leverage points of government agencies or organizations involved directly in service delivery — even though they are often seeking similar goals. As a rule, the amount of money that a local or state foundation has available for grantmaking is a small fraction of the budget of local and state government agency. And unlike

the organizations they fund, foundation staff do not directly improve the lives of specific people. But foundations do have a unique ability to influence key institutions, public discourse, and the manner in which people work together to solve problems and make the world a better place.

Some of the strategic pathways and sub-pathways identified here — especially improving programs and services, improving systems, building capacity, and supporting policy change — are well recognized within philanthropy. The idea of changing social and political structures involves less charted territory for foundations. Foundations such as The California Endowment, Con Alma, The Colorado Trust, and Northwest Health are venturing boldly into this territory. Their strategic analysis has led them to embrace the idea of being disruptive. Other foundations have been equally strategic in their analysis, but decided to focus on stimulating more incremental changes in services, organizations, and systems.

Are foundations truly able to change the economic, social, and political structures that organize society? Is this truly a leverage point that is available to foundations? What capacities does a foundation need to build among its staff and board to actually have this sort of influence? And is this a legitimate strategic direction for foundations to take? These are questions involving not only strategy, but also the business of philanthropy in the 21st century.

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APPENDIX Foundations Participating in the Study

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

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[1] Year that assets were released from sale or conversion.

[2] Grantmakers in Health, 2017.

[3] Taken from tax data reported by GuideStar tax forms; 2014 figures shown where 2015 figures not available.

[4] The Colorado Health Foundation changed its tax status from 501(c)(4) to a 501(c)(3) private foundation in 2016.

[5] The Health Foundation of Central Massachusetts serves Worcester County and the communities sharing the county border.

APPENDIX Foundations Participating in the Study (continued)

Name	Office Location	State(s)	Service Area	Year Est.[1]	Legal Entity	Assets (in millions)[2]	Annual Grantmaking 2015 (in millions)[3]
Missouri Foundation for Health	St. Louis	MO	Multicounty	2000	501(c)(4) social welfare organization	$1,079.8	$50.3
Montana Healthcare Foundation	Bozeman	MT	Statewide	2013	501(c)(3) private foundation	$61.6	$1.2
John Rex Endowment	Raleigh	NC	Single county	2000	501(c)(3) private foundation	$75.4	$3.3
Endowment for Health	Concord	NH	Statewide	1999	501(c)(3) private foundation	$85.3	$2.8
Con Alma Health Foundation	Santa Fe	NM	Statewide	2001	501(c)(3) private foundation	$25.1	$.6
Greater Rochester Health Foundation	Rochester	NY	Multicounty	2006	501(c)(3) private foundation	$238.8	$7.8
Health Foundation for Western & Central New York	Buffalo & Syracuse	NY	Multicounty	2000	501(c)(3) private foundation	$120.4	$2.5
Interact for Health	Cincinnati, OH	OH, IN, KY	Multicounty	1997	501(c)(4) social welfare organization	$218.4	$6.7
Saint Luke's Foundation of Cleveland	Cleveland	OH	Single county	1987	501(c)(3) private foundation	$178.9	$8.9
Sisters of Charity Foundation of Cleveland	Cleveland	OH	Single county	1995	501(c)(3) public charity	$93.0	$1.7
Northwest Health Foundation	Portland	OR, WA	Multicounty	1995	501(c)(4) social welfare organization	$50.0	$3.5
HealthSpark Foundation	Colmar	PA	Single county	2002	501(c)(3) private foundation	$45.6	$.5
Mary Black Foundation	Spartanburg	SC	Single county	1996	501(c)(3) private foundation	$80.5	$2.9
Paso del Norte Health Foundation	El Paso	TX, Mexico	Multicounty	1995	501(c)(3) private foundation	$227.2	$10.2
Danville Regional Foundation	Danville, VA	VA, NC	Multicounty	2005	501(c)(3) private foundation	$219.9	$5.7
Allegheny Foundation	Covington	VA	Multicounty	1995	501(c)(3) private foundation	$64.8	$5.0
Empire Health Foundation	Spokane	WA	Multicounty	2008	501(c)(3) private foundation	$77.5	$4.1