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Integrating Racial Equity in Foundation Governance, Operations, and Program Strategy

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Keywords: Racial equity, racism, governance, grantmaking, capacity building, philanthropy

Introduction

The Consumer Health Foundation (CHF) envisions a nation in which everyone has an equal opportunity to live a healthy and dignified life. By “everyone,” we mean all people regardless of race, ethnicity, immigration status, gender identity, sexual orientation, disability, age, or income. In order to achieve this vision we advocate for health equity, with an explicit lens on racial equity. John Powell, director of the Haas Institute for a Fair and Inclusive Society at University of California, Berkeley, describes racism or structured racialization as a “principal threat” in the United States (personal communication, May 23, 2013). We interpret this to mean that racism is a historic and enduring means for structuring opportunity, which has significant implications for health as evidenced by numerous studies documenting the relationship between race, racism, and poor health and social outcomes (Bertrand & Mullainathan, 2004; Institute of Medicine, 2003; Mays, Cochran, & Barnes, 2007; Williams, 2012; Williams & Mohammed, 2009). Therefore, CHF has an explicit commitment to addressing the structures and systems that contribute to disparate health outcomes for people of color.

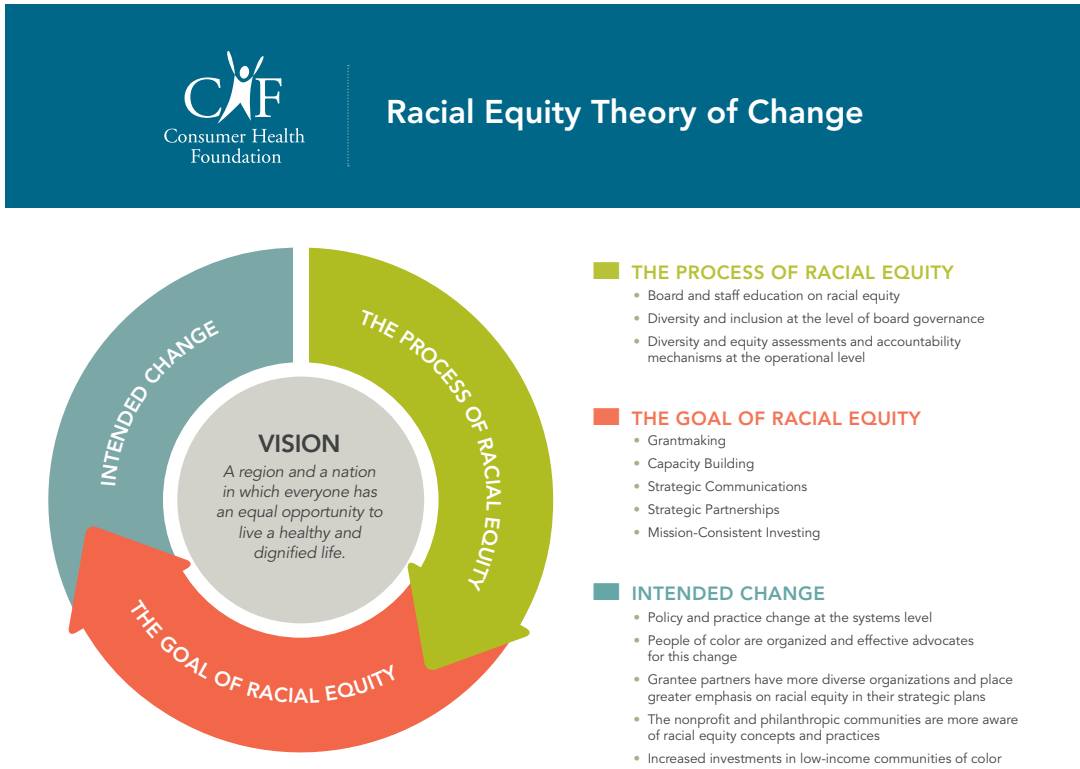
What do we mean by racial equity within the context of health? To answer this question, we draw two definitions of health equity from the health-equity literature. Braveman and Gruskin (2003) define health equity as the absence of systematic disparities in health or in the major social determinants of health between social groups

Key Points

- This article is intended to provide the field of philanthropy with a useful framework for organizing racial-equity efforts.
- When the Washington-based Consumer Health Foundation became a staffed foundation in 1998, its initial grantmaking focused on health promotion and access to health care. As a learning organization, however, it took steps that led to greater support for efforts addressing the interconnectedness between health status and racial equity. This included support for advocacy as a strategy to create systems change benefiting low-income communities of color.
- This commitment to racial equity is not a separate initiative; it is integrated into all aspects of CHF’s governance, operations, and program strategy: board and staff education on structural racism, developing diversity and racial equity indicators to guide operations, providing capacity-building support to grantees to enable racial-equity planning, and advocacy grantmaking in areas such as language access for populations with limited proficiency in English.
- This article presents historical milestones and the key drivers that stimulated an organizational commitment to this approach, with examples of how racial equity is operationalized in all aspects of the foundation’s work and opportunities for continued growth.

who have different levels of underlying social advantage and disadvantage – that is, different positions in the social hierarchy. We note that this

FIGURE 1 Racial Equity Theory of Change



definition refers to health equity as an achievable goal. Another definition offered by Camara Jones in a report from Grantmakers in Health (2012) is the assurance of the conditions for optimal health for all people, which requires valuing all individuals and populations equally, rectifying historical injustices, and addressing contemporary injustices by providing resources according to need. We note that this definition refers to a process. In the context of these two definitions of health equity and CHF’s identity as a health funder, we define racial equity as both a goal and a process whereby people of color have an equal opportunity to live a healthy and dignified life.

The purpose of this article is to describe the evolution of CHF’s commitment to racial equity as both a goal and a process. (See Figure 1.) We will illustrate how we use our program resources toward the goal of racial equity and will share our progress and opportunities for growth in the areas of grantmaking, capacity building, strategic communications, mission-consistent investing,

and strategic partnerships. We will also highlight how we structure our governance and operations toward the process of racial equity; we will present practical strategies that we have employed to strengthen and advance CHF’s work in this area. We hope this article will provide the field of philanthropy with a useful framework for organizing racial-equity efforts.

Background

The Consumer Health Foundation is a private foundation in Washington with a regional grant-making footprint that includes the District of Columbia, northern Virginia, and parts of suburban Maryland. The foundation has its roots in Group Health Association, a cooperative health maintenance organization started in the 1930s to provide prepaid health care to its members in a racially integrated environment. In some senses, therefore, racial equity is built into the fabric of the organization. Racial equity as a process, however, requires ongoing and intentional commitment and action, especially where communities of color

face high levels of health inequities.

These inequities are clearly visible in the District of Columbia metropolitan region. According to population estimates by the U.S. Census (2012), approximately 5.9 million residents live in the Washington region. The region's incredible wealth is juxtaposed with deep pockets of poverty, primarily among people of color. A map of the region in the *Atlantic Cities* article "Class-Divided Cities: Washington, D.C." (Florida, 2013) highlights three striking points: 1) almost half of the region is made up of highly skilled, highly educated workers (also known as the creative class), the third-highest percentage in the nation; 2) there is almost no working class; and 3) the service class of low-wage, low-skill workers making up 40 percent of the region's workforce is relegated to the outskirts of the region and to the eastern part of the District of Columbia. Seven of the 10 top service-class census tracts are in historically African-American neighborhoods. According to data prepared for the Robert Wood Johnson Foundation Commission to Build a Healthier America (2013), life expectancy can be almost seven years less on average for the parts of the region with the largest population of people of color compared to primarily white communities that are better off socially and economically.

When it became a staffed foundation in 1998, CHF focused its grantmaking on programs and services to promote health and improve access to health care. Its grantmaking has evolved, however, to include a focus on advocacy to create systems change benefiting low-income communities of color. Two milestones in the foundation's evolution toward a more explicit focus on advocacy and racial equity are worth sharing here.

First, as a learning organization, CHF wanted to expand its knowledge of and identify solutions to pervasive issues that contribute to poor health for people of color and people living in low-income communities. As a result, in 2004 and 2005 CHF hosted a series of forums – locally known as "community speakouts" – across the region to learn directly from community members about factors that influence health in their communities. In those forums, residents consistently articulated

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the impact of structural racism on their health and well-being.

Structural racism is defined by the Aspen Institute Roundtable on Community Change (2004) as a system in which public policies, institutional practices, cultural representations, and other norms work in various and often reinforcing ways to perpetuate racial-group inequity. For community members attending these forums, this included the lack of cultural and linguistic competency among health care institutions, experiences of racial and ethnic discrimination in their daily lives, and the disproportionate presence and impact of poor social conditions in communities of color: lack of access to high-quality education, opportunities for jobs that pay a living wage, healthy food choices, and affordable housing. Lessons learned from the forums served as the impetus for the next generation of the foundation's work – a new approach that focused on the intersection of health and racial equity.

The CHF board and staff recognized that this new direction was rare in the field of philanthropy and, as a learning organization, its leadership was committed to increasing its own knowledge and intellectual capacity. Throughout this learning phase CHF engaged in conversations with thought leaders in the field, including the Philanthropic Initiative for Racial Equity (PRE) and the Applied Research Center (ARC).¹ In 2007 CHF was invited to participate in an assessment conducted jointly by PRE and ARC whose primary aims were to help foundation staff and leaders understand the benefits of being explicit about racial equity and to determine the extent to which their work advances racial equity.

¹ The Applied Research Center is now known as Race Forward, but in this article will be referred to as ARC.

Board and staff meetings included specific agenda items to establish a common understanding and consistent use of language regarding racial equity, and the foundation updated its strategic plan, mission, vision, values, and theory of change to reflect an explicit commitment to health and racial equity. This commitment meant activation of our belief that health is determined by social factors including and beyond access to health care, such as education, income and wealth, and structural racism.

The assessment lasted approximately a year and included a review of foundation documents, interviews with staff and board members, a review of recent grant proposals and grantee websites, and surveys and focus groups with grantee partners. While the assessment found that CHF had a strong commitment to racial equity and acknowledged that the “community speakouts” contributed to a deeper structural-racism analysis of health issues, certain areas required more attention – including more consistent and explicit communications about racism, both internally and externally. For example, CHF was encouraged to clarify what it means when it uses terms such as “vulnerable” and “underserved.” These words are often used in reference to low-income people of color, and it was important to CHF to be more

explicit in order to identify strategies and solutions most likely to benefit this population. PRE and ARC also recommended that the foundation collect demographic data on its grantee partners, such as the racial and ethnic composition of staff, board and populations served.

When the findings were released, CHF board and staff met to discuss the PRE/ARC report (2009). It turned out to be a profound and decisive conversation – on both personal and institutional levels – about race, racism, equity, inclusion, and explicitness. Ultimately, the group arrived at some key understandings around the foundation’s next steps in fulfilling its commitment to racial equity. The board clarified that CHF intended to achieve health equity, with a racial-equity lens; it also decided that the foundation would revisit its own vision, mission, values, theory of change, and strategies to reflect this commitment.

The report’s findings were the second milestone in CHF’s organizational commitment to racial equity. The foundation began collecting demographic data on its grantee partners and featuring structural racism more prominently in its communications, specifically in annual reports and annual meetings. Board and staff meetings included specific agenda items to establish a common understanding and consistent use of language regarding racial equity, and the foundation updated its strategic plan, mission, vision, values, and theory of change to reflect an explicit commitment to health and racial equity. This commitment meant activation of our belief that health is determined by social factors including and beyond access to health care, such as education, income and wealth, and structural racism. Grantmaking was focused on advocacy to address many of the systemic and policy issues that perpetuate racial inequities. As CHF began supporting systems-level reforms, it officially ended funding projects aimed at individual behavioral change.

The Process of Racial Equity

To achieve the goal of racial equity, the foundation had to undergo – and continues to undergo – the process of racial equity, which involves fundamental changes to the way it operates.

Recall that Camara Jones's definition of equity includes rectifying historical injustices (Grantmakers in Health, 2012). Because we recognize that racism is embedded in U.S. institutions, including philanthropy, we intentionally educate board and staff about these injustices and work to eliminate institutional racism in our organization's governance and operations.

Education

Since 2008 CHF board and staff retreats and facilitated discussions have been the primary venue for education regarding structural racism. At one such retreat we screened the PBS documentary *Unnatural Causes: Is Inequality Making You Sick?* (California Newsreel, 2008), which includes segments about the impact of racism-related stressors on health. The 2011 retreat was an intensive racial-equity development opportunity in which board and staff members shared stories about their first experiences with race. Some of the themes discussed were micro-aggressions ("a thousand little cuts"), challenges in explaining race, internalized racism, and the ways in which language perpetuates racism. The discussion then moved to examples of structural racism, such as the policy of redlining African-American neighborhoods and preventing home ownership for African Americans who qualified for mortgage loans under the GI Bill. As a result of this retreat, we developed a proposal to Grantmakers in Health for a session at its 2013 annual meeting focusing on the board's role in providing leadership on racial equity. We believe that the board's education and leadership has been critical to the foundation's strategic focus on health and racial equity and the integration of racial equity in CHF's governance, operations, and program strategy.

In 2011 the CHF board also conducted its first "learning journey," to Langley Park, Md., a primarily Latino suburb of the District of Columbia. The purpose was to enable board members to see firsthand and be connected to the issues faced by the communities served by CHF's grantee partners. Board and staff members visited a large Langley Park apartment complex, where they heard residents describe unacceptable housing conditions such as mold and code violations such as broken fire alarms and poor lighting in com-

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mon areas. Board members also learned about community members' feelings of fear versus security in interactions with local police. At the same time they observed strengths, such as the community's ability to organize to address these issues and the presence of many small businesses in the community.

Foundation staff took advantage of multiple learning opportunities separate from the board that allowed them to engage in thinking at the intersection of health and racial equity. Staff members attended conferences, meetings, and special trainings and reviewed and discussed educational resources, including the PBS/California Newsreel documentary *Race: The Power of an Illusion* (California Newsreel, 2003). These experiences increased engagement in the theory and practice of racial-equity work and proved instrumental as the foundation staff moved to implement the board's decision to strategically focus CHF's work on health and racial equity. It would take an educated staff to consider how the foundation's portfolios might focus on systems change and to develop the relationships in the community to enable the implementation of this new strategy.

Governance

If education is the tool used to prepare for practice, then governance and operations are the mechanisms for the implementation of the process of racial equity inside of a foundation. Good governance in our demographically diverse region

If education is the tool used to prepare for practice, then governance and operations are the mechanisms for the implementation of the process of racial equity inside of a foundation. Good governance in our demographically diverse region requires that our board be similarly diverse.

requires that our board be similarly diverse. According to an Urban Institute report on nonprofit diversity in the Baltimore-Washington region (2010), the population of counties in the District of Columbia, northern Virginia, and Maryland ranged from 40 percent to 70 percent people of color, but people of color in those areas hold between 19 percent and 33 percent of board positions. While diversity is not sufficient for racial equity, it is a critical component. Since its inception, CHF has prioritized board diversity as one aspect of our process of eliminating structural racism inside the foundation.

The 2013 CHF board has 13 members, eight of whom identify as African American, Latino, or Asian American; 62 percent of the board's members are people of color. According to a Council on Foundations survey (2010) of more than 500 foundations, only 16.5 percent of foundation board members nationally are people of color, a number that likely skews high because most foundations that responded were diverse. Therefore, CHF is in the minority in the philanthropic sector when it comes to board diversity. The nominations and governance committee monitors the CHF board's diversity using a matrix that includes each board member's demographic characteristics (e.g., gender, race/ethnicity, age, geography) and areas of expertise. During the annual call for board members, the committee works to close

gaps in expertise and diversity by using diverse networks to ensure the highest probability of recruiting people of color as board members.

Racial equity at the level of governance also means working to create an inclusive and empowering decision-making environment. The Denver Foundation defines inclusiveness as the process through which people from all backgrounds are involved in the organization, how their perspectives are valued, and how their needs are understood (Denver Foundation, n.d.). In order to ensure an inclusive environment, board members of color are actively involved and elected to serve in leadership positions. For example, the current board chair, the chair of the finance and investment committee, and the chair of the Futures Task Force, a special strategic planning committee, are people of color. In order to better understand how board members perceive the extent to which their opinions are heard and considered, we include a question on this topic in our annual board survey. In the 2013 survey, which had a response rate of 85 percent, 73 percent of respondents strongly agreed and 27 percent agreed that their opinions are heard and considered when shared.

While we have made strides in the process of diversity and inclusion as critical components of racial equity, we acknowledge that there is still more work to do. We know that there is a significant correlation between race and socioeconomic position and between socioeconomic position and health (LaVeist, 2005; Phelan, Link, & Tehranifar, 2010; Shapiro, Meschede, & Osoro, 2013), and no meaningful work on health and racial equity can ignore its intersection with class equity. The CHF board does not have members of a low socioeconomic position. The board's nominations and governance committee is working to determine how this dynamic might be addressed as we challenge ourselves to address race and class equity inside of the organization.

Operations

The Consumer Health Foundation strives to ensure that its operations also reflect its commitment to racial equity. Staff members and consultants are recruited using diverse networks, and

CHF ensures that a diverse pool of candidates is interviewed prior to making a hiring decision. During CHF's recent search for a president and chief executive officer, for example, the board's search committee selected a search firm that could demonstrate experience and success in placing diverse candidates in leadership positions. The committee also required that the firm place the position announcement in media outlets that would reach the most promising applicants of color. As a result the foundation was able to recruit a diverse pool of candidates from which it selected its next president and CEO – a woman of color, one of few in the philanthropic sector. Beyond recruitment, there are formal opportunities for new staff members to learn about the organization's commitment to racial equity, including the annual staff retreat and the annual board and staff retreat. Staff orientation also includes a one-on-one meeting with the president to talk about the organization's values and commitment to diversity and equity.

The foundation is developing a set of internal diversity and equity indicators and accountability mechanisms to codify its operational practices. The president's performance will now include an assessment of her progress on CHF's diversity and equity indicators. The role of the board in influencing organizational change is significant but is limited by the chief executive's attitude and behavior regarding inclusive practices (Denver Foundation, 2002). Therefore, CHF's nominations and governance committee is determining how the internal diversity and equity indicators will be used as a part of the CEO's annual performance review. In addition, all staff members will be assessed on indicators such as the inclusion of CHF's commitment to diversity and equity in requests for proposals for accounting, communications, and investment advising services; soliciting proposals from vendors that are led by and employ people of color; and translating written materials into relevant languages when engaging with audiences with limited English proficiency.

The Goal of Racial Equity

Drawing from Braveman and Gruskin's definition of health equity (2003), racial equity as a goal

Residents of these communities are plagued by little or no investment in neighborhood infrastructure, insufficient access to safe and affordable housing, unstable employment, and limited access to high-quality education.

Undergirding these inequities in health and social outcomes is structural racism.

would mean the absence of systematic disparities in health or in the major social determinants of health between social groups – for this discussion, racial and ethnic groups. The Consumer Health Foundation, therefore, organizes its programmatic resources toward the goal of achieving racial equity. This is undertaken through our five program areas: grantmaking, capacity building, strategic communications, strategic partnerships, and mission-consistent investing. Having access to good health care is critical when we're sick, and health care settings do provide opportunities for prevention and early detection. But the factors that actually make us healthy, or unhealthy, are the socioeconomic conditions in which we live and work – and those are shaped by public policies. This is particularly true for the communities of color served by our grantee partners. In addition to experiencing higher rates of illness and premature death, African Americans, Latinos, Asian and Pacific Islanders and other communities of color continue to experience deep and persistent inequities not only in health care, but also in the social determinants of health. Residents of these communities are plagued by little or no investment in neighborhood infrastructure, insufficient access to safe and affordable housing, unstable employment, and limited access to high-quality education. Undergirding these inequities

We believe that building a shared understanding, commitment, and language around diversity, inclusion, and racial equity in our larger community is critical if we are to succeed in changing policies and systems to eliminate racial inequities in health.

in health and social outcomes is structural racism. Therefore, in 2009 we expanded our mission and our logic model to address these social determinants of health, including racial equity.

Grantmaking

In 2012-2013, CHF awarded 51 grants to organizations in the Washington region. Most of our grantee partners are advocacy organizations working on an array of interrelated issues, including community development, budget and policy analysis, health care reform implementation, and language access. They also advocate for the rights of workers, justice-system inmates and those recently released from prison, people with disabilities, and youth of color. In addition, we provide grants to community clinics, health centers, and primary care associations that support the health care needs of many of the region's low-income communities of color. All of our grantee partners are addressing policy issues that ultimately impact communities of color, and 35 of the 51 are explicit about working with or serving communities of color.

The intended change of our grantmaking is policy and practice change at the systems level and the ability of people of color to be organized and effective advocates for this change. Since 2009 CHF's grantee partners have contributed to a number of reforms, including a new regulatory framework for direct-care workers that improves

the quality and oversight of worker-training programs in the District of Columbia; monitoring of the implementation of the district's Language Access Act; restoration of budget cuts to fund mental health services for children in Virginia; and the transformation of the social-service eligibility systems in Montgomery County, Md., to be centered at the neighborhood level. A number of these reforms have come about as a result of coalition building in communities of color. For example, the monitoring of the Language Access Act has included education and training of Vietnamese nail-salon workers. Other language access reforms have been led by a coalition of district residents with limited or no proficiency in English.

Capacity Building

In addition to providing grants, CHF strengthens the work of our nonprofit partners through capacity-building assistance. The foundation provides support in organizational development, program design and evaluation, and building racial-equity knowledge. We believe that building a shared understanding, commitment, and language around diversity, inclusion, and racial equity in our larger community is critical if we are to succeed in changing policies and systems to eliminate racial inequities in health.

To this end, we have invested in a two-day training for advocacy grantees, entitled Structural Racism and Racial Equity in Health. This training helps grantee partners to develop a shared understanding of how structural racism produces racial-health disparities and inequities and how developing and utilizing a racial-equity framework could help strengthen approaches to advocacy. The foundation has also provided support for consultants to work with nonprofit organizations that want to focus more deeply and intently on racial equity within their organizations. This work can include building a more diverse staff and board, training for staff and board on racial-equity concepts and principles, and integrating racial-equity plans into the work of the organization. We also partnered with the Meyer Foundation to offer a Board Source webinar training for grantees, entitled Moving Beyond Political Correctness: Cultivating a Diverse Board. Participants in the we-

binar also had access to a board-diversity toolkit, which provided concrete recommendations and steps for nonprofits committed to building a more diverse board. The intended change of this work is that our grantee partners have more diverse organizations and place greater emphasis on racial equity in their strategic plans. As a result of these investments, some of our grantee partners have diversified their boards, implemented outreach strategies to reach communities of color, and have begun translating materials into other languages and hosting bilingual meetings.

Finally, we acknowledge that talking about race and racism is difficult, and organizations often do not have the language to help them discuss these issues publicly. In 2012 we supported communications and media training for our nonprofit partners on effective ways to frame and discuss racial equity to a wide array of audiences. Together, these capacity-building activities support our grantee partners in engaging more fully in efforts to achieve racial equity.

Strategic Communications

One of the recommendations from the PRE/ARC racial-equity assessment was to bring the foundation's communications into alignment with our commitment to racial equity. As a result, the last seven of CHF's annual meetings have focused on topics related to health and racial equity. The foundation has also used its annual report and a special section on its website to advance this work. Most recently, CHF engaged a communications firm to help align our communications with our commitment to racial equity, which led to the development of a three-part message platform for use by board members and staff. The platform begins with our statement of health equity and posits key messages: CHF's commitment to racial equity with a focus on directing resources to low-income communities of color and an affirmation of solutions that go beyond health care to include the social determinants of health. By continuing to align our communications with our commitment, the intended change is increased awareness among the nonprofit and philanthropic communities of racial-equity concepts and practices and,

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thus, better identification and implementation of solutions that drive us toward our goal of racial equity. The foundation is developing an evaluation framework that will allow us to assess how our strategic communications work contributes to our intended change.

Strategic Partnerships

Partnering with other funders is a key element of CHF's programmatic strategy. These strategic alliances allow us to expand our work beyond health care and to expand our colleagues' capacity to apply a racial-equity framework. For example, we co-fund a peer network of community health workers who are trained to help people living with HIV/AIDS to establish and maintain a relationship with a medical professional. While this work focuses on a specific health outcome, it also

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integrates employment as a social determinant of health and racial equity with its focus on hiring and training people of color. As a part of this collaborative funding partnership, we also joined with Grantmakers in Health to host a convening on women of color and HIV/AIDS.

In addition, we co-fund an initiative focused on building wealth in low-income communities of color through the development of worker-owner cooperative businesses. Based on the Evergreen Cooperatives model in Cleveland, this initiative recognizes that a path to health can be secured for people from low-income communities of color by developing living-wage jobs within cooperative businesses that provide goods and services to existing anchor institutions like local governments, hospitals, and universities. Workers are supported

by workforce-development partners and are invited to share in ownership after a period of employment.

Finally, along with other funders, we support the Convergence Partnership, a national initiative aimed at developing equitable food systems. This initiative recognizes that access to good food is more difficult in low-income communities of color, and there are opportunities to create greater food access and spur economic development benefiting these same communities. These strategic partnerships allow us to pool resources with funders who do not identify as health funders to address issues at the intersection of health, racial equity, and the social determinants of health.

Mission-Consistent Investing

Foundations are legally required to spend a minimum of five percent of their assets annually on charitable activities, but more and more foundations are asking whether a more strategic investment of the endowment – the other 95 percent – can further the foundation’s mission. Approximately 35 percent of CHF’s endowment is invested in mission-consistent vehicles, including two program-related investments that have been used to develop community clinics and affordable housing in the region. The foundation is embarking on a process to become even more intentional about aligning our endowment with our mission to further racial equity goals in the Washington region. The intended change that we seek is increased investments in low-income communities of color. By adopting the principle that every business decision we make has the potential to advance our work toward the goal of racial equity, the foundation is seeking to maximize the totality of its resources.

Conclusion

The Consumer Health Foundation defines racial equity as both a goal and a process whereby people of color have an equal opportunity to live a healthy and dignified life. The goal of racial equity will be achieved when we are unable to predict advantage or disadvantage by race. We organize our programmatic resources – grantmaking, capacity building, strategic communications,

strategic partnerships, and mission-consistent investing – to achieve this goal. The process of racial equity means that we assure the conditions that allow all people regardless of their racial and ethnic background to live optimally. We practice this process internally by working to create an organization that is diverse, inclusive, and free from institutional racism. We believe we have made great strides toward both the goal and process of racial equity, and we acknowledge that there is still more that we can do.

In this article, we shared both our progress and opportunities for growth to support the field of philanthropy as it works to achieve the goal and implement the process of racial equity in its own organizations, including foundations, the affinity groups and vendors that support them, and the nonprofit organizations that receive financial and other resources from them. Though CHF focuses on health, we believe the framework provided here and the practical strategies that we have shared are valuable regardless of the focus of a foundation's philanthropic efforts. All foundations can become educated about structural racism by hosting facilitated conversations for board and staff members. All foundations can then define their racial-equity values and assess how their internal practices align with their values and begin to support any necessary changes. Concurrently or in succession, all foundations can assess how their programmatic resources are being used to ensure that all people regardless of their racial and ethnic backgrounds have an equal opportunity to live with dignity.

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