EMORY | ROLLINS SCHOOL OF PUBLIC HEALTH | Interfaith Health Program
Hubert Department of Global Health

Title Strong Partners Program Report to the US Centers for Disease Control and Prevention

Author Fran Wenger

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Location N/A

Background In 1997, the Interfaith Health Program worked with the Centers for Disease Control and Prevention to host an initial meeting on "Realigning Religious Health Assets." Health care conversion foundations with a religious mission and a commitment to improving the health of the public participated in this dialogue and became the foundational network later known as the "Strong Partners." The Strong Partners network helped to set the stage for IHP's work in community-based networks across the US—networks still in partnership today—through the Institute for Faith and Health Collaboration at the CDC. This document summarizes the activities carried out under the Strong Partners initiative as of November 2000.

Strong Partners
for Community Health
and Wholeness

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This document was prepared for distribution following the meeting held at the Wyndham Greenspoint Hotel in Houston, Texas on October 24-25, 1999, sponsored by Episcopal Health Charities/Houston and Interfaith Health Program, Rollins School of Public Health, Emory University, Atlanta, GA

Section 1

Meeting report: October 24-25, 1999

Strong Partners: Fall '99 Houston Meeting Report

October 24-25, 1999 - Houston, Texas

Sponsored by Episcopal Health Charities and the Interfaith Health Program

Introduction

The Interfaith Health Program (IHP) and Episcopal Health Charities (EHC) convened the meeting that included representatives from foundations that fund faith and health projects, IHP's Faith and Health Consortium Sites and several Houston based organizations. Fifteen of the 33 invited foundations were able to send representatives to the meeting. The remaining 18 foundations requested follow-up information on the meeting (see Sections 3 and 4).

The purpose of the meeting was to provide a venue for networking among the foundations and with key faith and health leaders from throughout the country. The topical focus of the meeting was evaluation accountability.

Each organization was encouraged to send copies of their key documents and their evaluation and accountability strategies. A summary document of that data was prepared (see Section 5).

This report provides highlights of each component of the meeting that began with an informal evening reception and discussion of expectations for the following day. The meetings were held at the Wyndham Greenspoint Hotel, Houston, Texas (See the agenda in Section 2).

Initial Discussion

The attendees presented these questions and concerns they wanted addressed the following day:

- How do we work with communities in communities?
- How do we work with congregations in communities?
- How do we break down the inter-Christian, interfaith, inter-racial barriers?
- What have you done to account for what you do?
- How do you enhance the spiritual well-being in a community?
- How do you study the spiritual well-being of a community?
- How do you evaluate the work that is done?
- We want to learn not only about evaluation of direct services provided for with foundation resources, but also about evaluation of advocacy, community change, and systemic change.
- How can we push to include services and human care with places of worship?

The meeting convened on Monday morning with a welcome by Dr. Fran Wenger and a meditation by Dr. Fred Smith, both of IHP. Dr. Carla Cooper added words of welcome from Episcopal Health Charities.

A Strategic Moment for Strong Partners – Dr Gary Gunderson, Director, Interfaith Health Program

Dr. Gunderson began by setting the context for what we have called the Faith & Health movement and by addressing issues of accountability and alignment. No health structure is capable of fulfilling its core mission by itself; the answer is alignment and is profoundly dependent on leaders operating at the boundaries between systems. Four issues have emerged regarding the complex and ambiguous religious history in the U.S. health infrastructure: (1) the link between private spirituality and private wellness; (2) the alignment of religious structures and public health; (3) renegotiations of social/political responsibilities; and (4) congregational vitality in community. What does it mean to be a faith structure at this point in American history?

The determinants of health include physical, mental, social, cultural and spiritual factors. Our different disciplines recognize all these different factors and point to methods of alignment. The measure of accountability is first, Do no harm. Do not obscure that which is clear. Do not add premature clarity (simplicity) to what are emerging (complex) phenomena. We are interested in evidence-based accountability, increased capacity and not just outcomes. We are interested in collaborative behaviors and transferable social capacity. We are interested in policies that are conducive to alignment. There is no "off the shelf" deal or system that is already doing all this. There is no next overhead with all the answers! But there is a movement in the United States that is talking about these hopes for the future. There is one agenda for this meeting: the institutions represented at the meeting have a critical strategic leverage point that the other structures don't have. They can challenge the rest of the system (larger foundations and hospital systems and denominations and congregations) to move deeper and further.

Interests in Alignment Around Common Standards – Mr. Michael Hatcher, Community Collaboration and Partnerships, Public Health Practice Program Office, Centers for Disease Control and Prevention

The CDC is a resource, a science-driven organization, focusing on what they know is effective in preventing health problems. Public health shares the value of social justice, and the CDC is looking for partners who can help them understand how they can best work together. To this end Hatcher discussed three program initiatives.

1. In January 2000, Healthy People 2010 will be announced, establishing broad-based objectives for the nation, providing guidance on activity and outcomes for changing and improving health, and addressing disparity issues. The program deals with infrastructure and community-based programs and a wide array of health-disease issues.

2. September 17, 1999, our *Morbidity & Mortality Weekly Report* (MMWR) presented a framework for program evaluation in public health. The purpose is to devote both skills and will to the social contexts that influence health disparities and to remain accountable to developing measurable health outcomes. The information is available online at

http://www.cdc.gov/epo/mmwr/preview/mmwrhtml/rr4811a1.htm. The evaluation framework is set up to address six steps. Step One is *engage stockholders*, Step Two is *describe the program*, Step Three is *focus the evaluation design*, Step Four is *gather credible evidence*, Step Five is *justify conclusions*, and Step Six is *ensure use and share lessons learned*. In Mr. Hatcher's opinion, this will become the standard for evaluating public health programs.

3. The CDC's Community Preventive Services Guide is available online at http://www.cdc.gov/epo/dpram/dpram.htm. Again, the focus is on measurable outcomes but is not a completed project. There are three categories of determinants: equity and social justice, environmental and societal resources, and physical/natural resources. They also want to identify what builds trust and social capital in order to better prepare communities for the kinds of interventions they need.

Discussion: Discussion ensued around the importance of the spiritual component, and whether it was missing on the CDC's list or implied. Questions were also raised regarding the definition of "social capital" and how spirituality can be measured. Some examples were given of various cities and organizations involved in such studies. There was much discussion around the community's decreasing trust in our healthcare system and the need to address how we pay for healthcare in this country.

Development in Denominational and Congregational Strategies - Rev James Wind, The Alban Institute

This is a powerfully critical moment in our culture and in our religious world, with an openness to change that has not been there before. The religious reality is restructuring, particularly in mainline Protestant denominations. In the 1950s a denominational leader could command the attention of the President or State Department, and the mainline groups had a great deal of clout. We're living through a period of the effacement of the denomination. He also sees great congregational entrepreneurism and changes in the leadership dynamics, renegotiation between roles of clergy and lay people. The great myth is the image of the homogeneous congregation, how similar and easy to direct these groups are. Churches are dying, being reborn, "reinventing themselves." The initiative is not coming from the denomination down, but up and across and around. Congregations are where the action is. The next dynamic to consider is the mixing of cultures; there is tremendous renegotiation and hard work going on under the surface. Engaging congregations requires creativity. We are calling on congregations and faith-based foundations to take on a new public role. We're redrawing the line of separation between church and state. In the 1960s people said these institutions were increasingly irrelevant. Now, from all angles of society, people are saying we need help from these institutions if we're going to make it.

We have all sorts of assumptions about what congregations do, but we don't really know their contribution to the public good. There is great irony in the assumption that congregations don't do much, alongside the assumption that they could easily do a

lot more (e.g., charitable choice legislation). Program evaluation in our denominations and faith groups is crucial, but what is there is "wishful thinking" too much of the time. We prefer anecdotal stories, and we don't get into evaluation unless there's an external funding source that requires it. If we're going to have congregations that thrive in this postmodern world, take on new roles, and are invested in the public good, then we have to build capacity, often in these small organizations, which are the majority. How many churches know how to write proposals? They also need management and infrastructure. How are we going to help them set up restricted accounts for dealing with money from the government for health initiatives? The tremendous danger here is that they lose their mission. Congregations do not exist for the purpose of taking over the welfare obligations of the federal government. The Indianapolis Center for Congregations (funded by Lillie) starts by asking congregations what they want to work, then they connect clergy and churches to other resources, where they can work on it together. The Center stays involved after the referral is made with labor-intensive follow-through. They eventually want an international, electronic way to offer a learning environment and feedback.

Discussion: Questions were raised about leadership development initiatives and how to resolve the dilemma that fundraising is a local issue. Dr Wind said one part of the solution is a website that is more interactive, with paths of learning. We also need resources working with people locally in an intentional way. The Indianapolis Center is an experiment with a new way of linking people with resources that does not require old denominational judicatory structures, which are already overstretched. Another attendee said that foundations with particular community focus do have a role to play in issues of locality; they help start-up programs learn how to do grant-making, how to mature and be sustained as an organization, etc.

Vision/Mission and Accountability for Outcomes in Foundations: Two Case Studies - Ms Diane Pavey, Episcopal Health Charities, Houston

In partnership with the diocese and community, EHC increases opportunities for health enhancement and disease prevention, especially among those otherwise under-served, and makes possible measurable improvement in community health status and individual well-being. Their key values are whole person, whole community, wellness, informed action, collaboration, and empowerment. They want to teach congregations how to fish. How can we empower churches to enhance health? How can we make a report card for them to compare among themselves? How do we set priorities, and how do those priorities drive specific grants of investment back into the community? Health assessment is crucial, as grant-making is to be driven by the most comprehensive understanding of needs. All the information from community profiles has been placed on the website, which includes a customized mapping function where one can self-define a geographic area to study. Seven years of information is on the website and is continuously updated, providing a means to build a case for a program and develop a plan for it. Their Evaluation Model is collecting, learning from, and sharing information, both what is working and what is not, and then housing this information in a "web-ready" way.

They ask grantees to assess the level of spirituality in their program, up-front as well as during the review process. Their first value is the whole person—body, mind and spirit. They ask grantees to share insights or examples (parables) of the relationship between spirituality and health, for individuals and the community. They have medical residents asking patients, for the first time, how spirituality contributes to their health. They also ask grantees to look at the logic and assumptions and to work with each member of the collaborative to see how to rank priorities, plus how to make adjustments as needed to meet those priorities. This tool has turned out to be helpful to them on a daily or quarterly basis and not just on a report to their funder a year later. They want to make it all "web-ready" so they can share the information, creating a community of miraculous expectations.

Discussion: Discussion focused on linking evaluation systems and the need for non-duplication with community systems.

Vision/Mission and Accountability for Outcomes in Foundations---Rev Jerry Paul, The Deaconess **Foundation, St Louis**

When the Deaconess Foundation sold their hospital and became a conversion foundation in 1997, they had to decide who they were and how they were going to operate. They knew how health care was delivered in health systems but not how it was delivered in community. They started by spending time examining the questions. First, what are faith communities? Then, what is the universe of interest? Is Gary Gunderson right when he talks about 10% of congregations being meaningfully engaged in health ministry? So do we work at expanding that universe (convince others to participate) and/or enhance what's there? Third, what is the capacity? Paul challenged the assumption that faith communities are sitting around with capacity and just waiting to take on a new role.

Deaconess Foundation has decreased its minimum award from $10,000 to $500 in response to the needs of pastors and churches, and requests have increased dramatically. But do foundations bring more value than just money? Foundations may get an audience just because they have the money, but we shouldn't be content with that. How do we collaborate as foundations? How do we take a seat alongside rather than in front of the institutions with which we work? We too easily get persuaded by the notion that money equals power and power equals getting to be the convener and adjourner. Are we willing to throw our money into the same pot and give up individual veto power? And what is the role of other organizations in the community, such as Schools of Public Health? What models have emerged for how to work with congregations? How do we take individuals from hospitals, and that mindset of huge budgets, and shift to microlevel, one-on-one? What is evaluation, especially for programs at this smaller level? We have to be careful about losing the mission. Finally, how do we evaluate our faithfulness in the end, for ourselves as a foundations as well as the program we're funding? How does faithfulness get instituted into a measurement? In the end, God does not call us to be successful, but to be faithful.

Outcomes Engineering - Dr Barry Kibel, The Pacific Institute for Research and Evaluation

The traditional way to assess performance uses the wrong paradigm--analytical. John Allen Paulos (1998) said: "The gaps separating statistics and stories, impersonal probability and subjective viewpoints, logic and informal discourse, information and meaning are bridgeable in places, not so in others, and seldom well-marked." The logic system can break down because we are dealing with a dialogical model. In putting things into statistical packages, we tend to lose the essence, the story. Through the process of dialogue, creating stories, things change.

Dr. Kibel developed a story-mapping technique called "results mapping "and has now simplified it to a 15-level prototypical journey. Each level is a deeper step, all falling along three stages: contemplation and preparation (4 levels), actions and successes (8 levels), and legacy (3 levels). Many hit the midway point and meet obstacles, and don't move on. Others realize that to move on they have to redefine themselves. Possibilities are sometimes limited by the programs around us. It is important to know who are not your boundary partners. In statistical buckets you have to be exact, but in journeys you have to be approximate. It is more for seeing where clients are on various journeys. It helps provide a sense of how all the people are moving along. You can still build statistics out of stories. Their new website (www.outcomeengineering.com) has real time evaluation for updating their own stories and looking at other people's stories.

The process begins with defining the vision; a vision or mission statement that gets outdated results in a loss of passion. The next step is defining your boundary partners. You don't measure the outcome; you measure the journey. It is not for looking out but for looking in. Outcomes Engineering is not very old, but it is being used by: International Family Research Center in Canada (Equivalent of USAID); West African Rural Foundation; Health Trusts in Santa Clara County, California; Tri-health in Cincinnati; Rod's program, Bon Secours; Interfaith Health Program in Atlanta; QueensCare. And we have a number of state contracts: Nebraska, Indiana, Ohio, Vermont, Colorado, Texas.

Discussion: Susan Fuentes shared positive experiences with the program. The story method resonates with pastors, school principals, agency directors, and parish nurses, who have something to say beyond counting numbers. Discussion ensued around issues of money management and resources going to the provision of services rather than evaluation. Gunderson suggested this practice is subversive: it is not a good way to hold people accountable and keep track of how they spend your money, but it is a good way to encourage people to reach for something that is beyond them. The gain is internal long before it's external. Questions were raised as to the application of Dr. Kibel's program to different settings, including the academic environment to evaluate students' journeys through the institution. Others said that if there was some common acceptance of this strategy, such as by these conversion foundations, there could be a critical mass of change. One attendee said she was intrigued with the need for those working in faith-based institutions to claim another way to measure, out of our deep understanding and grounding in who we are as people of faith, rather than simply the bottom line. Discussion ensued around imposing evaluation structures on grantees and the need to

adapt structures to fit each organization. Others spoke of the suspicion of stories representing selective exaggeration and the need for a countervailing force to recognize failure. Kibel argued exactly the opposite, that what we've been missing is the positive in our evaluations. With needs assessment, the focus is on the negative; with outcomes engineering, the focus is on assets. Mimi Kiser is the link at IHP if attendees want to try to develop this accountability process in their area.

Concluding Comments

- **The need for building consensus and trust**

There are deep chasms between not just African American and mainline White organizations, but among the different congregations. We often have not developed trust, the basis for conversation. Foundations are still stuck on "doing for" rather than "doing with." Working across and between different faith traditions and groups is messy and complicated, and it takes energy and a willingness to say that my world view is not everybody's world view. The first step is to know our own culture, our own world view. But at these types of gatherings there tends to be a significant absence of minority representation, and it is difficult to even have this type of discussion without that representation.

- **The diversity of opinions regarding evaluation**

Many were excited about Kibel's work for a variety of reasons, including the fact that people want to tell their stories, and it gets people interested in evaluation. Another said the telling of stories isn't absolutely dependent on Kibel's model, stating that there is still significant value in quantitative measures of health indicators, while not limiting ourselves to "health" meaning the absence of disease.

- **The need for direction**

This type of gathering is a way to start establishing some subconscious values, but how do we continue the conversation and extend it to other issues such as race? We've been developing the infrastructure for the faith-health movement, and now we need some type of next step or envisioning of where we go from here. At these meetings, it is never the same group twice, which makes dialogue difficult over time. We need to build on previous experience to develop community memory. Eighteen additional foundations couldn't be here but said they were interested in what happened and wanted to be included "next time." One attendee said we still have not found a common vocabulary.

- **The role of the church**

Concern was expressed about the role and function of the faith community in all of these endeavors; we are moving past them because they are absent, both here and at the local levels. As faith-based foundations, we need to examine the context in which we are funding, not just in the context of our own religious community. We have to learn from the successful interfaith endeavors of other foundations, the challenges of learning how to be collaborators in a number of different venues. One possible direction for this group is to address the lack of official congregational involvement and the need to bring others to this table.

The meeting closed with mention of upcoming events and prayer.

Section 2

Meeting agenda: October 24-25, 1999

FOUNDATIONS MEETING
October 24-25, 1999
Wyndham Greenspoint Hotel, Houston, Texas
AGENDA

Sunday October 24, 1999

7-9 PM **Setting the Stage Meeting---Brief meeting to share Foundation materials and review the agenda, including informal networking. Reception with food buffet and drinks**

Monday October 25, 1999 9:00AM – 4:30 PM

7:30–9:00AM Continental Breakfast

9:00AM **Welcome ---Episcopal Health Charities---Dr. Carla Cooper**

9:10AM **Introductions**

9:20 AM **A Strategic Moment for Strong Partners." A brief sketch of how IHP understands the current trends among key components of the faith and health movement that present opportunities and challenges for religious health assets-- including conversion foundations and strong religious health systems---Gary Gunderson, Director, Interfaith Health Program, The Carter Center**

9:40 AM **Interests in Alignment Around Common Standards---Michael Hatcher, Coordinator, Community Collaboration and Partnerships,**

	Public Health Practice Program Office, Centers for Disease Control & Prevention
10:00 AM	**Refreshment Break**
10:15 AM	**Development in Denominational and Congregational Strategies---Rev. James Wind, President, Alban Institute**
10:40AM	**Vision/Mission and Accountability for Outcomes in Foundations---Brief presentation of a few foundations with open discussion from others**
12:00 Noon	**Lunch**
1:30 PM	**Outcomes Engineering: Adapting a values based strategy for faith and health accountability crossing disciplinary boundaries---Dr. Barry Kibel, Pacific Institute for Research and Evaluation (includes discussion time)**
2:30 PM	**Refreshment Break**
2:45 PM	**Windows of Opportunity for Collaboration---Guided discussion**
4:00 PM	**Recommendations for the Future**
4:30 PM	**Adjourn**

Section 3

Attendee list with contact information

THE FOUNDATIONS MEETING
HOUSTON, TEXAS
OCTOBER 24-25, 1999
sponsored by
Episcopal Health Charities, Houston and
Interfaith Health Program of The Carter Center, Atlanta
(Asterisk indicates conversion foundation. All conversion foundations are religious, except the California Endowment and The California Wellness Foundation which are Blue Cross conversions)

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Section 4

Foundations invited but unable to attend

Foundations not in attendance who have expressed an interest in the outcomes of this meeting

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Craig E. McGarvey, Program Director,	(415) 777-2244 (tel)	The James Irvine Foundation	One Market Plaza Suite 2500 San Francisco, CA 94105

Civic Culture			
Dr. Karen Wolk Feinstein, President	(412) 594-2550 (tel) (412) 232-6240 (fax)	* Jewish Healthcare Foundation	Centre City Tower, Ste 2330 650 Smithfield Street Pittsburgh, PA 15222
Ms. Marni Vliet, President & CEO	(316) 262-7676 (tel) ext. 321 (316) 262-2044 (fax) mvliet@khf.org	* Kansas Health Foundation	A Philanthropic Exchange 309 East Douglas Wichita, KS 67202
Sharon Keating Beauregard, Director of Community Programs and Grants	(650) 498-7660 (tel) sharon.keatingbeauregard@lpfc.org (650) 498-2619 (fax)	Lucile Packard Foundation for Children's Health	770 Welch Rd, Suite 350 Palo Alto, CA 94304
Bruce Esterline, Vice President	(214) 826-9431 (tel)	Meadows Foundation	3003 Swiss Avenue Dallas, TX 75204-6090
Sandra Hernandez, CEO Dwayne Marsh, Faith Program Director	(415) 733-8500 ext 518 (415) 477-2785 (fax) (415) 733-8500 ext 572	The San Francisco Foundation	225 Bush Street Fifth Floor # 500 San Francisco, CA 94104-4224
Mr. Tom Keith	(803) 254-0230 (tel)	* Sisters of Charity Foundation (South Carolina)	2601 Laurel Street, Suite 150 Columbia, SC 29204
Dr. Jack Templeton President	(610) 687-8942 (tel) (610) 687-8961	The Templeton Foundation	Five Radnor Corporate Center Suite 100 100 Matsonford Road Radnor, PA 19087

Section 5

Brief overview of materials submitted by invited foundations

Brief Overview of Materials Submitted for Foundations Meeting in Houston, 10/25/99

Foundation	Represented by	Vision / Mission / Evaluation
CHRISTUS Houston, TX	Donna Meyer, PhD Vice President, Community Benefit Jeff Guidry, PhD	**"The CHRISTUS Health mission and vision call us to find new and more effective ways to respond to the needs of our communities and to hold our System accountable for the health and well being of those we serve."** The Social Accountability Directive outlines specific procedures for ensuring that the communities needs and resources are used to develop a "community owned" plan that emphasizes social action programs that seek justice for the underprivileged and work to bring about changes in the political and economic systems. An annual report will detail total amounts spent for Social Accountability and highlighting the best practices and innovative programs within the System.
Danforth Foundation St Louis, MO	(unable to attend Houston meeting / same weekend as trustees meeting)	**"The Danforth Foundation believes it is important to encourage an active faith community in the St. Louis region and to commend a congregation that collectively works to improve its community."** The annual I Dare You Award of $100,000 is to be used as the congregation best sees fit. The intent is to honor a congregation that has demonstrated a strong commitment to ministry beyond its walls and could serve as an example to others.

Deaconess Foundation St Louis, MO	Rev. Jerry W. Paul President & CEO	**Mission: "the improved health of the St. Louis metropolitan community & its people"** The Foundation is especially committed to supporting community-based initiatives to improve the health of children and others at health risk living in the urban core of the metropolitan area, with a particular emphasis on the needs of the poor. The Deaconess Foundation identifies organizations or coalitions of organizations that work in creative ways to address the community health issues for those people with the access to the fewest resources. The Foundations supports programs and services that measurably improve some aspect of community health, that emphasize prevention and wellness, and that positively reflect and project the mission of the Deaconess Foundation.
Episcopal Health Charities Houston, TX **EHC Heads Up Needs Assessment**	Carla Cooper, PhD Executive Director; Diane A. Pavey, Director, Community Support; Celene L. Meyer, Assistant, Community Support Gail Bray, PhD Director of Research	**Will be presenting during the meeting on Monday.** One evaluation asked of its grantees: "Because EHC's first value is the whole person: body, mind and spirit, we are deeply interested in how spirituality contributes to individual and community health. In order to explore and document the many dimensions and manifestations of spirituality and health in our grantee community, we would appreciate your sharing with us examples or insights you might have regarding the relationship of spirituality and health."

Incarnate Word Foundation St Louis, MO	Mrs. Bridget McDermott Flood Executive Director	**"A ministry of the Sisters of Charity of the Incarnate Word, the singular mission of this Foundation is to extend the healing ministry of Jesus Christ, the Incarnate Word….We plan to support or create faith-based ministries that foster healthy lives, promote spiritual growth, and support the building blocks that create healthy communities."** Collaboration is emphasized as key to success. Asks grantees to complete Summary Report in which original objectives are identified, along with plans to achieve them, and the extent to which the goals were met. Also includes evaluation of benefit of the program to the participants, to the grantee, and to the community.
Lutheran Charities Foundation St Louis, MO	Mr. Fred Bleeke President & CEO	**Mission: "Faithful to Christ Jesus, Lutheran Charities Foundation initiates and supports programs meeting the health and healing care needs of underserved people."** Oriented around **5 goals**: Infuse faith values (Christian) into service work of not-for-profit organizations. Engage Lutherans in ways to demonstrate Christian values and beliefs through community leadership, volunteer activities, and philanthropic support. Support the efforts of individual Lutheran congregations to provide health and healing care. Encourage not-for-profit organizations to take a collaborative approach to addressing the health and healing needs of people. Clarify the Foundation's membership, mission, and identity issues with the public and within the Lutheran community.

QueensCare (of the Greater Hollywood Health Partnership) Los Angeles, CA	Susan Fuentes President / CEO Ms. Barbara Pulley VP of Programs	**Vision and Purpose: "We seek to develop wholistic health programs in our community through congregations and other faith groups. We are committed to bringing together the resources of medical science, faith communities, public health and social organizations. Programs are designed to promote health lifestyles with an emphasis on personal responsibility."** **Mission:** (1) to develop and support health programs in faith communities, (2) to promote whole person health, (3) to facilitate partnerships between faith groups, health providers, and community organizations, and (4) to improve the health status and healthy behaviors of our community.
Rascob Foundation for Catholic Activities Wilmington, DE	John J. (Pete) Raskob III	**Purpose: "Engage in such exclusively religious, charitable, literary and educational activities as well as aid the Roman Catholic Church and institutions and organizations identified with it."** The Foundation accepts applications from official Catholic organizations for specific projects or programs. It is the practice of the Foundation not to make contributions to the same organizations on a continuing or regular basis. Need and the good to be accomplished are the prime considerations. To submit a proposal for consideration, the Foundation has an Application Form which must be used.
The San Francisco Foundation San Francisco, CA	Dwayne Marsh, Faith Program Director (unable to attend)	"Over a 4-year period, the San Francisco Foundation and its funding partners have invested almost $600,000 in the FAITHS Initiative, a relatively modest sum that has leveraged significant impact. While it was initially difficult to measure that impact in quantitative terms, there is growing evidence of FAITHS' success in achieving the **3 goals: (1) building capacity and strengthening organizational development, (2) building new relationships, and (3) informing philanthropy about the work of the faith community.**

Sisters of Charity Ministry Foundation Cincinnati, OH	Sr. Maryanna Coyle, President & Executive Director; Mr. Con Kelly, Vice President of Program Development	**"The mission of the Foundation is to support those efforts and ministries that promote the mission and philosophy of the Sisters of Charity of Cincinnati."** **Purposes:** (1) to further systemic change, (2) to support the development of alternate services and programs that will impact the poor and underserved where Sisters of Charity ministries are involved, (3) to promote collaborative initiatives for the extension of services beyond the institutions and for the building up of health communities, and (4) to provide financial support to those organizations identified with the Sisters of Charity and in need of support for viability and growth." Grant applications include an extensive "toolkit" with sample answers to questions on the application and with guidelines for creating realistic budgets. The Foundation regards awards of grants as creating partnerships with grantees; midterm as well as final progress reports are required. These progress reports are individually tailored to each grant application at the time of approval.
United Methodist Health Ministry Fund Hutchinson, KS	Mr. Kim Moore, President	**Mission: "to be a visible Christian witness of love and concern as we use our resources to (1) minister to those who do not have access to health care, (2) mobilize groups and volunteers to provide health care ministries of healing and wholeness, (3) facilitate health care education and preventive services, and (4) stimulate the development and expansion of innovative programs that improve the delivery of health care."** Stresses to its grantees that a grant is not a gift: We invest for results. With that said, our interest in evaluation is clear. Without an evaluation, there are no results to show for our investment." But also emphasizes that evaluation will help the grantee learn to improve services, to know if a program is successful, and to celebrate accomplishment and encourage more. Asks grantees to decide how they will measure productivity, cost effectiveness, quality assurance, and client-centered outcomes.

Wheat Ridge Foundation Itasca, IL	Dr. Richard (Rick) Herman, Vice President	**Mission: "Lutherans seeding new ministries of health and hope, in the name of the healing Christ."** Wheat Ridge encourages the development of innovative projects that seek to meet human needs in the spirit of the healing Christ. Proposals must be not-for-profit and credible, involve a ministry of health and hope, be new initiatives, include local and Lutheran involvement, be timely and unique and for a limited period of time, empower people, be viable with probability for long-term support, and share with others. Outcome goals and process objectives are required in the grant application.

Section 6

Selected References

Selected References

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2. **Gunderson, G. R. (1995, August 21).** ***Foundations must answer community health needs,*** **Modern Healthcare, 110.**

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