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The Cultivation Approach to Place-Based Philanthropy: Evaluation Findings from the Clinton Foundation's Community Health Transformation Initiative

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Reflective Practice

Introduction

As foundations become more ambitious in their aspirations for impact, they discover that they need to move beyond standard transactional grantmaking and take fuller advantage of the various forms of philanthropic capital available to them, including reputational, political, and social capital (Kramer, 2009; Ditkoff & Grindle, 2017).

These foundations are seeking to act as change agents through activities such as convening collaborative problem-solving efforts, strengthening networks, building organizational capacity, leadership development, policy advocacy, and raising issues on the public agenda (Hamilton, Parzen, & Brown, 2004; Bernholz, Fulton, & Kasper, 2005; Easterling, Smart, & McDuffee, 2016; Jellinek & Treanor, 2019). Rather than focusing attention and resources on specific grantees, some foundations adopt place-based approaches wherein they support multiple organizations within a community who are carrying out complementary, mutually reinforcing work (Brown et al., 2003; Kegler, Painter, Twiss, Aronson, & Norton, 2009; Connor & Easterling, 2009; Ferris & Hopkins, 2015).

Key Points

- Cultivation is a decentralized approach to place-based philanthropy where the foundation seeks to activate local stakeholders and assist them in translating their ideas into action. Rather than convening a strategic planning process, cultivation presumes that the seeds of high-payoff solutions are already circulating somewhere in the community. The foundation's role is to support local stakeholders in developing and implementing their own ideas in ways that produce meaningful impacts.
- This article describes the cultivation approaches taken by the Clinton Foundation, Kate B. Reynolds Charitable Trust, and The Colorado Health Foundation, and presents findings from an evaluation of the Clinton Foundation's Community Health Transformation model.
- Building on the results of this evaluation and our experience with all three foundations, we assess the potential of the cultivation approach and indicate how it complements collective impact.
- We also introduce a taxonomy of the six roles foundations play in place-based philanthropy, which is useful in clarifying intent and theory of change.

Place-Based Philanthropy

An increasing number of foundations refer to themselves as "place-based" funders, but there is considerable variability among these foundation with regard to philosophy and strategy. Some have a responsive orientation, investing their resources in attractive projects proposed by local nonprofit organizations in response to a request

for proposals (RFP) or more targeted invitations. Other foundations bring their own goals and values more directly into the community-change process. They might do this by introducing specific program models, by carrying out advocacy work, and/or by playing a leadership role in driving the process of community change. Most place-based foundations fall somewhere in between responsive and directive orientations, acting as a facilitator to help local stakeholders find and implement strategies that have the potential to address major community issues.

Many of the foundations that have a facilitative leadership orientation focus on collaborative problem-solving (Fawcett et al., 2018; Albert et al., 2011; Schwartz, Kelly, Cheadle, Pulver, & Solomon, 2018, Jenkins et al., 2004; Anderson et al., 2015; Easterling & McDuffee, 2018). The basic idea is to convene different organizations that are in a position to influence a major community issue that both the foundation and the community regard as crucial. Collaborative initiatives generally focus on complex, large-scale issues such as health care access, opioid misuse, obesity, and racial disparities in health outcomes — issues beyond the scope of influence of one organization.

In most of these initiatives, the funder supports an interagency coalition in developing a shared definition of the problem, setting a vision for success, analyzing the causes and consequences of the problem, and developing a collective strategy appropriate to the local context. This approach to place-based philanthropy has become more popular since the publication of John Kania and Mark Kramer's article on "collective impact" in 2011. When collaborative problem-solving initiatives succeed, the impacts can be profound (Lynn et al., 2018; Easterling & McDuffee, 2019). However, many of these initiatives have not produced tangible improvements in local conditions (Brown & Fiester, 2007; Kubisch, Auspos, Brown, & Dewar, 2010).

While collective impact presumes that high-payoff solutions emerge when agency leaders focus on a specific issue and engage in an intensive planning process, cultivation presumes that the seeds of high-payoff solutions are already circulating somewhere in the community.

Cultivating Solutions Throughout the Community

Because of the challenges associated with collaborative problem-solving, foundations such as the Kate B. Reynolds Charitable Trust, The Colorado Health Foundation (CHF), and the Clinton Foundation are experimenting with a "cultivation" approach to improving community health (Easterling & Smart, 2015; Benton-Clark, 2018; Easterling & Gesell, 2019). The cultivation approach is much more decentralized than collective impact. (See Table 1.) While collective impact presumes that high-payoff solutions emerge when agency leaders focus on a specific issue and engage in an intensive planning process, cultivation presumes that the seeds of high-payoff solutions are already circulating somewhere in the community. The foundation's role is to support local stakeholders in developing and implementing their own ideas in ways that are capable of producing meaningful impacts — meaningful both to those stakeholders and to the foundation.

Rather than convening an interagency coalition, cultivation calls for the foundation to play a constructive role in advancing the work that local stakeholders are either carrying out or contemplating. Foundation staff are deployed to selected communities to understand the local context,

TABLE 1
Comparison Between Collective Impact and Cultivation Approaches to Improving Community Health

Elements	Collective Impact Approach (Kania & Kramer, 2011)	Cultivation Approach (Easterling & Gesell, 2019; Easterling & Smart, 2015)
Premise	• Large-scale impact comes from better cross-sector coordination rather than the isolated intervention of individual organizations.	• Large-scale impact occurs when promising strategies emanating from the community reach their full potential. This requires focusing on sound ideas that have local momentum and translating them into effective actions. Foundations can use their resources and influence to stimulate and support this developmental process.
Where do health-improvement strategies come from?	• Centralized design and development of collective strategies by an interagency coalition	• Decentralized cultivation of ideas that community stakeholders have formulated but haven't fully developed or implemented
How do these strategies evolve?	• The coalition engages in an extensive strategic planning process and then implements key elements of the resulting plan. • Progress is gauged according to prespecified measures.	• Ideas are translated into concrete strategies, which are then implemented and evaluated. • Initial strategies are adapted and expanded based on experience. • Strategies become increasingly comprehensive through further learning and partnering.

How does the funder support this evolution?	• At a minimum, the foundation provides monetary support for the planning process, technical assistance, the backbone organization, and implementation of key elements of the strategy.
	• Foundations sometimes, but not always, do the following:
	  ○ Dictate the problem to be solved.
	  ○ Convene the coalition.
	  ○ Dictate which stakeholders need to be included.
	  ○ Participate directly in the planning process.
		• Foundation staff spend considerable time within the community to learn about issues of concern, build relationships with a wide range of stakeholders, and identify promising ideas.
		• Foundation staff encourage and advise multiple stakeholder groups to translate their ideas into action.
		• Consultants hired by the foundation support local groups with planning, analysis, advising, networking, etc.
		• Grants are used to activate, incentivize, and support project implementation.
		• Successive grants support more informed, ambitious, and strategic adaptations to the initial project.
		• Foundation staff and consultants broker partnerships between groups to foster more comprehensive strategies.

Who organizes and implements the work?	• The coalition sets the mission and goals, and then develops and monitors the strategy. • Organizations participating in the coalition implement relevant elements of the collective strategy. • The backbone organization manages the coalition, provides operational support, oversees measurement, and prepares reports for funders.	• Individuals and organizations cultivated by the foundation translate their ideas into action. • Multiple organizations design and implement specific projects, apply for grants, and report to funders. • Some projects may be designed and implemented by formal or informal networks, but the foundation does not convene networks.

engage with people who are interested in doing more to improve health, and assist them in developing and implementing projects that have the potential for large-scale impact. Once the foundation has selected promising prospects, it provides various forms of assistance (e.g., grants, consulting, training, facilitation) to support local stakeholders in developing and implementing their ideas, with special attention to ensuring that local actions achieve the intended outcomes.

Kate B. Reynolds Charitable Trust

To our knowledge, the cultivation approach to place-based philanthropy was initially defined by Doug Easterling and Allen Smart in 2011 when they developed the Healthy Places NC (HPNC) initiative of the Reynolds Trust.[1] Smart spelled out the rationale for HPNC in 2015, when he was serving as the vice president for programs and interim president of the trust:

> [We are] skeptical of a funder's ability to be effective in creating change and engaging people in rural communities when using traditional grantmaking. A top-down prescriptive model doesn't fit how people in these communities live and think, and whom they trust to help solve local issues. Grantmaking needs to foster and cultivate local assets, allowing change to come from within. (Smart, 2015, para. 4)

Under HPNC, the Trust is providing concentrated grant funding, technical assistance, leadership training, and a variety of other resources and opportunities to 10 rural counties identified by the North Carolina Department of Commerce as economically challenged. The counties were selected by the Trust based on population size, an analysis of local health issues, the capacity of local organizations, and geographic representation.

Once a county has been selected for HPNC, the initial steps of the cultivation process involve intensive exploration and relationship-building by the program officer assigned to that county. All program officers are based in Winston-Salem, where the Trust has its offices, but they spend four to eight days per month in their assigned counties. Operating in the mold of a community organizer or community development specialist, the program officers immerse themselves in their respective HPNC counties, getting to know a wide variety of people and organizations that might be interested in doing new work, while also learning firsthand how the local political, economic, and social systems operate. Through this reconnaissance, the program officers identify local stakeholders (including both established institutional leaders and emerging leaders) with an interest in leading new and/or expanded work that has the potential to improve the health of the community.

Initially HPNC was intended to stimulate and support community-based programs and projects that would address whichever health issues were most critical within the communities being supported. The Trust subsequently added an explicit goal around increasing health equity, which now informs both its grantmaking and the focus of the program officers' cultivation work (KBR, n.d.).

By offering the possibility of grants and, more generally, by encouraging and advising local actors, the program officers cultivate interest, ideas, projects, action, and, ultimately, community change and impact. The program officer's work is supplemented by a variety of additional resources provided by partner organizations commissioned by the Trust.

Colorado Health Foundation

The cultivation approach was transported from North Carolina to Colorado in 2015, when Karen McNeil-Miller left her position as CEO of the Reynolds Trust to become CEO of CHF. Upon her arrival, McNeil-Miller sent a clear signal that foundation staff would be spending much more time in community settings listening to a wide range of stakeholders, and that the foundation would direct resources toward community-driven change efforts. Her intent was spelled out in a 2017 blog post:

[1] See https://kbr.org/healthy-places-nc/

[W]e are changing our way of engaging with you. … In our new state, we will engage more deeply in Colorado communities in order to understand, listen, and support your agendas. We may even support you in developing a plan, but we aren't there to tell you what your plan of action should be or how to go about achieving your goals.

[W]e are changing our way of engaging with you. … In our new state, we will engage more deeply in Colorado communities in order to understand, listen, and support your agendas. We may even support you in developing a plan, but we aren't there to tell you what your plan of action should be or how to go about achieving your goals. … [I]n order to make impact at the community level, we need to be IN it and WITH you in your communities, experiencing it as closely as we can to the way you do. (McNeil-Miller, 2017, para. 4–6).

This vision of engaging stakeholders across the state was taken to a more intensive level within CHF's "Locally-focused Work" (LFW), under which the foundation commits to a long-term investment of philanthropic resources within a small number of foundation-selected "communities" (defined as either a rural county, a moderate-sized city, or a geographically defined portion of a large urban area). This work is led by Jehan Benton-Clark, who previously served as a senior program officer at the Reynolds Trust. The process was launched in four Colorado communities in 2017 and expanded to five additional communities in 2020 (Benton-Clark, 2018). The foundation regards LFW as a concentrated body of place-based work rather than a formal initiative.

From the outset, LFW has had an explicit focus on advancing health equity. The following "core outcomes" point to LFW's overarching intent:

- Community members use their power to engage, lead, and take action.
- Strong, responsive, and inclusive institutions enact policies and systems that promote health.
- Community members (people, organizations, and networks) work together to address health-related challenges.

When referring to "people using their power" and "community members working together to address challenges," the foundation is prioritizing people who have been historically underserved or disenfranchised by current systems.[2]

Given that the individuals providing leadership for LFW were deeply involved in Healthy Places NC at the Reynolds Trust,[3] it is not surprising that the LFW approach has a number of similarities to HPNC. Each community is assigned a Denver-based program officer who spends four to eight days per month in the community, meeting with a broad mix of people who can provide perspective on the community's issues and who have the potential to serve as longer-term partners in carrying out new work to address those issues. CHF supports promising work with grants and with technical assistance from consulting groups such as Civic Canopy. CHF's approach to cultivation includes major investments in leadership development and capacity-building for organizations and networks

[2] One of CHF's "cornerstone" beliefs is, "We serve Coloradans who are low income and/or historically have had less power or privilege."

[3] Doug Easterling was centrally involved in the design of both HPNC and LFW, serving as an external strategy advisor for the Reynolds Trust and CHF, respectively.

that are addressing issues related to health equity. The Center for Creative Leadership delivers leadership development training within a local venue to two cohorts of 30 to 40 participants.

In addition to cultivating promising projects that promote health equity, LFW is designed to affect the underlying structures and norms that determine how decisions are made and how things are done (or not done) within the community. As such, when program officers choose which people and organizations to engage, they are explicitly looking for opportunities to create more inclusive institutions and to build the power of community members who have been historically excluded from decision-making.

Clinton Foundation

The Clinton Foundation employed the cultivation approach with its Community Health Transformation (CHT) model, which was implemented in six communities across the United States between 2011 and 2019. The model was developed by the Clinton Health Matters Initiative (CHMI), which is the division of the foundation that focuses on domestic health issues. The stated intent of the CHT model is to "encourage sustainable bold action steps that promote systems strengthening and systems change resulting in improved health outcomes" (Clinton Foundation, 2015, p. 9).

CHMI frames its work around the concept of "activation" rather than "cultivation," (Clinton Foundation, n.d.), but the CHT model is highly consistent with descriptions of cultivation (Easterling & Gesell, 2019; Easterling & Smart, 2015). (See Table 1). Moreover, CHMI leaders have come to regard their approach as cultivation based on conversations that have occurred as the authors conducted an evaluation of the CHT model.

The CHT model had three major elements:

1. Within each participating community, a full-time regional director recruited from the community was employed by the Clinton Foundation for three to five years (depending on the terms of the sponsorship).

The stated intent of the CHT model is to "encourage sustainable bold action steps that promote systems strengthening and systems change resulting in improved health outcomes."

   This person was responsible for cultivating and advancing lines of work with the potential to improve health outcomes that matter to community stakeholders. Regional directors operated in a variety of roles, including project manager, research analyst, advisor, coach, broker of relationships, convener, meeting facilitator, and advocate. Regardless of the role, the regional director sought to facilitate the work of others rather than becoming the identified leader of projects and programs.

2. A Blueprint for Action was developed for each CHT community based on input that local stakeholders provided at a daylong planning summit. The summit occurred at the outset of the CHT process and included between 50 and 150 community leaders, including directors of local health systems, nonprofit organizations, governmental agencies, and foundations. The Clinton Foundation organized and facilitated the summit. The invitation list was compiled based on what foundation staff had learned during their background research and "community listening" sessions with local leaders. Participants at the summit reviewed data reported by the County Health Rankings and Roadmaps (CHRR) program (University of Wisconsin, n.d.), supplemented by additional data concerning the community's health issues (with "health" defined broadly). Participants then broke into small, sector-specific groups, where

The CHT model is comparable to the cultivation approaches of the Reynolds Trust and CHF in that foundation staff spend considerable time in community settings encouraging and supporting local stakeholders in carrying out work that has the potential to improve community health.

they created vision statements and identified potential projects. The options that attracted the most interest were elevated as "Bold Action Steps" within a Blueprint document written and published by CHMI. The Blueprints for the six CHT communities contained between 30 and 45 steps covering the different domains of health and social determinants specified in the CHRR framework.[4] The Blueprint provided a starting point for the regional directors in determining where to focus their cultivation efforts.

3. The name recognition associated with the Clinton Foundation and its leaders drew community stakeholders into the CHT process. Former President Bill Clinton made personal appearances at summits held in three of the six CHT communities and highlighted CHT-supported projects in his public remarks. The foundation's reputation also helped to build awareness, interest, and credibility for specific projects developed through the CHT process.

The CHT model is comparable to the cultivation approaches of the Reynolds Trust and CHF in that foundation staff spend considerable time in community settings encouraging and supporting local stakeholders in carrying out work that has the potential to improve community health. However, the CHT model is distinctive in a few important ways, including the following:

- The Clinton Foundation's regional directors carried out cultivation in a single community as a full-time job, whereas program officers with the Reynolds Trust and CHF have other responsibilities that extend beyond their foundations' place-based work.

- The regional directors were recruited from within the CHT communities, whereas program officers with the Reynolds Trust and CHF live in the cities where their foundations are based.

- The Clinton Foundation is not a grantmaking foundation, so the regional directors did not use funding opportunities to entice local stakeholders to develop and implement projects. As at least a partial substitute, the foundation's name recognition attracted interest and participation in the CHT process. While many foundations are able to bring visibility and credibility to the work of local stakeholders, the Clinton Foundation has heightened influence in this regard. In our evaluation of the CHT model, we observed this influence within six communities with qualitatively different demographics.

Evaluation of the Clinton Foundation's Approach to Cultivation

Cultivation is a relatively new and uncommon approach for foundations, especially as a means of improving community health. As such, little has been published on the effectiveness of the approach. All three of the foundations discussed here have contracted with external evaluators, but only one evaluation of the cultivation approach has been published to date. In particular, Dupre and colleagues (2016) showed

[4] As an example, the Blueprint for North Florida is available at https://www.clintonfoundation.org/sites/default/files/neflorida_091814_web.pdf.

that the Reynolds Trust was able to activate residents, enhance leadership, and expand networks through its Healthy Places NC initiative. That study did not evaluate the projects cultivated by the foundation or health outcomes. Building on that research, we evaluated whether the Clinton Foundation's approach to cultivation — the CHT model — was able to stimulate new or enhanced community-based work to improve health.

Implementation of the CHT Model

The CHT model was introduced in six sites across the United States where either the Clinton Foundation or a corporate sponsor had a specific interest. The sites were:

- Coachella Valley, California (the eastern end of Riverside County);
- Central Arkansas, including Little Rock (Pulaski County);
- Greater Houston, Texas (Harris County);
- Northeast Florida, including Jacksonville (Baker, Clay, Duval, Nassau and St. Johns counties);
- Adams County, Mississippi (including Natchez); and
- Knox County, Illinois (including Galesburg).

These sites included a mix of urban, rural, and suburban communities. Four sites were single counties, one was a multicounty region, and one was a subregion of a large county.

The CHT process was initially implemented in Coachella Valley, in late 2012. The subsequent sites launched their CHT work between 2013 and 2016. All six sites had completed the CHT process by the spring of 2019.

Evaluation Approach

The Clinton Foundation hired a team of researchers from Wake Forest School of Medicine in April 2016 to conduct a process and outcome evaluation of the CHT model. The first year of the evaluation was devoted to clarifying the assumptions and expectations of the CHT model, assessing how the model was being implemented in the six sites, and identifying where the model might be producing benefit. Beginning in the second year of the evaluation, the evaluation team focused on answering the following two questions:

1. What types of health-improvement projects took shape and were implemented through the CHT process?

2. To what extent and how did the foundation's resources and actions contribute to these projects?

To answer these questions, the evaluation team asked the regional directors to identify promising projects or initiatives within their community where they believed the CHT process had made a difference. Based on semistructured interviews with the regional directors and with 43 individuals directly involved with those projects and initiatives, the evaluation team characterized each of those projects in terms of issue addressed, approach, and stage of development. We also determined whether each project was leading to "systems change," which required evidence that multiple agencies had changed their approach, coordinated services (e.g., through new referral protocols), developed new governance structures, enacted new policies, or in some other way aligned efforts to generate a more comprehensive approach to addressing a cross-cutting issue. These criteria for systems change are consistent with the conceptualization developed by Foster-Fishman, Nowell, and Yang (2007).

We also assessed whether and how the Clinton Foundation contributed to the development of each project and any associated outcomes that might be occurring. This approach was informed by the methodology of contribution analysis articulated by Mayne (2008), but we focused less on the question of attribution and more on the question of what role the foundation played in moving the work forward. (See Appendix 1).

Among the 16 cases of new, expanded, or enhanced programming, the majority involved a discrete program or a change in a particular organization's programming. However, we also observed six instances where the CHT process was leading to "systems change."

Health-Improvement Projects Initiated Under the CHT Model

Each of the regional directors interviewed by the evaluation team was able to identify either four or five "significant projects" that they believed had been influenced by the CHT process. Interviews with local stakeholders directly engaged in those projects affirmed that each project had progressed notably over the course of the CHT initiative and that the foundation had contributed to that progress.

A total of 24 CHT-supported projects were identified across the five sites.[5] (See Appendix 2.) They addressed a variety of health-related issues, including food insecurity, healthy eating, physical activity, pedestrian safety, substance misuse, behavioral health, HIV screening, emergency medical services, cancer survivorship, services for seniors, and volunteerism. These projects employed a broad mix of approaches, including new and expanded services, education and training, public health campaigns, new information technology, enhancements to the built environment, research and planning, new centers, and increased coordination among agencies.

The 24 projects were at various stages of development at the time of our analysis. Based on the interviews and other information available, we determined that 16 of the 24 projects had either produced new programming and services or else enhanced existing programming and services. The other eight projects included a mix of (a) planning efforts that had not reached the point of strategy implementation, (b) research and mapping that lays the groundwork for strategy development, and (c) one program that was designed but not implemented.

Among the 16 cases of new, expanded, or enhanced programming, the majority involved a discrete program or a change in a particular organization's programming. However, we also observed six instances where the CHT process was leading to "systems change" (as defined earlier). Those instances of systems change are as follows:

- Get Tested Coachella Valley, which has overhauled the way in which health and social service organizations throughout the region carry out HIV screening, follow-up, and referral. The number of local residents tested for HIV increased by 49% over a three-year period.

- The substance-use coalition in Northeast Florida, which has established new approaches to prevention, screening, intervention, and harm reduction within health care systems, workplaces, and other settings.

- The Northeast Florida Food, Hunger, and Nutrition Network, which has implemented multiple programs that expand the availability and accessibility of food for food-insecure families throughout the region.

- The Food Insecurity coalition in Knox County, which is increasing the supply of healthy food and improving aggregation and distribution among multiple agencies.

- An interagency substance-misuse initiative in Knox County, which is expanding and

[5] The sixth site had turnover in the regional director, which precluded evaluation interviews.

coordinating services for prevention and treatment throughout the county.

- A partnership among all the behavioral health providers in Knox County, as well as smaller surrounding counties, which is improving referral procedures and coordinating intake and follow-up in line with the principles of "system of care" (Stroul, Blau, & Friedman, 2010).

Four additional projects involved the creation of formal networks among agencies. One of these is Arkansas Impact Philanthropy, a coalition of funders interested in coordinating their. The other three networks were built at the Coachella Valley site in support of improving services for seniors (Senior Collaborative), cancer-support services (Better Together), and connecting volunteers to opportunities (Desert Volunteer Connect).

The Clinton Foundation's Contributions

Local stakeholders were the primary designers and implementers of these 24 projects identified through the evaluation, but the Clinton Foundation also played a substantive role in their development. Interviews with community stakeholders directly engaged in each project affirmed that the foundation, and more especially the regional director, had provided forms of support that allowed the projects to take shape and/or move forward in ways that would not have occurred in the absence of the CHT process.

In order to clarify more precisely how the Clinton Foundation contributed to these projects, the evaluation team developed a taxonomy of four distinct roles that the foundation played across the 24 projects:

- *Activator:* The regional director and/or the events sponsored by the Clinton Foundation activated local stakeholders to pursue an idea, translate an idea into a tangible project, or reinvigorate a dormant line of work.

- *Driver:* The regional director played a lead role in developing the project and provided ongoing support that was essential in implementing the project.

- *Enhancer:* The regional director brought assistance, expertise, and/or resources that allowed an existing project to expand in scale, scope, and/or effectiveness.

- *Supporter:* The regional director was involved in developing and implementing the project, but did not directly influence its design.

Local stakeholders were the primary designers and implementers of these 24 projects identified through the evaluation, but the Clinton Foundation also played a substantive role in their development.

The Clinton Foundation played an activator role in eight of the 24 projects. These were instances where the regional director stimulated community stakeholders to take concrete action to address a particular need or take advantage of a particular opportunity. This was done through actions such as convening stakeholders with shared interests, or highlighting a particular health issue or remedy at a foundation-sponsored event. One example is Arkansas Impact Philanthropy, where the regional director partnered with leaders from two other Arkansas-based foundations to host a gathering of grantmakers to promote more strategic approaches and collective action, especially with regard to health equity.

When the regional directors played a more direct role in developing the project, we assigned the driver role to the foundation. The evaluation team classified three projects as

"foundation-driven." One is the Bike Pedestrian Safety project in Northeast Florida, where the regional director alerted local government agencies to a grant opportunity for an innovative technology to assess traffic patterns at dangerous intersections. The regional director also assisted in writing the proposal and implementing the project once it was funded.

With the driver and activator roles, the regional director was actively engaged when the project was initially conceived. Regional directors were also expected to assist in advancing efforts initiated by community stakeholders; this was done as either an enhancer or a supporter. A project was classified as foundation-enhanced when there was evidence that the project was augmented, strengthened, or accelerated through contributions from the regional director and/or other Clinton Foundation resources. As an example, the foundation enhanced the scale and impact of Get Tested Coachella Valley by publicizing the program at its national summits and through the regional director's work to encourage regional health systems to collaborate with the community-based program by being testing sites and ensuring linkage to care. Based on the evaluation team's interviews, the foundation played an enhancing role in 10 projects. Three pre-existing projects were not directly influenced by the foundation, and thus the role was classified as supporting.

To provide a more concrete sense of how the Clinton Foundation contributed to the 24 projects, the evaluation team developed a second taxonomy that defines seven ways that regional directors contributed to a project: increasing readiness for action, network development, strategy development, project management, elevating issues and approaches, leveraging resources, and building individual and organizational capacity. (See Table 2.)

Regional directors contributed to each project in multiple ways; the average was four ways per project. The most frequent ways of contributing were elevating issues and approaches (22 projects), network development (19 projects), leveraging resources (18 projects), and increasing readiness for action (17 projects).

Summary of CHT's Outcomes

With one full-time regional director employed for three to five years in each community, the Clinton Foundation tangibly contributed to the development and implementation of four or five health-improvement projects in each of the five CHT communities included in the evaluation.[6] These projects were "community-based" in the sense that local stakeholders identified the problem to address, set the objectives, and designed the approach (Easterling, Gallagher, & Lodwick, 2003). The regional directors provided a variety of supports that allowed those projects to move beyond what would have occurred in the absence in the CHT process.

Sixteen of the 24 projects identified through the evaluation had reached the point of delivering tangible benefits to local residents, while eight were at an earlier stage of development. While most of the projects involve specific programming, some adopted a more comprehensive approach. Six projects showed clear evidence of interagency systems change — in the areas of substance-use prevention and treatment, behavioral health, HIV testing and treatment, and the distribution and availability of healthy food.

The foundation's contributions occurred primarily through the work of the regional directors. Drawing on an extensive list of action steps generated at the one-day Blueprint planning meeting, each regional director identified a short list of promising opportunities with significant local interest and the potential for impact. The regional directors then ascertained what was required to move these projects forward, including the specific roles they needed to play and which stakeholder groups they needed to engage. In some instances, the regional director

[6] The 24 projects analyzed in this study were the ones that the regional directors identified as having moved forward with their assistance. It is possible that the CHT process had an effect on additional projects, although we believe that these are unlikely to have been as significant as the projects described here.

TABLE 2 Ways That the Clinton Foundation Contributed to Projects Under the CHT Model

Contribution	Description	Relevant Activities
Increasing readiness for action	People and organizations are activated to do new work or additional work that improves community health. This occurs through encouraging people to take initiative, develop new ideas, gain a greater sense of possibility, and find others to work with.	• Recruited partners • Hosted meetings where the Blueprint for Action was developed and released • Posted Blueprint on the Clinton Foundation website • Hosted gatherings of project personnel and key stakeholders ("summits") to highlight work • Facilitated groups and meetings • Connected people with shared interests • Stimulated interest and action through informal interactions
Network development	Networks of people and/or organizations with shared interests become stronger and better able to develop and implement health-improvement projects, services, programs, etc. This occurs through expansion of the network, stronger relationships, identifying shared interests, clarifying purpose, increased capacity for problem-solving, etc.	• Organized work groups that may evolve into ongoing networks • Connected people with shared interests • Facilitated communication among network members • Provided guidance to nascent or underperforming networks
Strategy development	Organizations, workgroups, coalitions, and/or networks develop clearer, more informed, and more impactful strategies to achieve their health-related goals. In the process, the participating actors deepen their strategic thinking and develop more comprehensive analyses of the issues they are addressing.	• Facilitated strategic-analysis and strategy-development sessions for organizations, work groups, networks, etc. • Brought research and community data to inform strategic analysis • Compiled and synthesized strategy ideas from multiple partners • Encouraged strategic thinking in ongoing interactions with partners
Project management	Administrative, logistical, and analytic support allows organizations, work groups, coalitions, and/or networks to move forward with the development and implementation of key projects.	• Organized meetings and events, including convening, scheduling, finding venues • Identified tasks required to move work forward, taking responsibility for some and delegating others • Facilitated communication among partners involved in a project
Elevating issues and approaches	Visibility, awareness, and buy-in for specific approaches to improve health increase across the community as a whole, as well as among key constituents such as policymakers, funders, and health institutions.	• Highlighted issues and projects at national summits and other major foundation-sponsored meetings • Highlighted issues and projects in Blueprint and reports to the community • Produced additional communications efforts (e.g., blogs, foundation website) • Emphasized issues and projects in interactions with stakeholders
Leveraging resources	Projects gain increased access to financial and other resources.	• Connected local partners with private and public funders as well as corporations that can contribute financial resources, products, time, and expertise • Advised on grantwriting and identification of funders • Wrote letters of support for grant applications
Building organizational and individual capacity	Organizations involved in health-improvement work become more effective in developing and implementing their programs and stronger in their operations, staffing, finances, governance, etc. Leaders within those organizations develop their individual capacity.	• Advised and mentored leaders of key organizations on programmatic, strategic, and organizational issues • Connected partners who can support one another • Provided foundation-supported networks and work groups opportunities for advising and peer learning

This evaluation of the CHT model provides evidence that new health-improvement work can be advanced when a foundation uses the cultivation approach. Multiple projects moved forward in all five of the evaluated sites, some of which involved interagency systems change.

contributed to efforts that were already underway in the community, while in other cases the regional director stimulated new work — either by creating the conditions for people to come together to design a project or by actually taking the lead and advancing a particular opportunity.

The regional directors' contributions were reinforced by the name recognition associated with the Clinton Foundation. In each of the five sites where the evaluation was conducted, a large number of local leaders with varying backgrounds responded positively to the foundation's invitation to participate in the Blueprint meeting. The regional directors were then able to build on this interest and momentum to engage influential local stakeholders in carrying out specific action steps described in the Blueprint. In communities where President Clinton made personal appearances, the CHT process attracted even greater attention and participation.

Implications for the Cultivation Approach

This evaluation of the CHT model provides evidence that new health-improvement work can be advanced when a foundation uses the cultivation approach. Multiple projects moved forward in all five of the evaluated sites, some of which involved interagency systems change. Although the foundation did not convene coalitions (as is done under collective impact), the cultivation process did lead to new and expanded networks of agency leaders and service providers in each community.

Cultivating With and Without Grantmaking

In assessing the impact of the Clinton Foundation's cultivation approach, it is important to recognize that the foundation was not in a position to make grants that would reinforce the efforts of the regional directors. In contrast, the Reynolds Trust and the Colorado Health Foundation build grantmaking directly into their cultivation approaches. Grants ranging from thousands of dollars to hundreds of thousands of dollars are awarded to promising projects identified by the foundations' program officers (Dupre et al, 2016; Metz & Easterling, 2016; Easterling, 2016; CHF, n.d.; KBR, n.d.).

New funding obviously makes it easier to implement whatever opportunities for programming or systems change emerge through the cultivation process. In addition, the prospect of grant funding often entices people and organizations to invest effort in the development of new projects. This can be helpful not only on the front end when a project is designed, but also as projects evolve from their initial design to more complex and sophisticated strategies.

The Skill Set Required for Cultivation

It is important to appreciate what was required to actually cultivate projects. The CHMI regional directors stimulated people to action and performed a variety of strategic and operational functions to translate ideas into tangible projects, including facilitating groups, offering advice, and providing critical forms of support during implementation. The cultivation approaches of the Reynolds Trust and CHF call for program officers to play comparable roles. All three foundations have discovered that cultivation requires high levels of interpersonal, strategic, and operational skills.

In the Reynolds Trust's initial implementation of the cultivation approach, the National

Implementation Research Network (NIRN) developed a practice profile to characterize the work that program officers were expected to carry out within HPNC (Metz & Easterling, 2016). That profile identified 10 "essential functions" that program officers need to carry out as they engage with local stakeholders:

1. active listening,
2. building and managing relationships,
3. communication,
4. power analysis,
5. brokering connections,
6. facilitating networks and collaboration,
7. strategic analysis and problem solving,
8. questioning and advising,
9. critical thinking, and
10. grantmaking, management, and monitoring.

These are applied across three phases of engagement: exploring, initiating action, and learning together.

CHF expects its LFW program officers to be skilled at a similar set of functions. These are spelled out in the Community Engagement IMPACT Practice Model (CHF, 2017), which Benton-Clark developed based on the NIRN's practice profile for Reynolds Trust's program officers. The IMPACT model calls for program officers to carry out the following work within their LFW communities:

1. Engage in active listening;
2. Act intentionally and professionally as ambassadors of the foundation;
3. Cultivate and develop diverse, authentic, respectful, trusting relationships;

It is important to appreciate what was required to actually cultivate projects. [...] All three foundations have discovered that cultivation requires high levels of interpersonal, strategic, and operational skills.

4. Connect individuals, networks, and organizations to resources and to one another;
5. Continually seek to clarify and understand power structures;
6. Stimulate and facilitate individuals, networks, and organizations to think and to act differently together to improve health;
7. Use critical thinking skills to understand and define problems;
8. Maintain regular interaction to ask probing questions; and
9. Learn and adapt to challenging environments.

The Clinton Foundation's regional directors are expected to demonstrate similar skills. (See Table 3.) The evaluation team, working in conjunction with CHMI leadership, identified six essential tasks that regional directors needed to be able to do:

1. Communicate effectively with people throughout the community;
2. Build strong, trusting relationships;
3. Lead groups through facilitative and directive techniques;

TABLE 3 Behaviors Required for Clinton Foundation Regional Directors

Communicate • Engage with people throughout the community in ways that they feel heard. • Clearly explain (verbally, in writing, and visually) the model and how to become engaged. • Actively listen to and engage with people who come from a range of backgrounds.
Build Relationships • Connect with stakeholders who will be involved in developing, implementing, promoting, and funding the work. • Develop strong, trusting relationships with all stakeholders who can either advance or obstruct high-priority projects. • Help stakeholders build and strengthen their relationships with one another.
Lead Groups • Provide guidance in ways that are appropriate to the context surrounding any given project. • Build enthusiasm for ideas that have emerged as priorities. • Encourage people to act and to try new things. • Bring people together, facilitating conversations and helping groups find common interests and a shared sense of purpose. • Discern when to provide facilitative leadership and when to provide more directive leadership.
Collect, analyze, and synthesize information • Present information that will allow for smart planning, prioritizing, project development, and sustainability. • Identify what sort of information is needed for the task at hand, where to find or elicit the information, and how to organize and analyze the information in order to answer critical questions and guide high-priority work.
Conduct strategic and situational analysis • Bring a strategic orientation and a nuanced understanding of the local context in order to identify opportunities, challenges, threats, and underlying dynamics that either facilitate or impede progress. • Carry out specific analyses that allow for strategic decision-making, including the environmental scan of the community, stakeholder analysis, identifying which project ideas have the most promise, determining how and where to implement projects, and finding ways to sustain projects.
Manage multiple lines of work • Assess the potential and importance of the opportunities that present themselves, and set priorities appropriately. • Develop work plans that move the high-priority work forward and follow through to carry out those work plans, adjusting as necessary. • Keep track of a long list of tasks, people, meetings, deadlines, project details, and big-picture issues. • Monitor simultaneously the different lines of work and be able to shift attention quickly from one project to another.

4. Collect, analyze, and synthesize a variety of data;

5. Conduct strategic and situational analyses; and

6. Manage multiple lines of work.

The ability to think strategically about which opportunities to pursue is especially critical to the role of cultivator. The evaluation found that the CHT process was more likely to generate larger-scale and higher-dose projects, as well as interagency systems change, in communities where the regional director was more strategic in choosing which action steps to pursue. These regional directors focused their attention on project ideas that had the prospect of bringing new services and/or benefits to significant numbers of people, and were likely to move to fruition because there was a critical mass of community stakeholders willing to invest effort and willing to change how their organizations did business. Other regional directors were more opportunistic in selecting projects, either pursuing projects in line with their experiences and interests or

being responsive to stakeholders with whom they had strong pre-existing relationships. For the cultivation approach to reach its potential in generating meaningful community impact, foundations need to hire cultivators who are skilled at strategic analysis.

Revisiting the Distinctions in Place-Based Philanthropy

One of the more important features in our approach to evaluating the CHT model involved categorizing projects according to the role played by the regional director: activator, driver, enhancer, or supporter. As we shared this taxonomy with colleagues in the philanthropic field, we came to recognize that these roles also apply at the foundation level. While the Clinton Foundation acted primarily as an activator and enhancer in advancing the work of local stakeholders, other place-based foundations operate as a supporter, providing grants to community-defined projects through an RFP process. And other foundations operate in a driver role, where they introduce a particular intervention into the community which they believe will resolve a major issue.

Our conversations regarding the taxonomy also pointed to two additional roles that place-based foundations play: facilitator and capacity-builder. The facilitator role involves supporting local stakeholders in planning and problem-solving so that they arrive at better developed and more effective solutions. This support can take a variety of forms, including convening and facilitating coalitions, advising on program design, and providing research on local issues and conditions.

The capacity-builder role also involves helping local stakeholders to be more effective in addressing the issues they regard as most critical, but the focus is on strengthening the ability of individuals, organizations, and networks to do their work and accomplish their goals. Capacity building can be done through leadership development, coaching, support for information technology, training for staff, and consultation on organizational issues such as strategy, programming, funding streams, board development, and succession planning. The updated taxonomy includes for each of the six roles what we regard as the underlying premise of each role (i.e., why this is an appropriate way to engage with local stakeholders). (See Table 4.)

The evaluation found that the CHT process was more likely to generate larger-scale and higher-dose projects, as well as interagency systems change, in communities where the regional director was more strategic in choosing which action steps to pursue.

In addition to serving as a tool for evaluating place-based initiatives, we believe that this taxonomy can be useful to foundations in clarifying their intent and in developing strategies consistent with their intent. A frequent theme in the evaluations of community initiatives is ambiguity regarding the funder's "theory of change" (Grantmakers for Effective Organizations, 2014). In particular, foundations sometimes fail to describe in clear terms the pathways through which its target outcomes will be achieved, as well as how the foundation's actions and resources will affect that change process. Failing to specify the theory of change can undermine alignment and focus within the foundation, while also creating confusion and frustration among community stakeholders.

The taxonomy can help a foundation clarify its theory of change by making a more deliberate choice as to how it will support the community change process. For example, will the foundation act in a directive, responsive, or facilitative mode? Who will determine which lines of work are supported with the foundation's resources? Does the foundation expect to stimulate new projects or enhance pre-existing projects?

TABLE 4 Taxonomy of the Roles That Foundations Play Within Place-Based Work

Role	What the Foundation Does	Premise
Driver	• Takes the lead in choosing, designing, and developing local projects • Provides resources that are essential to implement those projects	The foundation has the expertise and perspective to know what approaches will be most effective in allowing communities to reach their goals.
Activator	• Sparks action that moves forward a new or dormant line of work	Promising ideas exist throughout the community, but many are not developed and acted upon. Foundations can stimulate forward movement on these ideas.
Facilitator	• Creates the conditions to allow local stakeholders to plan, develop, and implement projects in line with their interests	The most powerful solutions emerge when local stakeholders engage in well-facilitated, collective problem-solving. Foundations are in a position to convene and to design such a process.
Capacity-Builder	• Provides training, consultation, and other assistance that brings people and organizations to a level where they are capable of accomplishing their goals	Promising ideas don't reach their potential because people and organizations don't have all the skills and expertise they need to develop, implement, and scale effective work. Foundations can use their resources, expertise, and connections to bring the right resources to the community.
Enhancer	• Brings expertise and resources that increase the effectiveness and/or reach of projects designed by local stakeholders	Community-defined projects reach their full potential when foundations actively partner with local stakeholders and bring their own expertise and experience into design and implementation.
Supporter	• Provides funding, visibility and other resources that allow local organizations to implement their projects	Communities are in the best position to know what needs to be done. Foundations should respect that expertise and direct their resources toward the projects that communities regard as most important.

As a foundation answers these questions and determines its role, it will be defining its theory of change. In addition, exploring the merits and premises associated with the six roles will allow a foundation to clarify its underlying values, beliefs, and assumptions. As such, we believe that the role taxonomy can be a useful tool in developing a foundation's "theory of philanthropy" (Patton, Foote, & Radner, 2015).

Conclusion

Cultivation is a highly nuanced approach to place-based philanthropy where the foundation actively encourages the development of promising work throughout a community. There is much more engagement with local stakeholders than occurs with place-based foundations that rely on transactional grantmaking (including many community foundations). Moreover, cultivation calls for facilitative engagement that supports local stakeholders in optimizing and acting upon their ideas, rather than directive engagement where the foundation is promoting its own solutions.

Foundations that act as cultivators can be expected to play a number of roles, especially those of activator and enhancer. The roles of facilitator and capacity-builder are also relevant, although this work is often carried out by intermediaries or consulting groups rather than the foundation itself.

Cultivation is defined in part by the roles that the foundation plays, but also by the decentralized approach to activating, facilitating, enhancing, and capacity-building. It is important to note that foundations can play these same roles (especially

the facilitator role) in collective impact initiatives. But collective impact involves a single, centralized problem-solving body focused on a particular issue (Kania & Kramer, 2011).

As foundations explore whether to pursue cultivation, collective impact, or some other place-based approach, they will need to take into account a number of factors. These including the foundation's goals, philosophy, and assets; the skill sets of staff; the foundation's reputation and relationships within the communities it intends to support. In addition, it is crucial to align the approach with the local context, and the context that exists within those communities, including the strengths and limitations of current programming, the capacity of local nonprofit organizations, community leadership structures, and the local culture, especially as it pertains to taking initiative and working together toward shared goals.

Informed decision making also requires further evaluation of place-based initiatives and more dissemination of these evaluations. The critical practical question for foundations considering a place-based approach is, "Which approach is most effective, and under what conditions?" The current study demonstrated that the Clinton Foundation's model of cultivation was able to advance multiple lines of work in each community, including some projects that improved the functioning of interagency systems. More evaluations of other foundations' cultivation models are needed to gain a full sense of what this approach is capable of producing, which approaches to cultivation are most effective, and what contextual factors either facilitate or inhibit effectiveness.

Collective impact has also been shown, in some cases, to produce solutions that improve the health and well-being of populations and communities (Lynn et al., 2018; Easterling & McDuffee, 2019). Rather than regarding cultivation and collective impact as competing models, we believe they can be complementary. Cultivation may be the more appropriate approach in a community that has a turf-oriented culture that precludes effective collaboration. Conversely, collective impact may be the next logical step in a community that has developed a track record of translating ideas into action.

In evaluating any place-based approach, we would strongly recommend that there be an emphasis on the question of whether the observed outcomes are broader and deeper than what is possible when foundations focus their grantmaking on individual organizations or programs.

In evaluating any place-based approach, we would strongly recommend that there be an emphasis on the question of whether the observed outcomes are broader and deeper than what is possible when foundations focus their grantmaking on individual organizations or programs. The rationale behind place-based philanthropy is that intervening at a holistic level will yield more fundamental shifts within the systems, structures, and norms that determine how well a community solves its problems and how fully the residents are able to lead healthy, fulfilling lives.

Place-based foundations have multiple options for supporting positive community change. Selecting the right approach involves clarifying their theory of change, understanding the nature of the communities they will be supporting, and paying attention to what is known about the effectiveness of the alternative approaches. Regardless of which approach is chosen, it is crucial for the foundation to engage respectfully with community members and to evaluate the approach to determine if it is actually achieving the foundation's goals and serving the interests of local stakeholders.

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References

Albert, S., Brason, F. W., Sanford, C. K., Dasgupta, N., Graham, J., & Lovette, B. (2011). Project Lazarus: Community-based overdose prevention in rural North Carolina. *Pain Medicine, 12* (Suppl. 2), S77–S85.

Anderson, L. M., Adeney, K. L., Shinn, C., Safranek, S., Buckner-Brown, J., & Krause, L. K. (2015, June 15). Community coalition-driven interventions to reduce health disparities among racial and ethnic minority populations. *Cochrane Database of Systematic Reviews*. Retrieved from https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD009905.pub2/full

Benton-Clark, J. (2018). *A kaleidoscope of possibilities: Addressing health from a local perspective.* Denver: The Colorado Health Foundation. Retrieved from https://coloradohealth.org/insights/good-health/kaleidoscope-possibilities-addressing-health-local-perspective

Bernholz, L., Fulton, K., & Kasper, G. (2005). *On the brink of new promise: The future of U.S. community foundations*. San Francisco, CA: Blueprint Research & Design and Monitor Company Group.

Brown, P., Chaskin, R. J., Hamilton, R., & Richman, H. (2003). *Toward greater effectiveness in community change: Challenges and responses for philanthropy.* New York, NY: Foundation Center.

Brown, P., & Fiester, L. (2007). *Hard lessons about philanthropy and community change from the Neighborhood Improvement Initiative.* Menlo Park, CA: William and Flora Hewlett Foundation.

Clinton Foundation. (2015). *Clinton Health Matters Initiative collective impact evaluation: Request for proposals*. New York, NY: Author.

Clinton Foundation. (n.d.). *Clinton Health Matters Initiative: Our approach*. New York, NY: Author. Retrieved from https://www.clintonfoundation.org/our-work/clinton-health-matters-initiative/programs/about-clinton-health-matters-initiative

Colorado Health Foundation (CHF). (2017, November). *Community engagement IMPACT practice model.* Denver, CO: Author. Retrieved from https://www.coloradohealth.org/reports/community-engagement-impact-practice-model

Colorado Health Foundation (CHF). (n.d.). *Locally-focused work*. Denver, CO: Author. Retrieved from https://coloradohealth.org/locally-focused-work

Connor, R., & Easterling, D. (2009). The Colorado Trust's Healthy Communities Initiative: Results and lessons for comprehensive community initiatives. *The Foundation Review, 1*(1), 24–42. https://doi.org/10.4087/FOUNDATIONREVIEW-D-09-00002

Ditkoff, S. W., & Grindle, A. (2017, September-October). Audacious philanthropy: Lessons from 15 world-changing initiatives. *Harvard Business Review.* Retrieved from https://hbr.org/2017/09/audacious-philanthropy

Dupre, M. E., Moody, J., Nelson, A., Willis, J. M., Fuller, L., Smart, A. J., et al. (2016). Place-based initiatives to improve health in disadvantaged communities: Cross-sector characteristics and networks of local actors in North Carolina. *American Journal of Public Health, 106*(9), 1548–1555.

Easterling, D. (2016). How grantmaking can create adaptive organizations. *Stanford Social Innovation Review, 14*(4), 46–53.

Easterling, D., Gallagher, K., & Lodwick, D. (2003). *Promoting health at the community level.* Thousand Oaks, CA: Sage.

Easterling, D., & Gesell, S. (2019, February 7). Cultivating promising ideas to improve community health [Web log post]. *Health Affairs.* Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20190205.889103/full/

Easterling, D., & McDuffee, L. (2018). Becoming strategic: Finding leverage over the social and economic determinants of health. *The Foundation Review, 10*(1), 90–112. https://doi.org/10.9707/1944-5660.1409

Easterling, D., & McDuffee, L. (2019). How can foundations promote impactful collaboration? *The Foundation Review, 11*(3), 23–40. https://doi.org/10.9707/1944-5660.1479

Easterling, D., & Smart, A. (2015). Place-based philanthropy in rural settings: Increasing the potential for whole-community change. In E. M. Hopkins and J. M. Ferris (Eds.), *Place-based initiatives in the context of public policy and markets: Moving to higher ground* (pp. 58–61). Los Angeles: Sol Price School of Public Policy, University of Southern California.

Easterling, D., Smart, A., & McDuffee, L. (2016). Philanthropy, health systems, and community health improvement. In T. Cutts & J. R. Cochrane (Eds.), *Stakeholder health: Insights from new systems of health* (pp. 149–166). Winston-Salem, NC: FaithHealth Innovations.

Fawcett, S., Torres, J., Jones, L., Moffett, M., Bradford, K., Mantilla, M. R., et al. (2018). Assuring health access and culturally competent health services through the Latino Health for All Coalition. *Health Promotion Practice, 19*(5), 765–774.

Ferris, J. M., & Hopkins, E. (2015). Place-based initiatives: Lessons from five decades of experimentation and experience. *The Foundation Review, 7*(4), 97–109. https://doi.org/10.9707/1944-5660.1269

Foster-Fishman, P. G., Nowell, B., & Yang, H. (2007). Putting the system back into systems change: A framework for understanding and changing organizational and community systems. *American Journal of Community Psychology, 39*(3–4), 197–215.

Grantmakers for Effective Organizations. (2014). *Evaluating community change: A framework for grantmakers.* Washington, DC: Author. Retrieved from https://www.geofunders.org/resources/evaluating-community-change-a-framework-for-grantmakers-728

Hamilton, R., Parzen, J., & Brown, P. (2004). *Community change makers: The leadership roles of community foundations.* Chicago, IL: Chapin Hall Center for Children at the University of Chicago.

Jellinek, P., & Treanor, K. (2019). *Making their mark: America's health conversion foundations.* Washington, DC: Grantmakers in Health.

Jenkins, C., McNary, S., Carlson, B. A., King, M. G., Hossler, C. L., Magwood, G., et al. (2004). Reducing disparities for African Americans with diabetes: Progress made by the REACH 2010 Charleston and Georgetown Diabetes Coalition. *Public Health Reports, 119*(3), 322–330.

Kania, J., & Kramer, M. (2011, Winter). Collective impact. *Stanford Social Innovation Review.* Retrieved from https://ssir.org/articles/entry/collective_impact#

Kate B. Reynolds Charitable Trust (KBR). (n). *Special initiative: Healthy Places NC.* Retrieved from https://kbr.org/healthy-places-nc/

Kegler, M. C., Painter, J. E., Twiss, J. M., Aronson, R., & Norton, B. L. (2009). Evaluation findings on community participation in the California Healthy Cities and Communities program. *Health Promotion International, 24*(4), 300–310.

Kramer, M. R. (2009). Catalytic philanthropy. *Stanford Social Innovation Review, 7*(4), 30–35.

Kubisch, A.C., Auspos, P., Brown, P., & Dewar, T. (2010). Community change initiatives from 1990–2010: Accomplishments and implications for future work. *Community Investments, 22*(1), 8–12.

Lynn, J., Gase, L., Roos, J., Oppenheimer, S., Dane, A., Stachowiak, S., et al. (2018). *When collective impact has an impact: A cross-site study of 25 collective impact initiatives.* Seattle, WA: ORS Impact.

Mayne, J. (2008). *Contribution analysis: An approach to exploring cause and effect.* Institutional Learning and Change Brief No. 16, p. 4. Retrieved from https://hdl.handle.net/10568/70124

McNeill-Miller, K. (2017). *Evolving for impact.* Denver: Colorado Health Foundation. Retrieved from https://coloradohealth.org/insights/good-health/evolving-impact

Metz, A., & Easterling, D. (2016). Using implementation science to translate foundation strategy. *The Foundation Review, 8*(2), 116–137. https://doi.org/10.9707/1944-5660.1302

Patton, M. Q., Foote, N., & Radner, J. (2015). A foundation's theory of philanthropy: What it is, what it provides, how to do it. *The Foundation Review, 7*(4), 7–20. https://doi.org/10.9707/1944-5660.1263

Schwartz, P. M., Kelly, C., Cheadle, A., Pulver, A., & Solomon, L. (2018). The Kaiser Permanente Community Health Initiative: A decade of implementing and evaluating community change. *American Journal of Preventive Medicine, 54*(5), S105–S109.

Smart, A. (2015, April 7) Funding to improve health in rural North Carolina communities: When buzzwords meet change [Web log post]. *Health Affairs*. Retrieved from https://www.healthaffairs.org/do/10.1377/hblog20150407.046205/full/

Stroul, B., Blau, G., & Friedman, R. (2010). *Updating the system of care concept and philosophy*. Washington, DC: Georgetown University Center for Child and Human Development. Retrieved from http://www.socflorida.com/documents/professionals/06-17_updating_SOC_concept&philosophy.pdf

University of Wisconsin. (n.d.) *Measures and data sources. County Health Rankings and Roadmaps*. Madison, WI: University of Wisconsin Population Health Institute. Retrieved from https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources

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APPENDIX 1 Methodology for Evaluating the CHT Model

Preliminary Approach

The first year of the evaluation was devoted to clarifying the assumptions and expectations of the CHT model, assessing how the model was being implemented in the six sites, and identifying where the model might be producing benefit. Semi-structured interviews were conducted with each of the six Regional Directors who were in place in September 2016. Subsequent interactions — by phone, email and in-person — provided with information about specific projects underway in each community, upcoming events, local issues and the Regional Director's activities and approach. We also conducted interviews with CHMI leaders to better understand the history and nature of the CHT model, the Foundation's expectations and assumptions, and how the CHMI process took shape in each of the six communities.

Also during Year 1, the Wake Forest Evaluation Team conducted 47 semi-structured interviews with local stakeholders and representatives of organizations that provided funding to implement the CHT model. These interviews provided information on how the CHT model was being received and perceived, what had occurred in response to the Blueprint Workshop and resulting Blueprint, how the Regional Director is supporting local actors and whether CHMI has stimulated new investments (direct and indirect) in health interventions. We also ask for recommendations for what should happen next in the community and how the CHT model might be revised.

Based on these interviews, site visits and other available information, the Evaluation Team determined that the primary benefit that the CHT model was delivering involved the development and implementation of health-improvement programs, services, technology and policy. Based on that determination, the evaluation design was refined to focus on assessing more concretely how and how much CHMI was contributing to specific bodies of health-improvement work in each CHT community.

Evaluation of the Foundation's Contribution to Health-Improvement Projects

Building on the general idea that motivates Contribution Analysis (Mayne, 2008), the second phase of the evaluation sought to identify tangible "outcomes" that could be traced, at least in part, to the CHT intervention. We used a broad definition of "outcomes" because the health-improvement work stimulated by the CHT process generally had not yet translated into measurable changes in health status at the time of the evaluation. Thus, we looked for intermediate outcomes such as the development and implementation of new programs, the creation of new organizations, the building or expanding of networks, and the completion of studies that set the stage for planning and program design.

The following two questions provided the basis for the second phase of the evaluation:

1. What types of health-improvement projects took shape and were implemented through the CHT process?
2. To what extent and how did the Foundation's resources and actions contribute to the projects that took shape?

Data Collection

The analysis was based on semi-structured interviews with individuals directly involved with those projects and initiatives, along with supporting materials pertaining to each project. The process began with interviews of the Regional Directors. They were asked to identify significant or promising projects within their community where they believed the CHT process had made a difference. The term "project" was used generically to refer to any of a variety of focused efforts to improve some aspect of health or a social factor related to health. Regional Directors identified either 4 or 5 projects for their respective communities (24 in total). For each such project, the Regional Directors described the work to date, accomplishments, and the role(s) they had played in the process. They also named community stakeholders who had played critical roles in the projects.

Each community stakeholder identified by the Regional Director was contacted to set up an interview. Semi-structured interviews were conducted with 42 stakeholders recommended by the Regional Directors, plus one additional stakeholder who was recommended by an interviewee. The interviews asked about the nature of their respective project, how it started, how it developed, the current status, who (if anyone) is benefiting from the project, and how the Clinton Foundation contributed. Interviewees were also asked for recommendations on who else could provide in-depth information about the project, as well as whether there were any materials that would allow a more detailed understanding of the project. Interviews were conducted with between 1 and 4 community stakeholders associated with each project identified by the Regional Directors.

All interviews were conducted by telephone between November 2016 and March 2019. Participants provided verbal consent. Interviews were audio-recorded and transcribed verbatim for coding and analysis. The evaluation study protocol and materials were approved by the Institutional Review Board (IRB) at Wake Forest School of Medicine.

Data was collected in the five CHT sites where there was continuity in staffing. The Adams County site had turnover in the Regional Director position midway through implementation which precluded the evaluation team from carrying out the necessary data collection.

Interviews with Regional Directors. These interviews asked about the Regional Director's background, the approach they took to mobilize community stakeholders and to move projects forward, and specific projects or initiatives that they believed had been advanced because of the CHT process. The term "project" was used generically to refer to any of a variety of focused efforts to improve some aspect of health or a social factor related to health. For each such project, the Regional Directors described the work to date, accomplishments, and their roles in the process. They also named community stakeholders who had played critical roles in those projects.

Interviews with Community Stakeholders. The evaluation team interviewed at least one community stakeholder associated with each of the projects identified by the Regional Directors.

Data Analysis

The evaluation team characterized each project in terms of the issue addressed, scope, and stage of development, and then assessed how the Foundation contributed to the project's development. To do this, each interview transcript was coded by at least two members of the evaluation team. Each coder independently extracted text about characteristics such as the project's intent, stage of development, key activities to date, outcomes, and individuals and organizations involved in the project. Coders met to compare their characterizations and to discuss instances where different informants provided inconsistent information.

In order to assess the contribution of the Regional Director and/or the CHT process more generally, the evaluation team extracted and coded quotes relating to the origin of the project and the involvement of the Regional Director. Codes were developed to characterize the role of the Foundation and the specific ways in which the Regional Director supported each project. The evaluation team explicitly assessed whether the information available indicated that the project would have taken shape in the same way if there had not been a CHT process.

Project summaries were validated through follow-up email and telephone conversations with interviewees. Assessments of the Foundation's contribution for each project were first vetted with the Regional Director and then with the community stakeholder(s) who were directly involved with the project. If there were disagreements about levels of involvement and influence of the Foundation, the evaluation team primarily relied on community stakeholder input when developing project summaries.

APPENDIX 2 Projects Advanced Under the CHT Model

Issue Area	Project	Site	Goal
Food insecurity / Healthy eating	**NEFL Food, Hunger, and Nutrition Network**	Northeast Florida	Develop a coalition, establish a new center, and initiate a new program to promote food recovery and distribution.
	Food insecurity	Knox County	Connect organizations and individuals working on food insecurity, identify potential resources, and take steps to establish a food distribution satellite facility.
	PRAPARE	Greater Houston	Coordinate the integration of food-insecurity data into health information exchanges being developed for health systems.
	Fresh2You	Central Arkansas	Develop a mobile food market to make healthy options available to traditionally underserved areas.
	ABC Market	Northeast Florida	Expand access to healthy foods via a farmers' market accepting food stamps and opening in an underserved community.
	Food-insecurity mapping	Greater Houston	Create a map of food deserts for food systems and hospitals to use in their planning.
Active living	**Mission One Million**	Northeast Florida	Initiate a citywide healthy living campaign promoting increased physical activity.
	Play deserts	Greater Houston	Create a map of play deserts, identify physical activity spaces, and build a playground in an underserved area in partnership with Too Small to Fail.
	United Way Weekly Walks and Wellness Challenge	Coachella Valley	Collaborate with existing community initiatives around wellness, weekly walks, and challenges for fundraising for a United Way initiative around an annual run.
	Walking School Bus	Knox County	Implement the Walking School Bus program designed by the National Center for Safe Routes to Schools to increase physical activity and provide positive role models for elementary school children.
Pedestrian safety	**Near Northside Intersection Revitalization**	Greater Houston	Develop options for improving the safety at intersections through planters and decorative applications in crosswalks.
	Bike-Pedestrian Safety	Northeast Florida	Identify an opportunity to utilize technology to capture data to analyze traffic at dangerous intersections.
Substance misuse	**Substance use**	Northeast Florida	Promote Drug Free Duval programs and link with Harvard continuing education. Donate Narcan units by Adapt Pharma.
	Substance use	Knox County	Create and implement a person-centered, support system for individuals and families affected by substance use.

(continued on next page)

Issue Area	Project	Site	Goal
Behavioral health	**Access to care**	Knox County	Create a comprehensive system of care for behavioral health that includes developing a local resource list, unifying referral processes and forms, and ongoing interorganizational case discussions.
HIV	**Get Tested Coachella Valley**	Coachella Valley	Promote HIV screening through awareness-raising, additional testing sites, a mobile testing unit, and changes in testing protocols among health systems.
Teen pregnancy prevention and sexual health	**Act 943**	Central Arkansas	Implement legislation authorizing sexual health education, mentoring, health care, and other resources for students in higher education institutions.
Cancer survivorship	**Better Together**	Coachella Valley	Develop a collaborative of cancer-care providers to raise awareness of cancer support services.
Emergency medical services	**ETHAN**	Greater Houston	Implement an emergency telehealth system to triage some of the health-related emergency calls coming in through 911.
Services for seniors	**Senior Collaborative**	Coachella Valley	Bring together providers to coordinate services and create an information sharing and referral system.
Self-sufficiency among youth with disabilities	**AR Promise**	Central Arkansas	Help youth achieve employment, education, and life goals and reduce dependence on Supplemental Security Income.
Access and use of digital technology in public housing	**ConnectHome**	Central Arkansas	Provide digital literacy training, technology, and connectivity for residents of federally subsidized housing.
Volunteerism	**Desert Volunteer Connect**	Coachella Valley	Collaborate with local partners to design and promote a program aimed at connecting volunteers and organizations.
Increase impact of foundation grantmaking	**AR Impact Philanthropy**	Central Arkansas	Promote networking and shared analysis among funders with the goal of coordinating their strategies and creating systemic change, especially with regard to equity.