The Foundation Review

Volume 1
Issue 3 *Open Access*

Article 3

2009

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doi: 10.4087/FOUNDATIONREVIEW-D-09-00030.1

Turning the Ship: Moving From Clinical Treatment to Environmental Prevention: A Health Disparities Policy Advocacy Initiative

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Key Points

- This article examines success factors for a statewide initiative to reduce health disparities by establishing environmental policies to reduce asthma risk factors for school-aged children.
- Twelve local coalitions and a statewide network focused on schools, housing, and outdoor air policies.
- Multiple types and levels of policy advocacy were encouraged by the Initiative so that issues at the local level linked to larger issues across the state, and conversely state-level policies supported local endeavors.
- Factors that contributed to the success of the initiative included: structuring the initiative on a systems change model; employing multiple technical assistance providers to assure fidelity to the model, building capacity, facilitating strategic partnerships, and facilitating mid-course adjustments; communicating "intentional" policy outcomes from the foundation; and structuring an evaluation team to analyze multi-level data and provide feedback at all levels.
- Local coalitions that developed meaningful community engagement and used data to educate policy makers were the most successful.

Introduction and Significance

Throughout the past decade, several foundations across the United States have stepped forward to address the prevalence of health disparities within communities (Behrens & Kelly, 2008; David, 2007; O'Donnell, 2006). One such foundation, The California Endowment (TCE), designed and implemented an initiative that focused on strengthening collaboratives throughout California in order to conduct environmental policy advocacy to reduce asthma risk factors for school-age children. The Community Action to Fight Asthma (CAFA) Initiative, which is currently in its seventh year, significantly shifted efforts from solely improving clinical asthma management and treatment to establishing environmental asthma trigger prevention policies. In addition, the initiative aimed to effect sustainable systems change in a wide variety of intersecting areas, including housing (regulating mold, mildew, tobacco smoke), schools (using green cleaning products, encouraging bus and car anti-idling policies near campuses), and outdoor air (curbing ozone and diesel exhaust from vehicles, refineries, and ports). Because asthma can be induced and exacerbated by environmental triggers, addressing the epidemic in California involves preventing exposures to toxins in both outdoor and indoor air. This "upstream" effort (addressing root causes to prevent asthma rather than treating "downstream" asthma exacerbations) was conceived as a means of reducing the overall prevalence and disparities of asthma by reaching into communities where children are most exposed to factors that adversely affect their health.

Throughout CAFA, TCE addressed underlying causes of asthma using a "grassroots to treetops" approach — incorporating local individuals, organizations, and community collaboratives; building the strength and capacity of existing organizations and resources, including concerned professionals and community members whose children have asthma; and connecting local issues with advocacy and policy at the state level. In this article, we highlight the experiences of TCE in expanding its approach to health policy advocacy by focusing on prevention and implementing a statewide, multipronged initiative to reduce health disparities by decreasing environmental asthma triggers.

Background

Improving Community Health

Literature on community health interventions stresses the importance of enhancing community capacity and facilitating empowerment to achieve desired health outcomes through policy advocacy and systems change (Aboelata et al., 2004; Bentley, 2007; Feinberg, Riggs, & Greenberg, 2005; Goodman et al., 1996; Green et al., 1995; Israel, Schulz, & Parker, 1998; Minkler, 2005; Minkler, Thompson, et al., 2001; Snowden, 2005). In the initial stages of collaboratives, capacity-building activities are among the first indicators that can be measured, because this groundwork must be laid prior to moving the collaborative partners toward accomplishing joint projects.

Easterling and colleagues (1998) described specific characteristics that the Colorado Trust found essential in building community capacity to improve community health. These echo the strategies outlined above but also include leadership, a sense of efficacy, trusting relationships among residents, and a culture of learning (Easterling et al., 1998). Without these components, collaboratives lack the skills and resources necessary to pursue community change. All these characteristics can and should be mapped out by the foundation in advance of implementing a project so that time is not wasted in its initial stages.

Additionally, Syme (2000) reviewed a number of community health promotion projects and emphasized the importance of control, or empowerment, to successful community interventions. Community empowerment may be one of the critical issues in systems change and policy advocacy endeavors; it appears to correlate with reduced risk factors for morbidity when controlling for socio-economic status (Marmot et al., 1997). Stokols et al. (2005) and Stokols (2006) delineated specific factors that promote and inhibit transdisciplinary collaboration. They noted that community empowerment, consensus building, and technical assistance are important activities that contribute to collaborative success and thus should be included as formative and summative measures in the evaluation of collaboratives. Important factors for fostering success in broad-scope projects include (1) frequent collaborative discussions by all participating organizations to maintain and adapt goals and outcomes (whenever possible, in-person meetings are recommended); (2) political and financial support for the life of the project; and (3) highly skilled leaders who can promote cooperation and gain support from others.

These concepts contribute to a better understanding of the creation and sustainability of community health interventions and were used to inform TCE's development of the CAFA Initiative.

The California Endowment: Moving Upstream

Since its inception in 1996, TCE has worked to promote health among all Californians, with a specific focus on increasing access to quality, affordable health care for the underserved. For the first several years of TCE's work as a grantmaker, its mission centered on creating improvements in health care systems and services, building capacity among organizations to improve community health, and increasing advocacy to improve health policies and health care delivery. Whereas these efforts served the foundation's main goals, the primary focus at TCE was "downstream," addressing existing chronic diseases and barriers within the health care system.

TCE's efforts to improve the treatment and management of chronic diseases underscored the growing prevalence of health disparities among

individuals with asthma, diabetes, obesity, and other chronic conditions. Low-income and minority populations experienced the highest prevalence of these illnesses, higher morbidity as a result of them, and greater barriers to accessible, affordable, quality treatment (TCE, 2003). During this time, the issue of health disparities was gaining national attention as well, as evidenced by the *Healthy People 2010* objectives (U.S. Department of Health and Human Services, 2000) and the Institute of Medicine's 2003 report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* (Behrens & Kelly, 2008; Institute of Medicine of the National Academies, 2003; Lasker & Committee on Medicine and Public Health, 1997). It soon became clear that efforts to address disease treatment and management were not enough to prevent or reduce disparities in health status and health care.

Low-income and minority populations experienced the highest prevalence of these illnesses, higher morbidity as a result of them, and greater barriers to accessible, affordable, quality treatment.

Through research and discussions with experts, the staff of TCE quickly realized that prior to disease onset or individuals' contact with the health care system, many other factors contributed to health disparities in underserved communities. TCE staff recognized the inherent value of the public health model — a model centered on primary as well as secondary prevention — to address population-related issues.[1] As a result of this research and reflection, the CAFA Initiative was formed in 2002.

[1] Primary prevention is focused on preventing the development of a disease. Secondary prevention is aimed at screening and early detection of a disease in order to enhance treatment options.

Aligning Board Members

Before fully implementing the prevention approach as part of the new initiative, TCE staff had to garner the foundation board's support. Accordingly, they held a series of discussions with the board, presenting research findings and expert recommendations, to obtain board approval for the new approach. Whereas TCE's previous efforts to improve health centered on the health care system itself, this initiative, as previously noted, took a much broader view of health, including opportunities for advocacy that were not solely based within the health care system.

Initially, some members of the board did not understand how these elements related to asthma prevention or why this strategy could more effectively address health disparities. Board members needed to reconcile their views regarding personal choice and individual responsibility for one's health with the social determinants framework of health, which acknowledges the many social, economic, and other community factors that shape the array of options from which individuals make their decisions. The growing body of evidence on the impact of social determinants of health — a complex mixture of barriers to preventive health practices, adequate housing, economic development, and educational opportunities — helped convince board members of the value of this framework. Once TCE received the board's approval, the CAFA project moved forward.

In 2002, TCE implemented a new strategic plan to create broad changes at the local, regional, and state levels to improve health through capacity building, policy change and advocacy, and initiatives to establish concurrent and sustainable systems change. Specifically, they identified seven strategies to create change:

1. Develop and support individual and organizational leadership.
2. Build and enhance community and organizational capacity and infrastructure.
3. Encourage and promote community-based programs.
4. Advocate for policies.

TABLE 1. Model of The California Endowment (TCE) Initiative Development

Long-term planning	Initiative structure	Implementation
Role of TCE	Role of grantees, technical Assistance, evaluation, collaborations	Community
Defines program model — theory of change.	Evolve structure through stages of collaborative development (Brindis & Wunsch, 1996).	Collaboratives evolve through stages of change to develop, implement, and expand strategies and policies at multiple levels (Prochaska & Di Clemente, 1983; Prochaska et al., 2002). Implement and provide input to the specifics of the logic model.
Address the social determinants of health that impact asthma in school-age children through systems change and grass-roots policy advocacy by supporting and building capacity among community coalitions.	Grantees, technical assistance providers and community collaboratives develop detailed logic model to implement strategies, activities, outcomes, indicators, policies, and systems change.	· Community needs · Strategies · Actions
	Evaluation team works in partnership with TCE and grantees to develop indicators and ways of documenting process and outcomes (e.g., collaborative functioning, activities being implemented, and policy outcomes).	· Community resources · Additional partners · Timeline

5. Foster partnerships and alliances.
6. Educate and advance awareness.

Advance the use of data systems, research capacity, evaluation, and planning methods (The California Endowment. (2008). *The California Endowment's grantmaking: Themes and case studies from the 2002 strategic plan.* Internal document. Oakland, CA.).

These strategies were designed to address disparities in health status and health care access by turning the focus away from health delivery systems and toward communities to address health in a more comprehensive manner.

Asthma in California

In California, asthma has become an epidemic. In some counties, one in six children suffer from the disease. Disparities in childhood asthma rates have been documented by county and legislative district, as well as by race and ethnicity (Mendez-Luck, Yu, Meng, Jhawar, & Wallace, 2007). The prevalence of childhood asthma ranges from 5 percent in two assembly districts in Los Angeles to 16 percent in a district that spans three Central Valley counties. Rates of ever being diagnosed with asthma for children ages 5 to 17 years are highest among African Americans (26 percent) and American Indian/Alaska Natives (28 percent). Whites, Latinos, and Asians follow at 16 percent, 15 percent, and 12 percent, respectively (UCLA Center for Health Policy Research, 2007). TCE sought to reduce these disparities through a comprehensive, place-based initiative that addressed the exacerbating factors present where children live, learn, and play.

Initiatives: A More Comprehensive Approach to Grantmaking

In contrast to funding projects that target one particular problem or disease through individual grants, TCE wanted to provide funding to establish systems and processes that overcome

TABLE 2. Spectrum of Prevention

Level of Spectrum	Definition
1. Strengthening individual knowledge and skills	Enhancing an individual's capability to prevent injury or illness
2. Promoting community education	Reaching groups of people with information and resources to promote health and safety
3. Educating providers	Informing providers to transmit skills and knowledge to others
4. Fostering collaboration	Bringing together groups for broader goals and greater impact
5. Changing organizational practices	Adopting regulations and shaping norms to improve health and safety
6. Educating policymakers	Developing strategies to inform policies

Source. Adapted from Cohen, L., & Swift, S. (1999). The spectrum of prevention: Developing a comprehensive approach to injury prevention. *Injury Prevention, 5*, 203–207, a publication of the BMJ Publishing Group.

the documented limitations of traditional single-stream approaches (Development Guild/DDI, Inc., 2002; Gray, 1996; Green et al., 1995; Israel et al., 1998; Shediac-Rizkallah & Bone, 1998). Thus, by widening their funding strategy beyond treatment-focused activities to creating initiatives, TCE enlarged their scope to encompass a wider, deeper, and more powerful approach to reducing health disparities. This "grassroots to treetops" strategy symbolized the foundation's new role as change-maker in addition to grantmaker. Table 1 illustrates TCE's initiative development model and demonstrates the roles of the foundation, the technical assistance partners, and the coalitions.

Initiative-based funding can encompass specific goals aimed at building coalitions, bringing together key stakeholders, and empowering communities. Initiative funding also can address broader community development and mobilization to promote health and well-being. This strategy is particularly useful for solving complex, multilevel issues such as chronic conditions, many of which have multiple environmental, social, and biological causes. Ideally, initiatives work together with funded organizations and existing networks — consolidating the efforts of stakeholders and combining forces among individuals and groups already grounded in the community — to address problems more effectively than can single agents or entities.

Methodology

To embark on its upstream approach to address health disparities in childhood asthma, TCE incorporated the six strategies of Cohen and Swift's Spectrum of Prevention (1999) to create change within a comprehensive initiative structure (Table 2). The spectrum illustrates the levels of prevention activity, from building individual skills through fostering collaboratives to educating policymakers.

CAFA Phase I (2002–2005)

At the outset, TCE identified organizations and networks already working in childhood asthma education, management, and treatment throughout California. TCE staff members conducted site visits with local groups to document activities, ascertain the strength of each organization, and understand the geographic context of the organization's work. After conducting this ground-level assessment, TCE created and distributed a request for proposals for local coalition grants.

The initiative's goal was to harness the power of existing networks by linking them together,

providing technical assistance and education, and enabling collaboratives to tackle multiple policy issues at the local and state levels. A key aspect of the initiative was the provision of technical assistance by separate statewide providers. Their role was to help ensure that the capacity and skills of collaborative members were strong enough to meet the challenge of the initiative's goals in such areas as policy advocacy or the use of the media to educate the public and policymakers. TCE also assembled an evaluation team to help grantees define evaluation questions of mutual interest, as well as to define valid indicators of progress, assist in data collection and interpretation (including the contextual meaning of the data collected), and assess progress and lessons learned throughout each phase of the initiative. Thus, both the technical assistance and evaluation components facilitated learning among the different stakeholders, assisted in measuring and enhancing progress, and contributed to community capacity and empowerment — a legacy of the initiative that will support future systems change efforts, whether or not they are related to asthma.

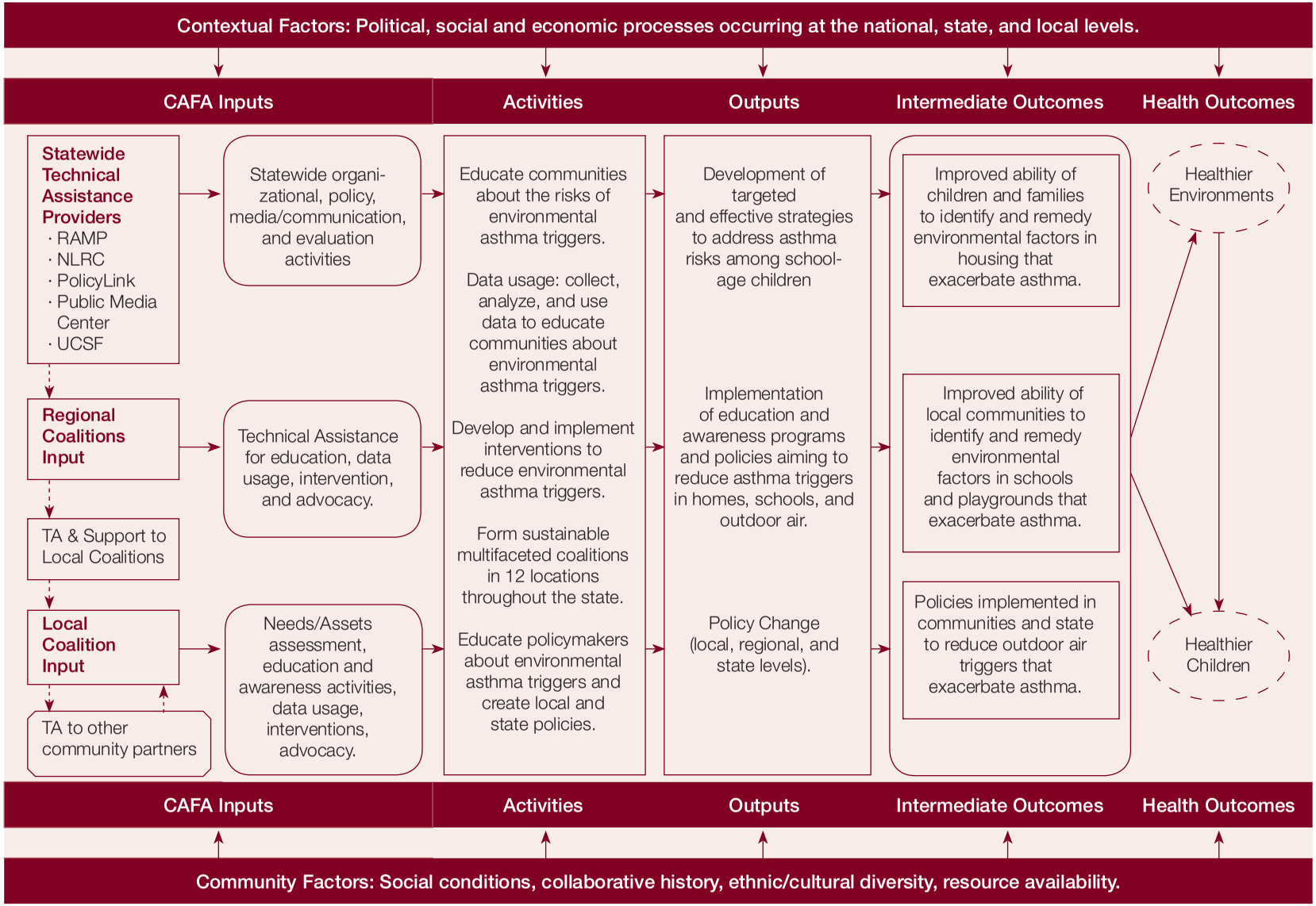
The evaluation team developed an overall logic model or theory of change to more clearly define the desired goals, resources, and general strategies for the initiative (Figure 1). As a means of building consensus for the set of progress measurement indicators, grantees worked with the evaluation team to tailor the model to their specific activities and policy needs. Grantees attained greater clarity and achieved greater consensus when the evaluation team and technical assistance providers helped them (1) clarify assumptions and develop a common language regarding the initiative; (2) understand the relationship between the types of proposed activities and the scope of the policy changes being attempted; and (3) recognize the antecedent and contextual factors that contribute to the challenges of achieving policy goals.

As TCE, technical assistance providers, the evaluation team, and grantees created a framework for policy and advocacy endeavors, the local coalitions identified three specific arenas — homes, schools, and outdoor air — in which they would address asthma triggers and create linkages to existing grassroots advocacy efforts on community- and state-level policies. For this first phase of the CAFA Initiative, grantee activities focused on five main strategies (University of California, San Francisco (UCSF), and Philliber Research Associates. (2006). *Community action to fight asthma: Evaluation report April 2006*. Internal document. San Francisco, CA.):

A key aspect of the initiative was the provision of technical assistance by separate statewide providers.

1. Coalition building: Bring grantees together to build social capital and share goals, strengths, and past experiences; deepen relationships via Web-based communications and conference calls that focused on next steps. During CAFA I, this process did not begin until the second year of the grants. During CAFA II, network meetings and policy conference calls were implemented at the outset, allowing earlier connections across local coalitions and among local and statewide organizations.
2. Education of coalition members, communities, and policymakers: Create a learning environment with the goals of sharing information and learning to work in a better and more strategic manner. This learning approach helped local coalitions to focus strategically on their areas of strength and their community's needs, while still encouraging multiple paths for their work to evolve.
3. Guidance on data collection and usage in policy advocacy: Include an evaluation component at the outset of the grant to collect and use data, document outcomes, and facilitate reflective learning. Documenting the lessons learned should start as soon as possible.
4. Design and implementation of an intervention: Create problem-solving venues among local coalitions and other "experts" and colleagues in the field. Local coalitions were energized by these exchanges, which allowed

FIGURE 1 CAFA Logic Model: To Reduce Environmental Risk Factors for School-Aged Children with Asthma



individuals to honestly discuss their mistakes without recrimination and to reflect on the lessons learned. One speaker turned his reflections into a problem-solving exercise with several local coalitions about how to address challenges facing youth in schools. The coalitions reported being both inspired and comforted by this session, which further encouraged them to engage in peer problem solving.

5. Assist in establish policies. Provide a balance between the sometimes conflicting needs of maintaining overarching guidance on policy issues and encouraging creativity in topics, ideas, and contexts unique to the local or state issues.

Many of these strategies hinge on fostering a sense of community within and among the coalitions and facilitating their empowerment to take on issues of importance to their membership. These strategies also facilitate the coalitions' maturation at all levels as they progress through the stages of collaborative development for a systems change model.

CAFA Phase II (2005–2008)

During the first three years of CAFA, TCE perceived many ways to improve the process of coordinating the initiative and creating a cohesive network. As a consequence, a midcourse correction was made to streamline the operational components of the initiative.

TCE decided that the governing structure of its statewide and regional administration, as well as the provision of technical assistance, was too cumbersome. The initiative was attempting to integrate organizations at different levels (local, regional, and state), each with varying degrees of knowledge about asthma. There were too many moving parts for such a young initiative, making the task of providing prevention and policy education extremely difficult and inefficient. Accordingly, two of the four regional coalitions, which oversaw the local community collaboratives, were eliminated. A third was elevated to serve in a statewide collaborative leadership role and as a technical assistance provider for the northern part of the state, whereas the fourth was reassigned to provide technical assistance to all local coalitions in the southern portion of the state. The regional coalitions whose functions were reassigned are shown in red text in Figure 1.

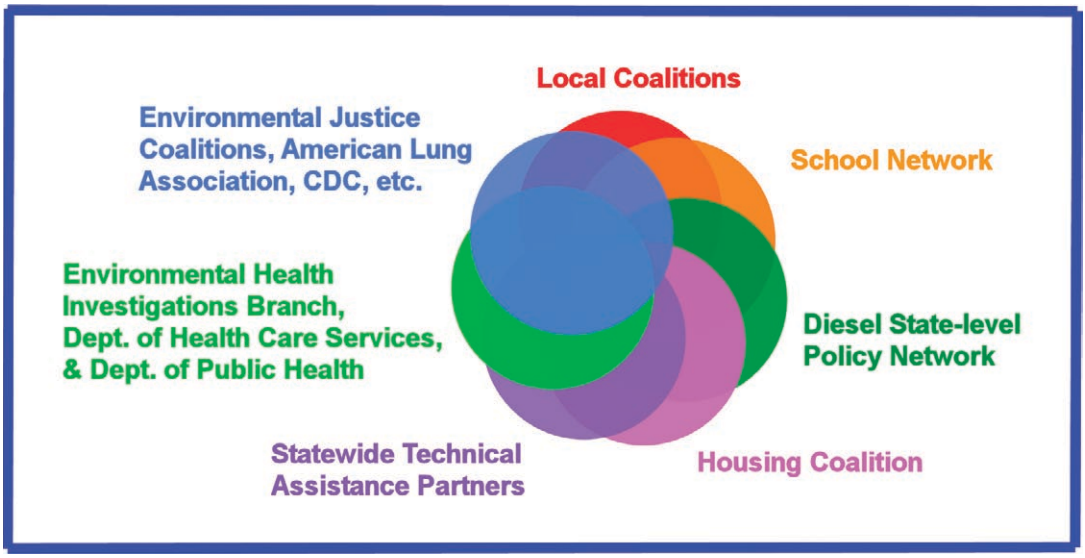
TCE decided to tie educational efforts to policy objectives, rather than merely providing general information about asthma environmental issues.

TCE also concluded that it and the statewide technical assistance partners should be more "intentional" in assisting the local coalitions to define objectives in more targeted policy arenas. During the second iteration of funding, TCE decided to tie educational efforts to policy objectives, rather than merely providing general information about asthma environmental issues. For example, instead of educating communities and policymakers that diesel emissions and particulate matter are problematic for children, the coalitions shared data and explained how proposed legislation to lower carbon fuels or enforce anti-idling regulations for school busses would affect air quality. For this phase of the CAFA Initiative, the grantees, with close guidance from TCE, the technical assistance providers, and the evaluation team, focused on the following activities:

1. Educate communities and policymakers, specifically focusing on policy issues.
2. Identify champions to further policy advocacy.
3. Develop policies focused on reducing environmental asthma risk factors.

As the coalitions matured and midcourse adjustments were made, strategic alliances with preexisting organizations solidified, and the initiative came to resemble the model shown in Figure 2.

FIGURE 2 Coalition Strategic Alliances



Results

The careful planning for and implementation of the CAFA Initiative was successful in creating a local and statewide structure that undertook upstream policy advocacy activities. The creation of the local coalitions filled a critical gap and established a much-needed infrastructure for addressing environmental triggers of asthma in homes, schools, and outdoor air quality. Before the inception of the CAFA Initiative, the "asthma network" in California consisted of a few local and regional organizations and the loosely connected network of the state American Lung Association (ALA) affiliates. These groups focused primarily on asthma education and on the management and treatment of the clinical aspects of asthma.

With the CAFA network established, the focus turned to environmental asthma triggers. The CAFA network made significant advances in educating stakeholders, including local coalitions, communities, and policy makers; collecting and analyzing data; creating and/or furthering environmental interventions; and creating and advancing state and local policies.

The coalitions engaged in all six levels of the spectrum of prevention model, but focused primarily on prevention-oriented activities in Levels 3 through 6 (Table 2). Legislative and regulatory policy advocacy efforts in which the initiative was involved are presented in Table 3. These ranged from reducing idling periods for trucks near the ports and removing air pollution exemptions from farm vehicles to replacing diesel engine school buses with less-polluting models and enabling students to have access to their asthma medications in schools. Major accomplishments of the first phase of the CAFA Initiative included

- Finding and funding a centralized "home" for environmental policy work.
- Furthering collaboration, education, and policy activities related to prevention.
- Employing asthma as a model for environmental prevention.
- Assisting communities to attain a level of action readiness to work on policy and systems change.

These advocacy efforts connected communities and regions to statewide policies and established the linkages needed for systems change endeavors that extend from local communities to statewide policy. The synergy between local and state levels also helped to energize each of the participants, with local activities helping to feed into statewide efforts, and statewide efforts, in turn, informing local actions.

After the midcourse correction, the focus shifted to a stronger concentration on both local and statewide outcomes, strategic partnerships, and policy advocacy within one or two of the defined sectors — housing, schools, and outdoor air.

By the end of the second phase of funding, the more mature coalitions increased their "grants funded" rate from 24 percent (Phase I) to 52 percent (Phase II). Furthermore, funding was received by many coalitions that had not previously written a grant proposal.

Statewide Outcomes

Of the 12 local sites originally funded, eight achieved "traction" in their work within their communities, meaning they were received well and were supported by their communities and by local organizations such as the housing authority, health department, and district board, allowing them to contribute to a wide range of policy changes. Some of the larger policies required substantial advocacy over multiple years and will require careful monitoring to assure that they are implemented as conceived.

Discussion

A central tenet of this article is that well-designed policy advocacy initiatives can succeed, even though coalitions and grantees do not have prior training or experience in advocacy. Stakeholders with disparate backgrounds (educators, service providers, and community members) can participate in policy advocacy and see the connections between their work and the larger arena of policy. This connection is important for democratic societies and allows stakeholders to address upstream causes of issues, rather than feel that they are merely providing temporary solutions to chronic problems. Furthermore, in the process, stakeholders can successfully establish prevention policies that address root causes of health disparities that impact not only asthma but other conditions as well. In the same way that environmental pollution can affect the health and safety of children playing in a local park, so too, for example, can other contextual problems such as street violence. CAFA's successful approach to establishing policies to reduce asthma-related health disparities also can be adapted to address other health risks and problems such as childhood obesity, diabetes, or violence (Garfield et al., 2003).

Several critical factors contributed to success in the CAFA Initiative. First, the initiative was structured as a learning endeavor for all participants, using a theory of change to outline system dynamics. Multiple technical assistance partners provided feedback to assure fidelity to the model and allow for midcourse corrections and adjustments. Additionally, TCE became intentional in its communications with coalitions, stressing the desired types of policy outcomes. Second, the multiple technical assistance providers, whose efforts were well coordinated, enabled local coalitions and the statewide network to build capacity more quickly and to be more agile in responding to strategic partnerships and alliances than would otherwise have been possible. Third, the evaluation team was structured to analyze multilevel data and provide feedback to all levels of the initiative, fostering and furthering the learning process and providing opportunities for ongoing quality improvement.

Multiple technical assistance partners provided feedback to assure fidelity to the model and allow for midcourse corrections and adjustments.

One of the successful strategic decisions in the design of the initiative was to fund multiple types of policy advocacy, so that issues at the local level could link to larger issues across the state. For example, a local coalition member contacted the leader of the statewide housing code enforcers' voluntary organization and persuaded him that asthma triggers should be included in housing inspections. This is an evolving relationship that holds the promise of providing statewide uniformity to what are currently inconsistent, primarily local, regulations. Additionally, policy advocacy to reduce ship, rail, and truck pollution at the

TABLE 3 Statewide Policies Supported by CAFA, by Year (2004–2008)
Key: Yellow: Outdoor air-related legislation; Blue: School-related legislation; White: Other

California Legislation
2004
Signed by Governor
AB 923 *Air Pollution, Replacement of Buses.*
SB 391 *Pesticide Drift Exposure*.
Vetoed by Governor
AB 2042 *Los Angeles & Long Beach Port Pollution*.
AB 736 *New School Construction Bill*.
Partial success in becoming legislation or progressing through ballot or legislature. Did not become law.
AB 2185 *Requires health plans to provide spacers and peak flow meters.*
AB 2628 *Hybrid Vehicles in Carpool Lanes.*
AB 1394 *Funds to Reduce Diesel Pollution.*
SB 700 *Remove Exemption for Agricultural Sources of Pollution.*
AB 2132 *Asthma Medications in Schools*.
SB 352 *Prohibits Building Schools Near Freeways.*
SB 1912. *Self-Administration of Auto-Injectable Epinephrine in schools*.
2005
Signed by Governor
AB 2132 *Ensure Students Access to Asthma Medications at School.*
AB 2185 *Ensure Health Plans Cover Outpatient Medications. .*
2006
Signed by Governor
AB 32 *Reduce Global Warming.*
Rule 9310: *Cleaner Running School Buses in Central Valley.*
AB 607 *School Facilities Emergency Repair*.
Vetoed by Governor
AB 2825 *Pesticide Buffer Zones Near Schools.*
Partial success in becoming legislation or progressing through ballot or legislature. Did not become law.
Proposition 87: *Alternative Energy Incentives*.
SB 760 *User Fees for Containers in Ports*.
SB 999 *Central Valley Air Pollution Control District Board Membership.*
SB 1205 *Increases Penalties for Violations of Air Pollution Laws*.

ports of Long Beach and Los Angeles evolved into a statewide movement and is now influencing ports and goods movements nationally and internationally. Multiple activities at various levels allowed the coalitions to stay active and engaged in advocacy, as well as to continue working on other concurrent policy efforts, even if one policy strategy was not successful. This approach informed TCE's understanding of policy advocacy and place-based work.

Midcourse Corrections

Despite the theoretical advantages of having regional organizations in the initiative structure, the

California Legislation
2007
Signed by Governor
AB 118 *Promotes Alternative Transportation*.
AB 233 *Healthy Heart and Lungs Act.*
AB 833 *Toxic Release Inventory Program.*
AB 995 *Trade Corridor Improvement.*
SB 7 *Prohibits Smoking in Vehicles with Minor Passengers.*
SB 23 *Central Valley: High Polluter Vehicles.*
SB 719 *Central Air Pollution Control District Board Membership.*
SB 1028 *Ambient Air Quality Standards.*
SB 1548 *Central Valley Air Pollution Control District Selection Committee.*
Vetoed by Governor
SB 210 *Greenhouse Gas Emissions.*
Partial success in becoming legislation or progressing through legislature. Did not become law.
AB 1472 *Requires assessment of land use and transportation planning.*
SB 9 *Trade Corridor Improvement.*
SB 240 *Establishes Standards for Central Valley Air Quality*.
2008
Signed by Governor
SB 375 *Establishes Greenhouse Gas Reduction Targets.*
AB 2522 *Central Valley Vehicle License Fees.*
Vetoed by Governor
SB 974 *Los Angeles, Long Beach, and Oakland Port Container Fees.*
Partial success in becoming legislation or progressing through legislature. Did not become law.
AB 1472 *California Healthy Places Act.*
AB 977 *Local Control of Pesticide Regulation.*
AB 2546 *Railyards Emission Regulation.*
AB 2808 *Environmentally Sensitive Cleaning Materials and Products in Schools.*
AB 2332 *Railyard Expansion/Development.*
SB 1468 *School Construction Close to Freeways.*
SB 1507 *Freeway Expansion Close to School.*

Note. CAFA = Community Action to Fight Asthma.
Sources. Official California Legislative Information. Retrieved February 5, 2009, from http://www.leginfo.ca.gov/. California League of Conservative Voters. Retrieved February 5, 2009, from http://www.ecovote.org/involved/alerts/04/09/sb391.html.

regional coalition partners generally had slower learning curves in understanding how to engage in environmental policy advocacy. This can be attributed to several factors: In some cases the regional coalitions lacked a substantive understanding of asthma and conditions that exacerbate the disease. One regional coalition's board was not in agreement with an environmental focus on prevention. Another regional coalition, though more sophisticated in policy advocacy than all of the other regional and local coalitions, did not have an extensive understanding of asthma; its local coalitions challenged it on expertise this area. Additionally, local coalitions frequently were confused about

which level of the organizational structure to seek assistance from for their varying needs. For all of these reasons, the regional coalitions ultimately were eliminated, although these problems may not be applicable to all coalition structures.

The concept of providing significant flexibility to coalitions was less effective than anticipated. On the other hand, providing greater clarity to coalitions about the types of outcomes desired enabled them to more successfully address issues specific to their geography and target population(s). This refocus on outcomes and clarity of expectations avoided frustration among coalitions about how to define their own success and allowed them to devote their energies to a range of activities such as establishing procedures, developing interorganizational partnerships, and formulating local and statewide policies.

The concept of providing significant flexibility to coalitions was less effective than anticipated.

Although the literature on coalitions cautions that they are not able to effectively engage in policy advocacy at an early developmental stage (Kreuter et al., 2003), this was not true for the CAFA Initiative, where policy "wins" occurred in its second year. The presence of multiple technical assistance partners providing "coaching" in such areas as policy advocacy, environmental data, asthma research, evaluation, and communications and media greatly enhanced the coalitions' learning rates.

Principal lessons learned from the CAFA Initiative include the ways in which community coalitions effectively engage in prevention policy advocacy, capacity building, fostering empowerment, and ensuring sustainability.

Coalition Engagement in Policy Advocacy

Coalitions progressed through the stages of collaborative development outlined in Table 4. However, the speed at which collaboratives progressed was not uniform, because the pace at which each coalition needed to share information, build trust, and explore solutions could not be rushed. Specific challenges occurred around sharing resources and working cooperatively. Some fiscal agents did not create a supportive environment and were not flexible with resource allocation or utilization.[2] Some collaboratives did not see the value of working together or felt they had more expertise than other partners. However, working together on statewide policy was catalytic for many coalitions, because they viewed firsthand the value of having diverse statewide groups join together to educate policymakers about "their" issues.

The most successful local coalitions developed a vision for their work, openness to new partners and approaches, and an ability to strategically assess opportunities. This willingness to venture into new, potentially beneficial, arenas enabled them to seize opportunities that less-enterprising coalitions may have missed. Dean and Bush (2007) noted that coalitions that are more open and inclusive in their approach are more likely to progress in systems change and paradigm-shifting activities. A common condition of coalitions that gained less traction with their work was an absence of strong community involvement, which is also an important component of sustainability.

It was critical for coalitions to build upon the experience and knowledge they gained by working with communities "where they are." For example, the coalition in one low-income community with a high prevalence of asthma among children of color initially focused on reducing environmental asthma triggers in the home. While working on this issue, they became aware of outdoor air issues related to the local oil refinery. As the coalition worked to establish a first-in-the-nation regulation of the refinery's toxic emissions, they also became aware of additional toxics. Specifically, diesel truck routes cross many portions of the community and are dangerously close to schools and neighborhoods. This community is now undertaking a major city and transportation

[2] As community-based organizations, many coalitions needed a fiscal agent, a nonprofit organization through which funding could flow to the coalition.

TABLE 4 Stages of Collaborative Development

Stage	Description
Stage 1: Information exchange	Groups exchange information about their agencies goals and target populations
	Assess what each stakeholder brings to the table and explore what a collaborative relationship might entail
Stage 2: Development of joint projects	Joint projects undertaken to accomplish something that cannot be achieved with one organization alone
Stage 3: Changing the rules	Recognize that the system's rules present major barriers to accomplish a goal of the collaborative
Stage 4: Changing the system	Weave together ingredients such as *changes in rules, new personnel, and new forms of accountability into a strategic package that represents real systems change*

Source. From *Finding Common Ground: Developing Linkages Between School-Linked/ School-Based Health Programs and Managed Care Health Plans: A Report on the Evaluation of the Foundation Consortium Initiative to Integrate School-Linked and School-Based Health Services with Managed Care,* by C. Brindis and B. Wunsch. Sacramento, CA: Foundation Consortium for School-Linked Services, 1996.

planning process to reroute trucks away from these high-risk areas.

Capacity, Empowerment, and Sustainability

An in-depth evaluation of individual coalition and statewide network outcomes demonstrated that those coalitions that held frequent participant discussions and had strong, open-minded, motivated, and inventive leadership (Items 1 and 3 in Stokols et al., 2005) gained the most traction in their communities and ultimately had the greatest success in effecting systems change.

Scheirer (2005) described five factors contributing to program sustainability: (1) programmatic flexibility, enabling change and evolution over time; (2) a champion to support the program; (3) good organizational fit between the program and its host organization; (4) readily perceived benefits to staff and clients; and (5) outside stakeholders who provide support for the program. Of specific interest to our discussion are findings addressing sustainability for community health initiatives with respect to policy and systems change. These areas are touched on in a number of other studies (Baum et al., 2006; Beery et al., 2005; Goodman et al., 1996; Green, 1995; Grove, Kibel, & Haas, 2005; Higgins, Naylor, & Day, 2008; Johnson, Hays, Center, & Daley, 2004; Pluye, Potvin, & Denis, 2004; PolicyLink, 2003; Scheirer, 2005; Shediac-Rizkallah & Bone, 1998). Pertinent factors contributing to sustainability gleaned from these studies include a confluence of interest and resources among coalition members; advance preparation for sustainability by coalitions and partners; a commitment among partners; aggressive grant writing or leveraging of other funding; and willingness to assimilate with other programs.

As the CAFA coalitions continue to tackle larger and more complex tasks and move toward sustainability, it will be important to note which partners and allies provide the best opportunities for supporting the advocacy work on environmental asthma triggers and what unanticipated consequences occur from these activities and relationships. For example, one coalition encountered a funding barrier to hiring someone to implement asthma-friendly school policies. After working with another city department, the coalition was able to create an agreement between the school district and the public health department so that funding could be routed through the public health department. This solution satisfied both departments, and the school district was

able to start mitigating environmental triggers in the schools.

The CAFA findings reinforce the importance of careful planning, frequent discussions, technical assistance, and evaluation with supportive feedback, as well as tailoring outcomes to local communities when designing initiatives for new arenas of policy advocacy.

Conclusion

The California Endowment's Community Action to Fight Asthma Initiative is at the forefront of a growing interest among foundations to support policy advocacy. The initiative provided TCE with evidence that partnerships that focus on policy outcomes in environmental prevention can succeed. Using the lessons learned about selecting grantees and fiscal agents, building capacity in a transparent manner, employing multiple levels of technical assistance and evaluation, and clearly defining anticipated outcomes, the initiative provided TCE with a wealth of data on how best to organize, implement, and monitor initiatives. These lessons were invaluable in informing subsequent initiatives aimed at reducing obesity and increasing physical activity, as well as improving the health of communities by focusing on place-based strategies. In addition to confirming the importance of elements described by Cohen and Swift (1999), Easterling et al. (1998), Syme (2000), and Stokols (2006) as essential to the success of coalitions in effecting systems change through policy advocacy, the TCE Initiative also demonstrated that coalitions initially inexperienced with prevention policy can indeed succeed in effecting policy change given the right types of technical assistance, evaluation, and funding support.

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Acknowledgments

The program and evaluation components of the Community Action to Fight Asthma (CAFA) Initiative was supported by The California Endowment. The insights and information shared in this article would not have been possible without the great support, involvement, and commitment of the program and evaluation staff at The California Endowment, local residents and advocates, the local, regional, and statewide CAFA coalitions, and the statewide technical assistance providers. Additionally, we would like to thank Teri Behrens and two anonymous reviewers. Finally, we wish to thank Simran Sabherwal for assistance in manuscript preparation and Maxwell Richardson for reviewing the article.

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