A NEW POWER GRID
BUILDING HEALTHY COMMUNITIES AT YEAR 5
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A NEW POWER GRID

SPRING 2016

Building Healthy Communities
at Year 5
Among our Board of Directors, management team and staff at The California Endowment, we take a special pride in a sense of accountability. We are entrusted with the care of a very special gift in the form of resources: the roughly $3.5 billion in assets we hold in the public’s trust in service of our mission. That mission is centered upon improving the health and well-being of California’s underserved communities.

As the year 2015 came to a close, we touched the halfway point of our 10-year Building Healthy Communities (BHC) strategic plan. This plan focuses on improving the conditions under which young people in underserved communities can be healthy and thrive. As you know, a significant portion of the plan involves “place-based” attention on 14 communities across the state. Of equal importance is how the collective learning and energy from these communities contribute to statewide policy and systems change to promote health, health equity and health justice. BHC is a place-based strategy, but with an attitude for statewide change — we call it “place-based-plus” in shorthand.

How are we defining “success” for BHC? For us, the key goals (indicators) of success will not be limited to an arbitrary 10-year timeline. It will be when three things happen to benefit the health of young people in lower-income communities in California:

- 100% coverage and access to health-promoting health services
- 100% of California schools have wellness and school climate policies and practices
- 100% of California cities and counties establishing local health-promoting policies and moving from incarceration to prevention

The thinking behind these three targets for policy and systemic change: the wellness of young people is optimized when the “systems” they encounter — the health care system, the school and the neighborhood — are supporting what families want and need for their children’s health and well-being.

However, we know achieving these policy milestones will represent only surface manifestations of the ultimate success we are seeking. That will be when the power dynamics in the communities have shifted to such an extent that families will be able to hold local officials accountable for full, ongoing implementation of these policies.

Already, thousands of community residents — adults and young people alike — are stepping up to take on this challenge. They are demonstrating courageous leadership. What they are accomplishing in their neighborhoods, at the state level, and in their online communities exceeds all our initial expectations. They are the heroes of the unfolding story of Building Healthy Communities.

We now have five years of implementation under our belt, plus a year or more of planning. We commissioned three independent reviews of our progress, lessons and mistakes. Over the past year, we reviewed the reports with our Board and staff, we listened to and learned from our community partners and we got busy making needed adjustments.

This document communicates our progress, lessons learned and key changes. We do so in the spirit of accountability to three sets of audiences: the community leaders with whom we work, the fields of philanthropy and public health, and ourselves as an organization. Thanks for listening in.
What Has Been Achieved?

Those among us in the field of social-change investing recognize that ascribing positive impact to a specific grant, set of grants, or grant-making strategy is a pretty tricky business; the matters of “attribution” and “contribution” must be carefully navigated. That said, the following is a top-line listing of key results where BHC grantees, with The Endowment’s partnership support, have made a significant contribution towards impact:

1. **IMPROVED HEALTH COVERAGE FOR THE UNDERSERVED.** BHC grantees and partners fought for and supported the successful implementation of the Affordable Care Act and the expansion of Medicaid in California.

2. **STRENGTHENED HEALTH COVERAGE POLICY FOR THE UNDOCUMENTED.** BHC grantees and partners successfully crafted and led the Health4All Campaign, paving the way for state-supported health coverage for undocumented children.

3. **SCHOOL CLIMATE, WELLNESS AND EQUITY IMPROVEMENTS.** BHC grantees, partners, and youth led or supported efforts across the state to reform harsh school discipline and suspension policies and are working to successfully implement school equity funding formulas.

4. **PREVENTION AND REFORM SUPPORT IN THE JUSTICE SYSTEM.** BHC grantees and partners led advocacy support for health- and prevention-oriented justice reform and are leading Prop 47 implementation efforts statewide; one of the key objectives is to funnel prison savings into prevention strategies.

5. **PUBLIC–PRIVATE INVESTMENT AND POLICY CHANGES FOR BOYS & YOUNG MEN OF COLOR.** BHC grantees joined with other coalitions supporting outcome improvement work in young men of color, bringing improved public policy and civic attention to the issue, and resulting in the creation of a Select Committee on the Status of Boys & Men of Color in the state legislature.

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**People enrolled in Medi-Cal**

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<th>2012</th>
<th>2015</th>
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<td></td>
<td>7.6</td>
<td>12.7</td>
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Sources: California Department of Health Care Services

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**Statewide school suspension rates have dropped by 41%**

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<th>2011–12</th>
<th>2014–15</th>
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<td>420,000</td>
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**Up to $1 billion in public funds (state and county) can be reinvested from incarceration to prevention each year.**
6. **LOCAL & REGIONAL PROGRESS, “HEALTH IN ALL POLICIES.”** Perhaps the most productive aspect of BHC progress resides in the more than 100 local policies and system change developments led by local BHC grantees, promoting a culture of “health in all policies” in local jurisdictions: more walkable communities, fresh food access, park space, access to clean drinking water, etc.

**What Has Been Learned?**

We commissioned independent reviews of our progress from three respected entities: FSG; The University of Southern California PERE Center; and the Center on Effective Philanthropy (CEP). (To be precise, we were approached by CEP as part of their “Philamplify” initiative and agreed to cooperate with their assessment tool on social change philanthropy.)

The three reports were generally consistent in their findings. In addition to describing significant levels of activity in each of the BHC communities, they also pointed out the challenges inherent in such a complex undertaking, such as maintaining clarity regarding operational priorities and alignment of understanding and effort across all the diverse participants in the enterprise.

Through our experience in BHC, we have learned a great deal about how to capitalize on key policy developments—some anticipated, others not—affecting our communities, such as the implementation of the Affordable Care Act, the advent of the Local Control Funding Formula, and upheavals in immigration policy such as DACA. Along the way, BHC has grown into a dynamic, continuously evolving hybrid of locally-driven work and state-level policy campaigns. That makes it a particularly challenging beast to evaluate in simple terms.

We also have some feedback from our grantees through the Center for Effective Philanthropy survey, where we learned our strengths lie in the realm of public policy and policy change, but need to improve in grantee relations. Finally, an internal survey of program staff revealed a consensus of desire to build on BHC-developed strengths and community capacity to drive systemic change in service of healthier communities.

**Overall We Learned the Following About Our Progress**

- The top-line lesson for us has been a crystal-clear affirmation about the importance of leaders in underserved and lower-income communities flexing the civic and political power required to affect health-promoting systems change. For all of the attention heaped upon the roles that “good data,” “research effectiveness,” and “innovative approaches” have in driving public policy, the building of healthier communities is fundamentally a game of power, voice...
and advocacy. Plugging the voice of community into the right kind of political power grid will do more to create health and wellness than any other single intervention.

- Our “theory of change” to help communities and health advocates assert power in economically challenged communities actually works. We have invested a substantial amount of grant dollars funding key “Drivers of Change” for grantees at the state and local levels: People Power, Youth Leadership, Collaboration, Partnerships, and Narrative Change. Community engagement has ranged from solid to excellent across the BHC spectrum, levels of trust between communities and our foundation are improving, and we have some local and statewide results to show for it.

Local BHC and Statewide Campaigns Have Taken Flight

- Locally, residents and leaders led efforts to shape “health in all policies” approaches, scoring more than 100 victories across the sites in land use planning and walkable communities, healthy eating and wellness policies in schools, public health emphases in municipal and county General Plans, and new skate parks, soccer fields and after-school programs for children and youth. Institutionally, we have developed a sharper understanding about the role a private foundation can play in supporting a community-driven and community-engaged campaign.

- On the statewide front, residents and youth leaders joined hands to advance healthier school climate policies, educate and enroll uninsured residents into the ACA and Medicaid expansion opportunities (we are proud to have contributed to California’s success in the ACA and Medicaid expansion enrollment), successfully advocate for undocumented residents to have access to affordable, quality health care, and push for more prevention-oriented law enforcement and criminal justice reforms.

- All 14 BHC sites have experienced progress at varying levels. Early bumps and bruises experienced in several sites were managed through a combination of patience, improved communications, candor and trust-building. Any fears experienced about needing to “drop” any troubled sites have been averted. As a result, we are now trusted across the sites to stay the course and not flee at the first sign of difficulty.

- Youth engagement in and across the 14 sites has been a particularly strong point. All sites have young people meaningfully engaged at the table, and youth organizing to promote health is emerging as a signature hallmark of BHC. That said, we have also learned through young people directly communicating their experiences—and backed up by the data—that they are coping with substantial levels of stress, adversity and trauma in their daily lives. The depth of the issues of toxic stress, exposure to trauma, and resiliency in young people of color and young people in poor white, rural communities—and its collective effects on their wellness—represents a major “discoverable” in the BHC journey. Based on the combination of the emerging science and the emerging voices of advocates for young people of color, exposure to trauma and stress is a significantly under-recognized public health crisis in this nation.
How Are We Evaluating This Work?

We decided early on not to commission a single comprehensive evaluation of BHC. Based on the experience of other place-based initiatives, it seemed unlikely that a single evaluation contractor could provide what we would need. After a labor-intensive initial planning process that featured the development of detailed site-specific logic models, we also felt it would be wise to hold off on placing too many evaluation demands on the sites too quickly. While we may have missed some useful “baseline” data as a result, we believe that the subsequent evolution of BHC has validated our decision to not prematurely lock in an evaluation framework.

Instead, we have experimented with a variety of methods of building continuous learning into the daily work of BHC.

• BHC communities have contracted with local learning and evaluation teams to document their work and provide regular formative feedback.

• Our Learning and Evaluation team periodically convenes those local evaluators and other contractors to provide a space for sharing information and best practices.

• In addition to the three independent reviews mentioned above, we have also commissioned a series of case studies that provide more in-depth analysis of specific bodies of work.

• In partnership with external contractors, we have developed a set of four annual cross-site measures that align with the Drivers of Change: Collaboration Assessment Tool; Resident-Driven Organizing Inventory; Policy Advocacy Inventory; and an Annual Reporting Template to document the major stories of the year.

• We have contracted with Prof. Veronica Terriquez of UC Santa Cruz to conduct a longitudinal analysis of the short-term and lasting impacts of BHC programs on the healthy development of youth participants.

• We periodically schedule retreats for BHC staff and for Hub Managers to reflect on their work and foster a culture of continuous improvement.

• Finally, we have a “Learning & Performance” Committee of the Board of Directors where quality time is allotted to review evaluation reports and extract lessons.

Mistakes Along the Way

Philanthropic investment strategies in “place” are not for the faint of heart or foolhardy, and we certainly made our fair share of mistakes, particularly in the early stages. Here are the five biggest ones:
• **WE “OVER-COOKED” THE DISH.** Under the banner of clarity about results, we “over-cooked” the early process, resulting in rigidity and prescriptiveness in the planning phase that was not only unnecessary, but also harmful. We entered the community planning process with Four Big Results, 10 key outcomes, and a logic model process that struck many community partners as philanthropic arrogance. The smarter move would have been to engage community leaders with the clarity of a shared vision and operating principles, and allow community leaders and residents to spend more time incubating goals, results, and strategy. Fortunately, we were able to course correct, and community leaders and partners were patient while we did so.

• **THE BROKEN TELEPHONE.** Early reliance on intermediaries in several of the 14 BHC sites in the planning phase resulted in communication and expectation issues that provided for a lot of bumps. Early evaluation findings showed we had over-delegated addressing and answering key questions to some intermediaries, and our program staff embedded in the sites were compelled to manage their way through the confusion. In a number of cases, these relationships were complicated by the fact that the Hub host organizations were also grantees actively involved in community change work in addition to their intermediary responsibilities. The subsequent blurring of roles and responsibilities led us to separate those functions for the benefit of all.

• **THE SUPER-HUB FANTASY.** We went into the BHC planning process with assumptions about a centralized “Hub” of civic leaders to coordinate local planning and execution. The thought here was a single locus of inside-out, outside-in activity where community residents, leaders and systems leaders could collaborate on defined goals. To quote an old-school television series, “Welcome to Fantasy Island.” Community leaders distrusted many “systems” insiders (like agency/department directors and electeds), and systems leaders viewed outsider/activists as unreasonable. We underestimated the importance of the roles of history, context, relationship and trust at the local level. Hubs were reorganized and customized to meet local realities, and we threw the concept of a single Hub template across the sites out the window.

• **UNDERESTIMATED TRAUMA & OPPRESSION.** Even as a private health foundation tuned into the root causes of poverty, violence, and inequality in lower-income communities, we significantly underestimated the roles that oppression, trauma and toxic stress play, particularly in young people of color. The stress and trauma that young people of color in distressed communities cope with has a triple-whammy effect, leading to: unhealthy, disengaged, or defiant behavior in the immediate; substantially increased juvenile justice and incarceration risk in the near-term; and significantly
increased risk of chronic disease and depression in the long-term. We are now in catch-up mode: issues of resiliency and transformative healing practices are now much higher on our radar screen in advancing wellness in underserved communities as a result. Traditional American-isms like “Buck Up,” “Man Up,” and “Shake it Off” fall short in the face of the emerging neuroscience and research about the roles that trauma and toxic stress play on the developing brain. In partnership with grantees, we have co-developed healing/leadership camps for young men and young women alike.

**The Myth of “The Market” as Cavalry.** We initiated the planning and community engagement phase of BHC during the tail end of the ’07–’09 economic recession, and matters of economic development, jobs and affordable housing were rife across community discussions in the sites. We naively hoped or assumed that private foundation investment would trigger corresponding private sector, capital investments in communities—and that some increase in jobs and economic activity would materialize. With some exceptions (like our healthy food access FreshWorks program), this largely has not happened, and our early efforts to launch a mission-investing program has thus far failed to catalyze any real tangible economic benefit in our 14 sites. In fairness, as a health foundation, we come to the “economic development” conversation in distressed communities as neophytes—but our “blink” reaction to this issue as a private health foundation—for all of the political lip service paid to economic development strategies and job creation at the community level, there is substantially more heat than light on this front. There is precious little infrastructure—and even less of a strategy—in place to benefit these communities economically. The absence of an equity-promoting economic development strategy in our nation and state is a huge gap in the battle to eliminate health inequality.

**We Underestimated Staffing Requirements.** This is not a typical Program Officer job. Particularly as the roles of our Program Managers quickly evolved from “grantmakers to changemakers,” we had to constantly play catch-up to provide the kinds of training, technical assistance and professional support that they needed. We also needed to augment our support staff to better handle the sheer volume of daily communications and other work being generated at each site.

**Things We Did Right**

- We tried our best not to “lead with our money.” That was a major shift in practice from our previous history of statewide responsive grant-making. That required a renegotiation of relationships with organizations accustomed to coming to us to request substantial multi-year funding for specific projects. We focused more on goals, results, trust-building, and defining success rather than engage in grantee puppetry and high-profile...
announcements about available funding. That said, by no means do we minimize the perceived power gradient between grantor and grantee — this matter requires constant attention.

• Our Board of Directors insisted on dynamic learning and allowed space for mistakes and learning from them. We learned that while results and outcomes are important, no one would be fired for making an honest mistake, and sites would not be “dropped” when difficulties were encountered; difficulties were, in fact, expected.

• We were agile enough to respond to emerging or unanticipated opportunities, such as the Affordable Care Act, changing attitudes on immigration and criminal justice policy, and a new school equity funding formula legislation. Events like civil unrest in Ferguson and Baltimore, the movement work of undocumented immigrant “Dreamers,” and the more recent Black Lives Matter movement are infused into the work of BHC through advocacy and organizing grantees.

• We tried to authentically engage and listen to young people and completely overhauled our communications and social media platforms as a result. The outrage of young people in BHC sites on the matter of harsh school discipline and suspension practices — which they viewed as a community wellness issue, and the front end of the prison pipeline — is one example. The engagement and support of young leaders has been the single most powerful game changer in BHC. I was inspired to create a “President’s Youth Council” of young people from our BHC sites who advise me on leadership, strategy and youth engagement.

• We responded reasonably well to community voices around matters of racial, ethnic and cultural tensions in the sites. We embraced, rather than fled, from these issues with training, support and convenings as requested by community leaders.

• We restructured the foundation and hired new staff to support the results we sought. One point of emphasis that has served us well: being more organizationally attentive to the power of community storytelling and narrative as central to policy and systems change. While the science and data are important, policy change requires a “no numbers without stories, and no stories without numbers” approach; storytelling brings the mundane aspects of policy change to life. We recruited and/or created three new positions in the organization who focus on curating the voices and stories of community and grassroots warriors, and strengthening community capacity to drive change through narrative.

Narrative-change philanthropy is now a core strength of our foundation that we did not possess prior to embarking on BHC.
Narrative-change philanthropy is now a core strength of our foundation that we did not possess prior to embarking on BHC, and communications in service of policy and systemic change has been rated highly by grantees and staff alike.

**Changes We Made or Are Planning to Make**

We overhauled the Goals Framework. Armed with lessons shared from previous foundation initiatives at the community level, we were careful to engage selected sites being up-front with results that we sought. We wanted to be transparent and clear about these results, avoiding landing in a place where community leaders would later discover some hidden agenda from our foundation under the pretense of “community driven-ness.” We initially identified an ambitious list of Ten Goals to guide BHC’s work.

As the sites began to develop their work plans, community leaders across a number of sites expressed concerns about how the desired results and goals were framed. In an effort to clarify and simplify our ambitions, we internally (i.e. with our Board and staff) identified four “big results” to guide BHC: expanded health coverage, reduced childhood obesity, reduced youth violence, and improved school attendance. Leaders in the sites expressed a preference for a more positive assets frame. This ultimately led to a collapsing of “the four big results” into three positively framed, goal-oriented “Health Happens Here” Campaigns: With Prevention, In Schools, and In Neighborhoods. The language took off—and evolved into slogans, onto t-shirts, into community events, and in statewide messaging.

We now have measurable results arrayed underneath the three “Health Happens Here” campaigns, such as enrollment in health coverage, wellness and school discipline policies in schools, and health-promoting land use policies in communities. Underneath the three broad campaign themes, we have identified a dozen “transformative policies” where both community voice and emerging science conspire to provide a road map for how distressed neighborhoods can build healthy communities for young people.

**We Are Strengthening the “Alignment” Function**

Local leadership and ideas shaping statewide and regional change were key features of the BHC plan from the very beginning. But, in concept, this is a far easier and attractive idealized notion of how our democracy and civic engagement should work than in practice.

At the risk of going a bit “inside baseball” in strategic philanthropy, our foundation has grown increasingly comfortable with funding advocacy and organizing work to achieve our health mission (as opposed to funding direct services, or solely “innovation” projects). But there are local advocacy efforts—for example, a local youth development organization pushing for fitness and recreation opportunities in the city—and statewide advocacy organizations based in Sacramento. The “magic” is when these efforts connect to create synergy, with the locals testing and driving needed changes in neighborhoods, while statewide advocates push for statewide, scaled-up policy and systemic change.

But these synergistic relationships between local and statewide do not occur naturally, and we are instituting some changes that encourage integration and accelerate
impact through systemic change. Internally, we created an “alignment team”: program staff who identify and pursue areas of local-statewide confluence. Secondly, we established a new “Enterprise” function internally, responsible for identifying and lifting up opportunities to “spread and scale” effective strategies at the local level.

We Are Increasing the Use of Our Assets Towards Mission

Addressing matters of poverty and community economic deprivation are not spelled out in our mission statement as a foundation. However we recognize the powerful link between poverty, unemployment and health status—so we are not blind to calls for us to do our part in ways that we can. While we cannot and should not re-invent our mission, our Board of Directors has directed greater use of Program-Related Investments (PRIs), and we have begun exploration of Mission-Related Investments (MRIs). We applaud the efforts of our colleagues in the field of philanthropy who are becoming more assertive in the developing world of impact investing.

We Are Leaning Towards More Multi-Year Grants

We understand that multi-year, operating grants represent the “mother’s milk” of the funder-grantee relationship. It is my assessment that an overly-zealous emphasis on our part on the achievement of goals and indicators in the granting relationship has led to some tensions and frustrations expressed by grantees, resulting in grantee relationship feedback (through the Center for Effective Philanthropy survey) that we need to be attentive to improving. We have been utilizing a sizable proportion of one- and two-year project grants in BHC, and while well-intended on our part, it signals either an abundance of control, a lack of trust, or an excess of bureaucracy infused into the relationship with our grantee partners. Over the second half of BHC, we’ll need to do better on this front.

We Are Continuing to Revise Our Staffing Configuration

In many of the sites, Program Managers are appropriately focusing more of their efforts on systems-level coordination rather than day-to-day operations at the site level. To make that possible, we have added Program Associates to more efficiently handle labor-intensive grant-making tasks, and we are continuing to refine what an appropriate sustainable Hub structure might look like in each place. We are also encouraging more cross-site efforts such as a set of regional communications campaigns. As we look toward a potential BHC 2.0, we are also exploring additional ways of integrating the talents of staff from across The Endowment in support of BHC’s work.

Thoughts for Our Colleagues in Philanthropy

In a sentence: You have to think about place, narrative change and power. These are, prodded by questioning from evaluation consultant Frank Farrow, the key “story lines” of BHC at the mid-point.

“Place” is where inequality, inequity, injustice, and exclusion all reveal themselves; these issues are real, tangible, palpable and visceral for communities. It is also where matters of courage, leadership, innovation and hope show themselves. Working at the level of neighborhood does not permit
philanthropy to “whistle while walking though the cemetery”—pretending that matters of race, ethnicity, and various “-isms” can be ignored, overlooked, or glossed over. Even in the most well-intended grant-making strategy, addressing the needs of underserved communities, any logic model or theory of change that fails to consider race, or class, or context, or power, is fundamentally flawed and intellectually dishonest. There is a very good reason why America’s most accurate predictor of life expectancy is one’s zip code—place matters.

At the five-year mark of BHC, we have benefited tremendously, learning a great deal about building the capacity of community and advocacy organizations to fight needed battles for wellness. While we would not expect or encourage philanthropic institutions to select 14 different communities for long-term partnership investment, we can say—with the learnings that a half-billion dollars in grants have brought us—pick a neighborhood or two, stick with and by the leaders there, and learn and grow together.

“Narrative” is admittedly an elusive term, but we have experienced and witnessed the value of narrative change in advancing meaningful progress in policy and practice. When we supported the activities of grantees working directly with undocumented young people, and they began to directly express their voice, enthusiasm and energy for contributing to a more vibrant California, this was a game changer with respect to public and political attitudes about immigration and health in our state (and yes, we tracked polling numbers precisely on this question). The second example was with school discipline reform, when young people of color themselves owned and shaped the policy messaging about needed reforms.

Thirdly, we in philanthropy need to be much more assertive and comfortable about power-building and advocacy. The science and data about effective strategies is necessary, but hopelessly insufficient in America’s political and policy landscape. In short, we need to help community leaders on the front lines of the battles against inequality get more effectively political about what the science, and their own experiences, tell them what works.

Lastly, while the work of place, policy and inequality is exhilarating, it is difficult and it is hard. Faithfully executing a logic model that doesn’t fit in a test tube, and is subject to all manner of political and civic developments operating at multiple levels, is simply not for the faint of heart. We wish we could impart some wisdom that simplifies how to address health inequality in a meaningful, sustainable fashion. It’s simply not that easy, but the path begins with a greater appreciation of advocacy, voice and power building at the level of community: civic engagement on steroids.

**Thoughts for Our Colleagues in Public Health and Public Agencies**

Similar to our observations for colleagues in the field of philanthropy, assuring the conditions under which populations can thrive and be healthy requires a lens framed by matters of equity and power. It is fundamentally clear that social exclusion, marginalization, inequality, civic disengagement and hopelessness have a lethal effect on community health. By the same token, inclusion, engagement, power building and civic voice lay the groundwork for the reduction of health disparities and closure of the gaps in health status.
What does this mean for local and regional public health specifically, and our health delivery system generally? It means that public institutions and agencies at the local level must be more attentive to and intentional about meaningful, engaged listening of community members, especially young people—“good, hard listening” if you will—and pay as much heed to the voice and experiential wisdom of community leaders as they do to the federal and state funding streams that shape their work.

**We Are Thinking “Now” About “Then”...**

Our experience with “BHC at Year Five” leaves our Board with two sets of questions that require navigation. Internally and organizationally, we will need to make some decisions about what the pre- and post-2020 investment strategy will be for TCE. We have already begun to deliberate on these questions even though it is five years away. While the Board is pleased about the impact and results of BHC thus far, questions regarding community capacity, sustainability, scalability and momentum beyond 2020 now come into sharper view. What has BHC brought us (meaning, our state and our mission) that perhaps merits ongoing investment beyond 2020? As we wind down or transition work in BHC communities, what are the smartest and most dignified ways for doing that? Do we “turn off the BHC lights” in 2021, or should we be thinking more about a BHC 2.0? These are all fair-game questions and we will begin wrestling with them now.

The second set of questions relate to a much broader, and even more compelling, set of questions for the field of philanthropy in our nation—and about our role and roles.

While we appropriately maintain our focus within the boundaries of BHC and California, the backdrop and the landscape against which we carry out this work has reached a fever pitch on the matter of inequality in America. BHC represents a slice of this nationally embattled narrative: Ferguson. Freddie Gray. The Dreamers. Immigration. Black Lives Matter. The ever-widening wealth gap. Marriage equality and LGBT justice. With a national Presidential election about to go full-tilt, America is now at a very critical identity-defining moment on the matters of democracy, inequality, inclusion and exclusion. By the way, kudos to our colleagues at the Ford Foundation for calling out the matter of inequality as the key theme for their work in the years ahead, our colleagues at the W.K. Kellogg Foundation for focusing on racial inequality and racial healing, and our friends at the Robert Wood Johnson Foundation for their growing strategic emphasis on health equity and a “culture of health.” We think institutional philanthropy should be “all in” to address inequality in our nation.

A young person who serves on my President’s Youth Council embodies both the challenge and opportunity before us in the field of philanthropy. Chris is in his early 20s and hails from an economically challenged community in Long Beach. He is a young man of color, openly gay, and has a stepfather who was recently
detained by immigration officials. Chris copes with any and all matters of stress, with some portion of it brought to him in the form of structural and institutional oppression or marginalization. On any given day of his week, he is navigating the hazards of being either black, or gay, or economically challenged, or excluded, or having his family’s life impacted by immigration policy. These factors are hazardous to Chris’ physical, emotional and social well-being.

But Chris also demonstrates resiliency. By choosing to be connected, civically engaged in social movements, and championing community wellness, he effectively uses the experience of trauma and oppression—on multiple fronts—as fuel to propel his journey as a leader for positive social change and wellness. He aspires to be a city manager someday.

Chris represents two important lessons for us at the five-year mark of our journey. First, and this is stating the obvious, we cannot say enough about the roles that community, youth leadership and human development play as valued sources of capital. Secondly, the emerging notion of “intersectionality” (an unfriendly term, we know) in social justice and social change and its implications for addressing inequality in America. From the standpoint of justice, equity and opportunity, how does philanthropy meaningfully support the “intersection” of previously siloed battles for social change? What is the power of connecting and leveraging the energies of Black Lives Matter, the Dreamers, LGBT/Marriage Equality leaders, women’s rights, tribal leaders, and anti-poverty warriors into a compelling national narrative about addressing inequality in America?

Political scientist and strategist John Powell has defined the concept of “targeted universalism”—how supporting the justice and equity battle faced by one group can lift the tides of all boats, and all oppressed and marginalized groups—in service of a greater and more inclusive America. For those of us in the business of social change philanthropy, what is our role? What should we be doing more of, or less of, or do that is new and untried? Can we in philanthropy elevate our game to support the development of the political and civic “power grids” to drive needed policy and systemic change in service of wellness, opportunity, and equity for all?

Now, these are questions worth losing sleep over.

We would love to hear from you about your reactions to our BHC journey.

Please email or comment at PowerGrid@CalEndow.org

— Robert K. Ross, M.D.
President and CEO
The phrase “culture eats strategy” is commonly used to make the point that, inside workplaces and other organizations, even the greatest strategic plan will crash and burn if it clashes with the internal culture. But the phrase can also be applied to ways in which we try to make changes in our society. There are countless examples where our politics and policies changed only after prevailing cultural norms shifted.

Regulation of tobacco, drunk driving laws, intolerance for sexual harassment and the rise of marriage equality all prove the power of policy following the people. In each case, political changes were preceded by coordinated investments in strategic communications campaigns designed to shift the public’s attitudes.

In the case of Building Healthy Communities (BHC), our efforts to expand health coverage, improve schooling attitudes, and to value prevention over incarceration depend on changes in social norms. Each of these three areas faces its own narrative challenge.

For the goal of expanded coverage, an incessant barrage of negative misinformation about Obamacare stood in the way, along with negative perceptions about undocumented residents.

The goal of healthier school climates faces a lack of awareness around the scope and consequences of school discipline policies, and what are commonly positive perceptions about zero tolerance policies.

And promoting prevention over incarceration requires challenging popular perceptions about what makes us and our neighborhoods safer.

In each of these areas, BHC contributed to changing the narrative via targeted media campaigns like #Health4All, #FixSchoolDiscipline, and #SchoolsNotPrisons. And at the center of each campaign were the actual voices and stories of those most affected by the issue at hand.

The amplification of those local voices and stories to a statewide audience is what we mean when we use the phrase “narrative change.” The tactics and strategies by which we do that are sophisticated, calibrating a mix of earned, paid and especially social media. But the core of the campaigns is simple: provide platforms and avenues for the authentic voices of those with the most at stake to be heard.
Because those with the most at stake are often young and in most cases have not been a part of the elite conversations among insiders. The messages they bring are similarly simple and clear. “Health for All” does not equivocate. “Fix School Discipline” gets right to the point of action. “Schools Not Prisons” takes a stand.

A range of ongoing indicators for measuring narrative change—from polling and focus groups to social media analytics—show the impact of these authentic voices and simple messages. There is also strong evidence these shifts in narrative have been essential to progress in policy changes across the three campaigns.

The recent addition of millions of Californians to the ranks of the insured, including new eligibility for undocumented children, is hard to imagine without the contributions of the ‘Health for All’ narrative effort. The state legislation to make undocumented Californians eligible for Medi-Cal actually adopted the name of the Health for All campaign. Similarly, the recent dramatic reduction in school expulsions started with youth voices affected by the crisis.

And the recent turnaround in reforming California’s over-reliance on mass incarceration was catalyzed in part by narrative campaigns like ‘Schools Not Prisons’, ‘Sons & Brothers’ and ‘Do The Math’.

Internal surveys and external validators have affirmed the value and importance of BHC’s contributions to narrative change via strategic media. Independent surveys of both The Endowment internal staff as well as external grantees and partners rank our investments in narrative change at the top of our effectiveness. State and national recognitions and awards for BHC have emphasized The Endowment’s leadership in changing the narrative: The Governor’s Award for Foundation of the Year; Council on Foundations Award for Excellence in Communications; American Public Health Association Award for Excellence; National Committee for Responsive Philanthropy; American Alliance of Museums; and a growing list of awards from communications publications, associations and even an award from the Chicago International Film Festival.

It is important to acknowledge another dimension of narrative change work. Virtually all efforts to shift systems and policies in the direction of prevention operate within a larger and overarching American narrative that values individual responsibility, and has grown increasingly distrustful of government. That simple message of reliance on individual responsibility over government is repeated with discipline and regularity across a wide range of issues.

However, it’s fair to say that there is no equivalent meta-narrative regularly employed on the side of prevention and shared responsibility. In other words, we may be winning the narrative battles detailed above, but at the same time losing the narrative war around prevention. So tackling this meta-narrative challenge may be the next frontier in societal change.
Merced and South Los Angeles are very different places. One is rural and the other is quite urban. However, both places have large populations of lower-income people who suffer from health disparities and profound barriers to opportunity. So when BHC started, we needed to develop a core strategy that worked in Fresno and South LA, as well as 12 other disparate BHC communities. There are two threshold questions one has to answer when beginning work in partnership with communities: 1) What are we going to work on together? and 2) How are we going to get the work done? The “What” is the 3 Health Happens Here campaigns and their subset—The Transformative 12. The “How” is the Drivers of Change. The “What” and the “How” are deeply embedded in our BHC Theory of Change.

The Origins of BHC’s Drivers of Change

In 2002, a group of public health officials in the San Francisco Bay Area came together out of frustration that the tools of the traditional “medical model” approach to public health practice were not sufficient for the challenges facing modern public health. Chief among those challenges is health inequity. Recognizing that health outcomes are strongly influenced by the social and environmental conditions that many lower-income people are forced to contend with on a daily basis, these pioneering health officials created the Bay Area Regional Health Inequities Initiative (BARHII) whose mission is to transform public health practice for the purpose of eliminating health inequities using a broad spectrum of approaches that create healthy communities. Health doesn’t just happen in a doctor’s office, neighborhoods matter, and opportunity matters. The basic concept of prevention in health implies looking at the upstream conditions and trying to minimize risk and maximize resources. The BARHII framework is an effort to visualize and organize public health interventions and strategies across a spectrum from downstream to upstream. In essence, the BARHII framework is an integration of the medical and socio-ecological models with a specific eye towards situating different types of interventions along the upstream-downstream continuum.

The basic idea underlying the BARHII framework is that upstream inequity creates downstream disparity. The medical model focuses on preventing
disease and death by treating and managing disease and changing people’s risky behaviors like smoking, poor diet, and lack of exercise. The medical model is grounded in the somewhat simplistic assumption that all people, regardless of income or neighborhood environment, are equally free to make healthy choices from a broad array of healthy options. The primary tools of the medical model are medical services and health education. The medical model costs $3 trillion per year ($9523 per capita) or 17.5% of the gross domestic product. Meanwhile upstream, the socio-ecological framework recognizes that social inequities (e.g. inner cities, barrios, reservations) are the product of past and current unjust policy (redlining, racially restrictive covenants, housing policy) which ultimately derives from a narrative that values different people differently as a result of a set of well entrenched “isms.” A simple example is how a narrative of racism produces policies like racial segregation that leads directly to inner-cities, a stark and outrageous social inequity. The BARHII framework acknowledges that within the medical model we have defined interventions for each of the boxes: Emergency rooms to prevent death, clinical care to treat and manage disease, and health education to help change behaviors. However, within public health practice, we have no organized interventions to improve neighborhood conditions, change unhealthy policies, or change the overarching narrative about health. These environments lack basic health protective amenities like parks, grocery stores, decent schools, functioning transportation systems, affordable and decent housing, living wage jobs, and even potable water in some instances. At The California Endowment, we have translated the upstream elements of the BARHII framework into a public health practice focused on improving community environments by changing policies and systems and re-shaping the narrative and power structures that influence those policies. The Drivers of Change are designed to enlist the participation of the people most impacted by inequity to fully participate in remaking the policies and system practices that create and maintain the socio-ecological conditions occurring in lower-income communities. In so doing, these organized and politically engaged communities will reduce the downstream demand on healthcare and other downstream systems (criminal justice, foster care, welfare, etc.).

Power, Policy, and Narrative

Building Healthy Communities (BHC), is a holistic attempt to help reweave the fraying fabric of lower-income communities by harnessing the latent power and potential of their residents. It is an initiative that aims to transform communities by building power (social, political, and economic), implementing proven health protective policy, and changing the narrative about what produces health (beyond just health insurance and individual behavior). The idea is to revitalize local democracy so as to transform these environments into places where everyone has the opportunity to thrive. In short, BHC’s strategy is grounded in the belief that health is fundamentally political. The BHC model envisions these 14 lower-income communities as
proving grounds for community-driven policy and practice innovations that will serve to inform and advance statewide health policy and systems change.

The sobering reality is that the odds are heavily stacked against lower-income Californians, particularly communities of color. To achieve TCE’s mission of improving the health status of all Californians, it is not sufficient to just help a handful of lower-income Californians beat the odds. We must change the odds. Consistent with the BARHII framework, due to a legacy of racial and economic segregation, anti-immigrant policy and a host of other historical “isms”, there are many communities in California where residents are mired in environments that conspire to injure their health. These environments lack basic health protective amenities like parks, grocery stores, decent schools, functioning transportation systems, affordable and decent housing, living wage jobs, and even potable water in some instances. These same environments concentrate risk such as liquor stores, fast food, payday lenders, environmental pollution, and crime. In these environments, community residents are forced to constantly navigate multiple risks without the benefit of significant resources. These neighborhood and community environments are not natural, they are man-made, and can be unmade. Building Healthy Communities is an effort that enlists the very residents that have been the targets of exclusion, stigma, and discrimination in remaking their environments through holding local, regional and state systems accountable for creating healthy and equitable community environments.

The BHC theory of change is about building community capacity (increasing social, political and economic power and changing the narrative about health), to change policy and systems, in order to create healthy environments, that will (over time) improve health status. The targeted policy and systems change is multi-level: local, regional, and statewide. BHC is particularly focused on improving the social and health outcomes of populations that have been under threat such as Boys and Men of Color (BMOC), immigrants, LGBTQ, and formerly incarcerated and consequently BHC has a special focus on strategies that enhance opportunity structures for these populations.

BHC operates by creating unprecedented space for community organizing, leadership development, and sustained multi-sector collaboration by enabling residents, community groups, and institutional leaders to collaborate across all sorts of boundaries, such as race, ethnicity, age, as well as the boundary that can exist between local communities and external professionals. Across all 14 sites, the approach focuses on five drivers that we believe are necessary for propelling the priorities forward: building people power; youth leadership development; multi-sector collaboration and policy innovation; leveraging resources and partnerships; and changing the narrative.

While the approach is the same across all of the sites, how it manifests depends on the local circumstances. In Fresno, for instance, the work is taking the form of unlikely alliances between community and environmental groups all interested in ensuring the city grows sustainably, whether for the people who live there or the environment. In East Salinas, the community is coming together with public servants to transform the way the city governs so that racial equity is at the forefront of all policies, practices, and procedures.
Building Healthy Communities

Theory of Change

Capacity Building

Policy & Systems Change

Environmental Change

Health Status Change

Drivers of Change

3 Campaigns [Transformative 12]

10 Outcomes

2020 Goals
“Transformative Twelve” Policy Domains

Health Happens in Schools
- School Climate
- School Wellness
- Comprehensive Supports

Health Happens in Neighborhoods
- Food Environment and Food Systems
- Land Use Planning and Anti-Displacement
- Community and Economic Development
- Environmental Health and Justice
- Systems That Restore and Heal
- Healthy Youth Opportunities

Health Happens with Prevention
- Public Health
- Health Homes
- Health Care Services
## BHC 2020 Goals

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<tr>
<th>GOAL</th>
<th>OBJECTIVES</th>
<th>WILL MEASURE</th>
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| **Health4All**                   | • 100% coverage for all Californians, including the undocumented  
• Strengthen the primary care workforce  
• Pilot new model systems of prevention in BHC; new trauma-informed health models for youth | • # of enrollees  
• % of uninsured  
• # of primary care jobs supported  
• # of new prevention models |
| **Health in Every School**       | • 100% of BHC schools w/ wellness policies promoting healthy meals, fitness, and social-emotional-behavioral health  
• Statewide policy that promotes health/wellness funding in 100% of California schools | • # school district practices/policies in nutrition, fitness, counseling, and school discipline reform  
• FitnessGrams, suspension rates, attendance rates |
| **Health in Neighborhoods**      | • More parks & fitness and healthy food/water opportunities for youth in 100% BHC sites  
• New statewide policy shifts to dismantle the BMOC school-prison pipeline at the neighborhood level | • # of land use plans that include health principles  
• # new/upgraded opportunities for youth: healthy food opportunities, recreation facilities, youth programs  
• # of juvenile/criminal justice reform policies, law enforcement trainings and policies, emphasis on health |
The mission of the California Endowment is to expand access to affordable, quality health care for underserved individuals and communities, and to promote fundamental improvements in the health status of all Californians. We believe that we can best achieve this mission by using our financial and people resources to work in partnership with communities, non-profit organizations, academic institutions, public and private sectors and other allies by improving social, economic and political conditions so all Californians have the opportunity to live healthier lives. Our funding decisions and behaviors are guided by the following core values:

1. **DIVERSITY, EQUITY AND INCLUSION.** We value diversity, inclusion and equity, including gender, race, color, physical ability, marital status, geography, age, income, faith, sexual orientation, gender identity and expression, national origin, language, medical condition, disability or immigration status. We believe that diversity, equity and inclusion are essential to our effectiveness and the long term health of all Californians and commit to the integration of diversity, equity and inclusion in all our policies, practices, processes, relationships, internal working culture and systems.

2. **HEALTH AND JUSTICE FOR ALL.** We believe in health and justice for all. We are committed to meaningful and sustained improvements in health outcomes through a focus on the social, economic and political factors that drive health outcomes and believe that our working together will lead to changes in the traditional indicators of health.

3. **JUST SYSTEMS.** We believe in advancing “Just Systems” for opportunity and wellness for all, not isolated charity for some. We understand that poor health conditions in some communities are the result of systemic practices that privilege some groups and exclude others. We are committed to influencing profound changes in those systems and promoting just and equitable solutions and resources for all.

4. **HEALING PRACTICES.** We recognize the impact of trauma on both individual and community health and commit to instilling healing practices in organizations and institutions. We believe community residents are often the necessary healers and generators of solutions to longstanding community challenges and see our role as standing side by side and partnering with those struggling for health and justice.

5. **YOUTH ORGANIZING.** We value the energy, agility and fearlessness of youth leadership and youth organizing in its many forms including local, statewide and online community-building.

6. **LIFTING VOICES.** We value lifting voices of those typically excluded from public conversations and believe in creating opportunities for their stories to be told and heard. We recognize the value of widely disseminating differing ideas and sharing hope.
**RESIDENT POWER.** We cherish democracy. We value the importance of building and sustaining community resident power and resiliency, particularly those who historically are denied access or are underrepresented in our democratic process. Balancing the scales of power is critical to optimizing democracy, battling structural inequality and ultimately creating healthy communities for all.

**PREVENTION IN ALL PUBLIC SYSTEMS.** We believe in prevention in all public systems and seek strategic opportunities to advance prevention and secure resources to invest in schools, neighborhoods and health.

**LISTENING BEYOND OUR OWN PLANS AND INNER CIRCLES.** We value learning through action and listening beyond our own plans and inner circles. We commit to changing in response to what we are learning, to emerging challenges, diverse ideas and to healthier opportunities for all.

**LOVE OF HUMANITY.** We commit to humility, mutual respect, forgiveness, transparency and love of humanity in all our dealings with grantees, partners, communities, organizations and each other. We will always speak with honesty and integrity.

We recognize we cannot foster positive and lasting change without living out these values in our interactions with our colleagues, our grantees and the people and communities of California. We value mutual respect, courage in standing against injustice or powerful interests, giving one another the benefit of the doubt, and treating one another with kindness and understanding. We are grateful to be doing this work and are accountable to each other and our health mission.
Our special thanks to Tom David and Frank Farrow for the coherence of this report, which would have been impossible without their brilliant guidance, insight and thoughtful observations. We are enormously indebted to the two of you.