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The Revolution Within: What It Really Takes to Partner With Communities

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Keywords: *Resident-driven, community-led grantmaking, community change, building power, organizational transformation, power and privilege in foundations, risk taking in philanthropy*

Introduction

In October 2016, *The Foundation Review* published an article that described a new vision for grantmaking at The Colorado Trust; one that shifted power from the foundation to community residents to determine locally relevant issues and solutions for advancing health equity (Csuti & Barley, 2016). In the article, we discussed our frustrations with problems that continued to plague communities despite decades of funding from multiple sources. We talked about the arrival of a new CEO and his vision for a shift that focused simultaneously on social determinants of health as roots of health inequities and on resident-led solutions to problems facing communities.

We described what led us to eliminate the program department and replace program officers with Community Partners (CPs) — foundation staff throughout the state who lived in the regions where they would work and were thus better able to engage local residents and understand their challenges. We discussed our nascent journey into the diversity, equity, and inclusion (DEI) space, and how we felt that would contribute to our new vision. We were an organization heading excitedly into an unknown future that we believed would result in something we had not seen in Colorado — measurable change, authentically planned, implemented, and led by residents of Colorado communities.

We certainly knew this would not be easy; the road would be rough at times and we would often be outside our comfort zone when communities pushed us in directions we might not want to go. We also knew we would make mistakes, come up against unforeseen challenges, and need to evaluate and adjust as we went. We were clearly setting ourselves up for an adventure, but we had no idea just how adventurous the ride would be.

Key Points

- In October 2016, *The Foundation Review* published an article describing a new vision for grantmaking at The Colorado Trust that shifted power from the foundation to community residents to determine locally relevant issues and solutions for advancing health equity. It discussed major shifts underway at The Trust as it developed its Community Partnerships for Health Equity strategy, which it believed would result in measurable change that was authentically planned, implemented, and led by residents of Colorado communities.
- This article describes the initial years of the strategy, which began with a phased approach to sharing power with communities, and how the lessons from those years led The Trust to pivot to a new approach to achieving the effort's central vision. This next iteration, the Community Partnerships Organizing Strategy, has evolved to include both building power in communities and wielding power in support of communities.
- This evolution is not complete. The Trust is still learning from the communities that continue in the phased approach as well as those who are part of the Community Partnerships Organizing Strategy, and continues to go through major internal transformations that are necessary to authentically engage in community change work.

We began with a model we now refer to as the phased approach. After the period of restructuring and planning at the foundation, the regional CPs were first hired as full-time staff in 2015 and 2016. They joined a strategy team made up of Trust staff and a university-based researcher who were already envisioning guideposts for the work ahead.

Five years since the publication of that first article, The Trust continues to go through major transformations — not just in the Community Partnerships for Health Equity (CPHE) strategy, but in all of our grant strategies. There were other transformations as well — in staffing and in the policies, processes, and procedures within the foundation, including our communications, evaluation work, finance and operations, and in our internal DEI work. These transformations that have permeated every facet of the foundation have been at varying times surprising, joyous, painful, difficult, and, above all, necessary to authentically engage in community change work.

This article describes the tumultuous journey of the initial five years of our CPHE strategy: what we did, what we've learned, where we are now, and where we hope to be in the next five years.

The First Five Years

We began with a model we now refer to as the phased approach. After the period of restructuring and planning at the foundation, the regional CPs were first hired as full-time staff in 2015 and 2016. They joined a strategy team made up of Trust staff and a university-based researcher who were already envisioning guideposts for the work ahead. These guideposts committed us to work that was to:

- Be authentically resident led.
- Meaningfully involve affected individuals and groups in the leadership, planning, implementation, and evaluation of the work.
- Address one or more social determinants of health.
- Seek to narrow a health equity gap.
- Address an important, established need in the community (based on both quantitative and qualitative data).
- Require a deep understanding of an issue by community members, so that root causes and solutions can be identified.
- Resonate broadly across diverse groups of people in the community — that is, a self-defined sense of place.
- Build local resources, capacity, and a team to do the work — in both the short and long term.

The strategy team divided the state into seven multicounty regions based on Colorado's health statistics regions, the geography of the state, and input from the CPs. Each region was home to a CP who would work in that region's communities.[1] Extensive quantitative-data packets were prepared that included population demographics, data on social determinants of health, and geographic information system maps of each region. Processes were developed along with tools for CPs to provide guidance on how to get to know their large regions and the communities and people within it.

[1] Two of the original Community Partners turned over since the start of the strategy.

As a result of this ongoing work by Community Partners, five specific phases emerged that exemplified how the work was progressing. This phased approach became the foundation of the work for the first five years:

1. *Connecting phase.* The CP developed familiarity with the region at large and its communities, including local geography; demographic trends; major industries, institutions, and employers; local stakeholders; power dynamics; and regional issues. This enabled them to learn about local power dynamics as they determined where and with whom to connect. During this phase, CPs conducted community visits, reviewed data, met with residents, and explored community interest in partnering with The Trust.

2. *Early development phase.* After a mutual agreement by the community and The Trust to work together, community members were invited to join a resident team that would formally partner with The Trust to address health equity issues. Initial team members were trained and supported to collect information from the broader community about issues faced and who was most impacted by them. Resident teams worked to deepen their understanding of equity, race, and power, and team processes were developed that ensured team diversity and inclusiveness, met language justice[2] needs, and set practices for managing team conflict and having tough conversations.

3. *Development phase.* The resident team continued to build capacity around equity and internal team processes, selected equity issues to focus on together, and engaged community members most impacted by those issues. Because the foundation could not directly give funding to resident teams without nonprofit status, The Trust partnered with a fiscal sponsor. With the fiscal sponsor, staffing, capacity, and structures were put into place to facilitate moving into the next phase.

4. *Planning phase.* Resident teams received a planning grant to develop their community health equity plan (a requirement of The Trust), evaluation plan, and budget. Funding supported the teams to continue their capacity-building efforts to build power and take action on their issues. They researched potential solutions and formed partnerships to help implement solutions.

5. *Implementation phase.* During this final phase, the communities, with the resident teams leading, received five years of implementation funding, renewed annually, to implement their community health equity plan. The teams also worked with evaluators they selected to integrate evaluation and learning into their work. Building power and increasing community capacity to sustain these efforts was ongoing.

Learnings From the First Five Years

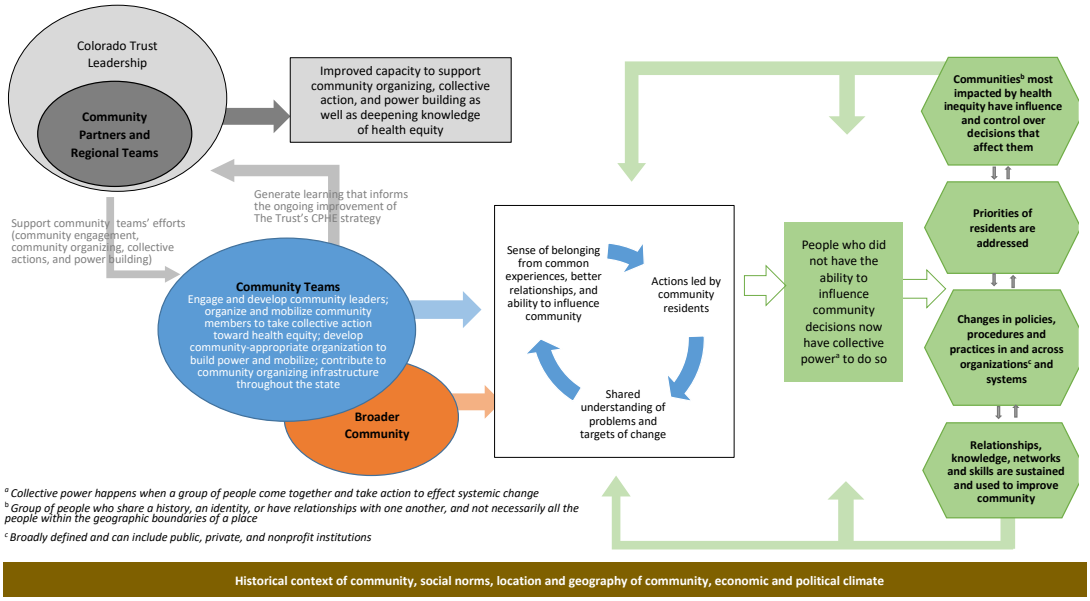
The many challenges, rewards, and learnings from the first five years of CPHE have been continuous, often painful, and always valuable. Despite the tensions inherent in ongoing learning and reflection and the changes in the work we have experienced, The Trust remains deeply committed to the CPHE strategy and its goal of building power in communities to achieve health equity. This section describes some of the prominent lessons learned from the phased approach that helped inform our current approach to the strategy as we move into the next five years.

Lesson No. 1: Clarify 'Resident Led' vs. 'Resident Informed'

The origin of the CPHE strategy came from our vision to fundamentally change the way the foundation operated: by creating direct relationships between The Trust and communities, rather than through nonprofits, and by shifting control and decision-making to communities. Because the original strategy, named Community Based Participatory Grantmaking (Csuti & Barley, 2016), did not resonate with

[2] Language justice is a practice that creates intentional multilingual spaces to ensure that everyone has the right to speak in the language they are most comfortable and that any one language is not prioritized over another.

FIGURE 1 Community Partnerships for Health Equity Pathway of Change



community members, strategy leadership began to talk about the work as "resident driven" or "resident led."

We wanted to relate to communities differently than we had in the past, to build the strategy alongside communities, and to hear unrestrained ideas from residents about how to make change. For these reasons, we erred on the side of less formality and structure and more openness to new ways of doing things when we initially entered communities. But what was intended as authentically partnering with communities felt unclear and confusing to residents who had not interacted with foundations before. Many communities, tired of being "helped" by well-meaning outside groups, were distrustful of us coming in with a different approach. Often communities were trying to figure out what this work was about, just as we were. We were walking the fine line between trying to give some guidelines and parameters and being too prescriptive, all while trying to build the strategy and internal systems to support it in real time.

Residents quickly began to come up with requests that challenged our notion of resident-led work. Could communities determine the amount of funding they received? Could they determine our organizational staffing and decisions? Would The Trust fund services that local government was responsible for? Would the foundation fund improvements to private property? Could the foundation build a recreation center? A sidewalk? If the work is resident led, why, they asked, do communities have to go through an established process with Community Partners?

It became clear very quickly that we were not willing or able to be resident led in all aspects of the foundation's work, and that we needed to communicate clearer parameters around what could be resident-led versus resident-informed. While there were certain aspects of the work that were resident led (e.g., determining team agreements and decision-making processes, defining which community issues to work on and their solutions), there were also many things that were resident informed. For example, while residents led the process of identifying the issues they wanted to address, often the proposed solutions were resident informed, with The Trust ultimately having influence over what was

funded. Or, while residents could select community evaluators or make requests for particular training or support around learning and evaluation, they could not themselves decide whether there would be an evaluation.

It also became clear that we needed to better align the resident-driven framework with our organizational vision of how to achieve health equity. Since the beginning of the strategy, we strived to build capacity and knowledge in communities around health equity, but in mid-2017, we shifted the focus to building power in communities to achieve health equity, which then became the explicit goal of the CPHE strategy. We built a pathway of change around power building, with long-term outcomes:

1. Communities most impacted by health inequity have influence and control over decisions that affect them.

2. Priorities of residents are addressed.

3. Changes are made in policies, procedures, and practices in and across organizations and systems.

4. Relationships, networks, knowledge, and skills are sustained and used to improve community. (See Figure 1.)

Evaluation interviews with community residents revealed the impacts of the early lack of clarity from The Trust on the strategy goals, roles, and parameters. Residents asked for a clearer, more streamlined process, with structures and supports in place. In response, The Trust set more explicit goals and milestones for each phase of the work and expectations for health equity alignment for community issues and solutions.

Lesson No. 2: Building Relationships, Structures, and Capacity Is Critical

Working directly with community members who were largely unfamiliar with foundations and had not previously engaged in this type of work was an early challenge. This was fundamentally different than working with nonprofits that are familiar with foundations, their culture and practices, and are poised to receive funding. Foundation staff were also not used to working directly with residents. We very intentionally focused on resident team members who were not nonprofit leaders or formal power holders. Consequently, residents needed more time to understand philanthropy and to build relationships with each other as they stepped onto newly formed teams together. Often, there were interpersonal conflicts on teams that mirrored racial, ethnic, and other dynamics of the community at large, and they needed to be addressed.

While the strategy team began to roll out tools and trainings on health equity and programmatic tools around issue selection, root cause analysis, solutions research, etc., it became clear that there was also a different set of capacities needed for this work — technical capacities like meeting facilitation and conflict resolution, as well as knowledge and skills necessary to work with The Trust, such as creating documentation and working with budgets.

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with The Trust, such as creating documentation and working with budgets.

Just as relationships needed to be built within community teams, relationships and trust also needed to be built between the Community Partner — a foundation staff member — and community members. The prospect of a resident-driven strategy that was funded by an unknown foundation seemed too good to be true, and residents were skeptical. Residents were hesitant to get into a community planning process without seeing some demonstration of commitment from the foundation.

Although The Trust was most interested in the long-term equity plan in communities, we recognized the importance of demonstrating commitment. This resulted in what we called "short-term-win funding," where communities were granted up to $20,000 for smaller events like festivals and cleanups, and for such infrastructure improvements as solar-powered streetlights, a community garden, or a drinking fountain at the park. While this was intended as a way to show commitment and build trust, interviews with community members showed that these short-term wins were extremely important to communities. They demonstrated not only that the foundation was serious, but perhaps more importantly, also showed the broader community that resident teams were credible and would be working to bring change to their communities through this partnership. It also was a clear indicator to The Trust of the community's need to take action earlier, rather than sitting in an extended planning period — a lesson that would become prominent in our revision of the model.

The Trust needed a mechanism for funding community groups that did not have a tax-exempt or nonprofit 501(c)(3) status. The Trust's decision to contract with one central fiscal sponsor, as opposed to several regional or community groups, created consistency in the strategy but also added a complicated layer of role coordination as this new partner entered the work. Resident teams put their processes and structures in place and hired staff,[3] through the fiscal sponsor, to support the work. The fiscal sponsor then managed personnel, budgets, human resources, and liabilities on behalf of the community. This meant that teams selected staff to support their work who then needed to meet a set of requirements set out by the fiscal sponsor, and for whom a staffing relationship was managed by the fiscal sponsor. The foundation and fiscal sponsor also required a full-time coordinator position to serve as a point person for the work. While this coordinator was selected by the resident team, the position itself was nonnegotiable and was funded through the grant to the community. These serve as further examples of resident-informed, and not resident-led, processes. While The Trust talked about its desire for resident-led work, we were making decisions that impacted the structures and staffing of the CPHE communities. Ultimately, the needs of the foundation to have consistent structures and systems in place came into conflict with desire to be truly resident driven.

The nuanced issues that we came up against in these first five years ranged from the liability associated with funding community events that included such things as pony rides and bouncy houses, child care, and food provision, to intense interpersonal conflicts and human resources issues. With each situation, the need for more structure and clarity became more apparent. As much as we wanted to create structures and processes that were simple, streamlined, and grassroots, this was difficult to do in practice, given the legal restrictions of a private foundation and the complexities of doing community work. The Trust did bend, adapt, and shift in important ways over these five years. However, we were not equipped as an organization to support resident-driven work to the extent that we wanted, and did not anticipate the vastness of issues we would need to confront.

[3] Project staffing depended on the region and community, and included a variation of part-time, full-time, temporary, and grant-funded staff.

Lesson No. 3: Engaging the Most Impacted Is Difficult — and Essential

The CPHE strategy at its core is both a place-based and people-based approach to grantmaking. Patterns of disinvestment in low-income communities and communities of color have resulted in disparities in access to health-promoting resources. Structural inequities are the result of power and resources being organized differentially across lines of race, class, gender, sexual orientation, gender expression, and other dimensions of individual and group identity (Baciu, Negussie, Geller, & Weinstein, 2017).

From the outset, CPHE sought to partner with people in communities who experience adverse impact and treatment (unintentional and intentional discrimination) in their everyday lives. By focusing on equity, we knew early on that who we were working with in communities was as important as where we were working, how we were working, and what we were working on. It was crucial to engage those most impacted by inequities in the process of defining community issues and solutions, but this proved to be more difficult than anticipated. Some resident teams began with a cross-section of community members that didn't include those most impacted by systemic inequities, hoping to recruit others later. However, these individuals were difficult for teams to recruit and retain, and those most impacted by systemic inequities often struggled within teams to advocate for their interests. The length of the process and time commitment also presented a barrier to participation. Community health-equity plans were focused on populations that experience inequities, but the level of participation of those individuals in the decision-making process varied. Community Partners struggled with this issue throughout the five years, trying different tactics to recruit, retain, and center those most impacted by issues in the work.

One approach was to seek out and form relationships with informal leaders in communities of identity, and train those leaders early to lead aspects of the work rather than the foundation staff. This proved successful in some communities. Another approach to recruit those most impacted by inequities was to pay them for their participation in the work. Once again, however, we experienced a gap between our commitment to honor the effort and participation of residents, and the execution of that commitment. We wanted to use monetary payments, with CPs and resident teams able to decide their structure for resident compensation. But teams across the state set up different systems for payment and had different expectations among team members around meeting attendance, responsibilities of the team members to receive payment, and so forth. It greatly increased workload for Trust staff, who managed all of the payments, and created tension across CPHE communities when they learned of different payment amounts in different communities. We shifted to a consistent and streamlined tiered-payment system with three levels of monthly payment depending on the level of resident participation, however, the practices remained inconsistent across regions and a challenge to manage. Regardless of how they were implemented, resident payments were controversial on the resident teams as well as within The Trust.

Payments at times created internal animosity on resident teams when people would not show up for all meetings but got paid nonetheless. Strategy staff at The Trust debated whether payments fostered community-mindedness in the right way. Most critical of all, despite exhaustive efforts we were unable to figure out how to pay everyone who participated in the work — including those who were undocumented or who were on public benefits and faced a cliff effect wherein they would lose public benefits because of the small increase in earnings for participating. Given the equity focus of this work, this reality was difficult for The Trust to accept. Ultimately, we made the difficult decision to end resident payments until we could find an alternative that met the needs of the diverse residents who participate in the CPHE work. Although most teams remained engaged, some lower-income residents left when that strong incentive for participation ended; their departure shifted the demographics of the teams

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and was a further setback to engaging those most impacted by inequities. In some communities, alternative approaches to compensation were piloted, such as a central pool of funding from the foundation based on participation that residents could then grant to partners (i.e., a donor-advised fund) or use for local projects. These had varied levels of success.

Lesson No. 4: Community Change Is Not Linear

The phased approach to the CPHE work was a response to requests from both the Community Partners and resident team members for clarity. While it was responsive to that request, it was implemented while work was already in process. We were forming the strategy as we were carrying it out, rather than forming it to meet our long-term vision of building power to achieve health equity. We were also working within a framework that foundations know well — planning and implementation grants.

Resident teams told us they appreciated the clarity of the phases and being able to see where they were going in the process. However, they were frustrated that the process took so long; many residents understandably did not want to sit at a table planning for many months. Some team members who had joined because they wanted to do things for their community got frustrated and left the team. While it is inevitable that this work is not for everyone — it is hard, long-term work, with a lot of relationship building — we agreed that the process needed to be streamlined and was not accommodating community rhythms or how change takes place. Resident teams wanted to be taking action earlier, not only because of their own motivations, but also because they perceived skepticism in the broader community. The early actions that teams were able to take were important for both establishing trust in the foundation and gaining credibility with the broader community. It also helped resident teams practice making decisions together, planning, and spending money, even if the projects were small community actions or events.

The CPHE strategy was launched with eight communities that formed the first cohort, but new communities were continually entering the work. In each subsequent community, we adapted to streamline the process and add clarity, so some issues around timing of the phases were adjusted. However, it was clear to us that we needed to shift to an approach that centered action.

Lesson No. 5: The Strategy Demanded Dramatic, Unanticipated Shifts

Community Partnerships for Health Equity quickly became a cornerstone strategy of The Trust. From the outset, Trust leadership made the difficult decision to restructure staffing to best support the work we were trying to do in communities (Csuti & Barley, 2016). We knew at the time that this decision would make waves in the organization, but we did not anticipate the extent to which the CPHE strategy would set off changes in the foundation — in every department, at every level, and perhaps most of all, culturally. Notions among foundation leadership of what the work could or should look like often came into conflict with CPs' approaches. There was a culture clash between CPs who had largely been hired because of their community-mindedness, community experience, and positionality outside of philanthropy. This exemplified the chasm we were trying to breach in shifting to community-driven work. The coming together of these two perspectives would take time, careful attention, and a

continual building and repairing of trust over the next five years.

Not all of the structural changes that took place were required to implement a strategy like CPHE, but all were necessary to do it well. At times, it felt as if the strategy itself was pulling the organization along. To the credit of Trust leadership and board, with each challenge the strategy presented to the organization there was an openness and willingness to make change, and the commitment to the strategy deepened.

Beyond the hiring of CPs, there were other major shifts. Total foundation staff increased in size by 82% in 12 months, and we grew from one central office in Denver to nine offices throughout the state. The strategy also used contractors for facilitation, training, note taking, data analysis, evaluation, etc., on an as-needed basis. In 12 months, consultant contracts increased in dollar value by 295%. Clearly, considerable resources were dedicated to supporting the strategy. New practices, policies, and structures within The Trust were needed to support these changes.

The sharp increase in the number of staff and their diverse skills and experiences fundamentally shifted the composition and culture of the organization. It increased the appetite for community power-building work and deepened our understanding of what it takes. At the same time, the increase, along with inconsistencies in positions, skill sets, and hours across regions, was a management challenge. More changes would need to take place for the second five years to be successful.

Creating the Community Partnership Organizing Strategy

The central vision of the CPHE strategy — building community power to achieve health equity — remains unchanged, but lessons from the past five years have led The Trust to pivot to a new approach for achieving that vision. Community organizing is central to this next iteration, called the Community Partnerships Organizing Strategy. The foundation has again restructured staffing to eliminate several positions that existed in the phased approach and add new staff positions to support the strategy. Aligning position descriptions and onboarding processes allowed for a consistency across regions and communities that did not exist in the phased approach.

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The Community Partner continues to oversee strategy in the region where they live and work. Each manages a regional team that now includes a senior community organizer, community organizers (one per community), and a project administrator,[4] all full-time staff of the foundation.

Community organizers in each CPHE community support the development of a group of seven to 11 grassroots community leaders to organize around health equity issues in their community and create a durable organization, networks, and partnerships across the state to pursue systemic change. These leaders have personal experience with equity issues facing the community and their participation is not based on professional roles. While they do receive an honorarium for participation, the honorarium system allows residents to designate all or a portion of the amount to a nonprofit of their

[4] Not all are new staff; some have shifted from previous roles in the phased approach.

FIGURE 2 Community Partnerships Organizing Cycle

This organizing cycle is not original to The Colorado Trust. It is a variation on many similar organizing cycles that have been developed in the field of grassroots community organizing over the course of the last 50 years.

choosing if accepting payment is problematic. A memorandum of understanding with The Trust outlines the responsibilities to be met to receive the honorarium.

Using the community partnerships organizing cycle as a guide (see Figure 2), these teams work together to prioritize local health equity issues. While communities may choose to work on similar issues, each develops a plan that is specific to their community's unique context, history, and environment. For example, a number of communities have prioritized safe access to parks and recreation; yet each has approached the issue differently: Some have organized and leveraged funding from other foundations to build park spaces, while others sought to persuade city government to invest municipal resources.

Currently, 27 staff have been hired into the organization for the CPHE strategy. As new communities enter into partnership with The Trust, additional organizers will be hired. At its maximum, the strategy will have 42 full-time staff across the state, and the organization as a whole will have about 65 full-time employees. This is in contrast to 25 full-time staff at the foundation prior to the CPHE strategy, none of whom were remote staff.

As in the phased approach, the foundation has grappled with this high number of staff to support one strategy. In philanthropy, this can often

read as supporting overhead and operations over direct investment in community. However, strategy and foundation leadership have committed to this investment in human capital as crucial to the community organizing approach and its long-term success. As an investment in people and their ability to organize more people, ideas, and resources to build power, it is central to the foundation's commitment to health equity.

In contrast to the first five years, the new approach was led by the CPs, with particular influence from those who had community organizing experience and had already been using organizing tactics in their CPHE work. It clearly lays out goals and tactics of the strategy up front, as well as the cyclical approach to the work. (See Figure 2.)

Goal No. 1: Support community organizers in developing leaders in communities.

- Hire and work with community organizers to identify and develop leaders in partnering communities.
- Work with community leaders to identify and develop, through training and/or practice, the core competencies of community organizing, such as relationship building, issue selection, issue research, action, and evaluation.
- Support leaders in creating and identifying leadership development opportunities for other people in the organization rooted in self-interest.
- Partner with local, regional, and national grassroots organizations to provide training and support for community leaders.
- Provide honorariums to value contributions of a defined core group of community leaders.

Goal No. 2: Support communities to take collective action to change the policies, practices, and living environments in and across places, organizations, and systems.

- Work with communities to develop a strategy and tactics to achieve shared short-term and long-term goals.
- Leverage funds, social capital, and resources from The Colorado Trust to support resident actions.
- Support residents in taking a variety of actions, and direct funds to advance their goals.

Goal No. 3: There is a durable, community-appropriate organization in place to build power and mobilize resources beyond the investment of The Colorado Trust: recruit people, develop leaders, gather information and organize the money needed to accomplish the goals.

- Support communities to develop a structure, including defining community, mission, vision, goals and strategy, values and group norms, issues focus, leadership, staffing and volunteers, and decision-making processes.
- Support communities to determine an appropriate, durable fiscal structure and legal status.
- Support practices to promote ongoing improvement via evaluation and strategic learning.

Goal No. 4: Support communities in being a meaningful part of an organizing infrastructure that is being built regionally and across the state.

- Contribute to the pool of skilled, trained organizers across the state by ensuring that the partnership's community leaders have the qualifications to be employable community organizers as the infrastructure gains strength.
- Build greater alignment with other foundation strategies and organizations through shared training, agenda alignment, capacity building, leadership development, and policy advocacy.

The Community Partnerships Organizing Strategy builds on the successes of the phase approach and learns from its failures. The CPHE strategy evaluation revealed an increased sense of empowerment, agency, and efficacy among community members who participated in the strategy.

- Support the partnership's community leaders in building networks and aligned agendas with community organizing and advocacy groups across the region. Tighter networks across the state increases the likelihood of achieving wins that significantly improve people's lives and closes the health equity gap.

The process that community teams will go through has been clearly laid out and visualized by the CPs. This cycle, based on community organizing approaches that have existed for decades, adapts tried and true elements of organizing to The Trust's philanthropic context. One such adaptation from a typical, direct-action organizing approach is expanding the spectrum of community actions that could be supported by the foundation to include those that The Trust has not historically funded, and in recognition of the diversity of Colorado's communities and their readiness to engage in organizing. While grants to nonprofits remain a prominent approach to making community change under this model, there has been a shift in who drives this process. Community members now decide when and why a grant is needed, the amount and length of the grant, and to which trusted partner the grant should go in order to accomplish the community's goals.

Why This Pivot, and Why Now?

The Community Partnerships Organizing Strategy builds on the successes of the phase approach and learns from its failures. The CPHE strategy evaluation revealed an increased sense of empowerment, agency, and efficacy among community members who participated in the strategy. Communities continue to have a number of successes. Team members have felt empowered to run for — and have been elected to — local positions of power. Resident teams have worked to expand the number of candidates on a local ballot, increased parent engagement in the selection of a school superintendent, created new opportunities for youth, closed technology gaps, funded programs to fill service gaps, created new partnerships, and convened stakeholders, among other achievements. The prior work of resident teams built trust with the broader community and laid the groundwork for teams to respond quickly and effectively when the COVID-19 pandemic hit Colorado. The evaluation of CPHE to date has uncovered key wins around resident-identified priorities, shifts in local systems, and the ability of people most impacted by inequities to have greater control over decisions that affect them. Teams will no doubt continue to add to, and deepen, their accomplishments in the remaining years of implementation.

However, the Community Partnership Organizing Strategy makes explicit the focus on not only individual skills, leadership, and empowerment, but on building collective power — what happens when a group of people come together and take action and effect systemic change. We are investing in community organizing as the approach to help communities intentionally build collective power and make systemic change more effectively, and believe that this will be a more direct approach.

The cycle is action-oriented, emphasizing learning through continuous action, in opposition to the linear-phase approach that separated the planning and implementation process. Actions can be big or small, and include:

- *community building actions* — building relationships and expanding the base of the support network and network of influence in the community;
- *direct service actions* — doing something for the community, such as making grants to nonprofits to help groups address an issue residents are concerned about or to provide a needed good or service that is currently unavailable or inadequate;
- *self-help actions* — communities working toward supporting themselves, including making the decisions about how this is best achieved;
- *education* — learning about an issue through forums, workshops, etc.;
- *advocacy* — speaking on behalf of self-and/or others; and
- *direct actions* — persuading a target to move with a specific engagement, request, confrontation, or demand, and shifting existing power structures.

In contrast to the phase approach, communities will draw upon action funding, administered by the foundation, depending on the size and scope of their proposed action. This is in contrast to the set amount of grant funding across each CPHE community, which was administered through a fiscal sponsor.

The new approach directly lays out a goal (No. 3) around the development of a durable community-appropriate organization, which could take a variety of forms (e.g., strengthening or joining an aligned organization, working through a fiscal sponsor, becoming a 501(c)(3), creating a donor advised fund, building a coalition). This makes clear the pathway for sustainability in a way that the phased approach did not. It also makes way for achieving Goal No. 4 — partnerships, networks, and coalition building that are necessary for systemic change, particularly in smaller communities.

In many ways, the pivot to the new approach is a natural deepening of the CPHE work of the foundation. While the CPs and strategy team needed to learn through experiences in communities, The Trust also needed to learn what it takes to support this work well.

In many ways, the pivot to the new approach is a natural deepening of the CPHE work of the foundation. While the CPs and strategy team needed to learn through experiences in communities, The Trust also needed to learn what it takes to support this work well. Five years ago, it was not ready to center and support community organizing in the CPHE strategy. This is likely for a variety of reasons, including a lack of understanding about community organizing and how it could be applied to a philanthropic context. It has also been an ongoing process to come to terms with the at-times controversial nature of community organizing, in which upsetting the status quo is a core tactic. Turnover in key leadership positions at the board and executive levels opened the door for more peer leadership and a deeper understanding of community organizing to create organizational readiness for this new approach.

Conclusion

This evolution is not complete, and The Trust will continue to learn from the communities that continue in the phase approach as well as those who are part of the Community Partnerships Organizing Strategy approach. The tensions we are grappling with now differ from those of the past five years, but the tensions will always exist.

Currently, we are learning what it means to center community organizing within a foundation.

This includes not only the legal and fiscal limitations of what private foundations like The Trust are able to do, but also what the appetite is among foundation leadership for the ways that communities might push and challenge power holders. We are learning how to leverage our power to effectively resource the action cycle and to show up in support of CPHE communities when we need to. While the CPHE strategy began with a vision of sharing power with communities, it has evolved to include both building power in communities and wielding power in support of communities.

We have a challenge ahead of supporting a large number of communities, some of whom are following the phase approach and some of whom will be using the Community Partnerships Organizing Strategy. This is in addition to many other ways that the CPHE communities with whom we partner are diverse (e.g., racially and ethnically, historically, in population size and density, politically, culturally). The new approach that amplifies organizing tactics, partnerships, and coalition building may be more challenging to get off the ground in some communities than others.

The work of the past five years has never felt settled. Operating in the space of constant tension, reflection, and change can be exhausting for strategy staff, for communities, and for the foundation. As we stated in the 2016 article, "It's not easy for us. It's not easy for residents. It's certainly not keeping us in our comfort zone" (Caustic & Barley, 2016, p. 80). Yet, we believe that this is the slow, long-term work that needs to be done to see equitable community change. The relationships we have been able to build with communities in Colorado and the impacts of the strategy over the past five years are what keep us going. Despite the tensions, challenges, and failures of the past five years, we remain committed, asking: "What if it does work?"

References

Baciu, A., Negussie, Y., Geller, A., & Weinstein, J. N. (Eds.). (2017.) *Communities in action: Pathways to health equity*. National Academies Press.

Csuti, N., & Barley, G. (2016.) Disrupting a foundation to put communities first in Colorado philanthropy. *The Foundation Review, 8*(4), 73–80. https://doi.org/10.9707/1944-5660.1328

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