Strategic Planning and Facilitation Services for the San Francisco Sugary Drinks Distributor Tax Advisory Committee

raimi + associates

SEAL OF THE CITY AND COUNTY OF SAN FRANCISCO
ORO EN PAZ · FIERRO EN GUERRA

May 10, 2019

Selection Committee
Sugary Drinks Distributor Tax Advisory Committee (SDDTAC)
Community Health Equity & Promotion Branch
chep@sfdph.org

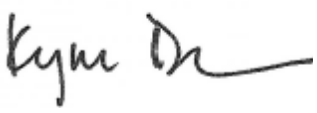
Dear Selection Committee,

Raimi + Associates is excited to present our qualifications to provide strategic planning services for the Sugary Drinks Distributor Tax Advisory Committee (SDDTAC).

Our mission is to provide a range of consulting services that support healthy, sustainable, and equitable communities. For this project, we have selected a team that brings deep expertise providing strategic planning and facilitation services to government agencies, community collaborations, nonprofits, and foundations. We also bring expertise in organizational development and deep experience working with the staff from San Francisco Department of Public Health (SF DPH) and health leaders in San Francisco, across California and the nation. We create participatory and transparent planning processes that result in strategic plans with broad buy in and data-driven strategies. We believe that our many years working closely with staff from SF DPH and leaders from across San Francisco, along with our deep understanding of data-driven healthy eating/active living policy, systems, and environment strategies makes us well positioned to contribute to this exciting project. We would welcome the opportunity to collaborate with SF DPH on this project.

Please contact me if you have any questions.

Sincerely,



KYM DORMAN

Principal and Chief Operating Officer

WHO WE ARE

Raimi + Associates was founded in 2006 to provide a range of consulting services to build strong communities with a focus on health, equity, and sustainability. Our team has grown to 15, and now includes staff members with diverse backgrounds in applied research, public health, urban planning, environmental health, and community development. With offices in Berkeley, Riverside, and Los Angeles, we have a lean administrative structure, and our mission remains focused on providing a range of consulting services that support healthy, sustainable, and equitable communities.

We bring expertise on a range of public health issues, including topics such as healthy eating/active living, community health and wellbeing, HIV prevention, mental health, chronic disease, as well as violence prevention. We bring deep experience combining rigorous qualitative and quantitative research methods (for example, data from surveys and focus groups) to inform strategic decision making. We also bring years of experience effectively partnering with government agencies, community collaboratives, nonprofits, and foundations to achieve their long-term visions by listening to and learning from diverse community stakeholders. Our successful track record of developing and conducting applied research projects, including strategic planning projects, assessments, and evaluations, is based on our highly collaborative approach, thoughtful use of data and research methodologies, and ability to engage diverse stakeholders in the process.

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We have selected a team that brings expertise developing strategic plans, leading assessments on a range of topics, and conducting evaluations that result in ongoing learning. Below we provide a brief overview of relevant experience each team member brings to this project.

Kym Dorman, MPH, Principal and Chief Operating Officer, will serve as the project director, overseeing all aspects of the strategic planning process. She will also serve as lead facilitator. She is a seasoned social sector consultant who excels at developing strategic plans, conducting assessments, and evaluating complex projects that emphasize organizational and community capacity. With more than 20 years of experience as a facilitator and an applied researcher, Kym's professional expertise spans a range of social and public health issues, including chronic disease, community health and wellness, family engagement, health care access, HIV prevention planning, intimate partner violence prevention, and prison diversion programs for mentally ill offenders. She is highly skilled in a wide range of qualitative and quantitative research methods, and has considerable experience using data to help communities make data-informed decisions for their future. Prior to joining R+A in 2015, Kym worked at Harder+Company Community Research for 15 years, where she served as Vice President for seven years. Kym earned a Master's in Public Health from San Francisco State University and is fluent in Spanish.

Paige Kruza, MPH, Senior Researcher brings experience applying a "Health and Equity in All Policies" framework to state and local policies and programs and has helped develop neighborhood and county-wide strategic plans that advance health and racial equity. For more than 15 years, Paige has worked with and supported disenfranchised communities to address racial, economic, and other health inequities. Prior to joining Raimi + Associates, Paige worked in community-based organizations and local and state public health departments. She also

has extensive skills in qualitative (e.g., focus groups, stakeholder interviews, etc.), quantitative (e.g., survey analysis, statistical modeling and GIS), and policy analysis. Paige's key areas of interest include data-informed strategies, community-driven planning, and making policies and resource allocation equitable. Paige earned her Master of Public Health degree from UC Berkeley. Paige will serve as project manager for this project, assisting in ensuring that all aspects of the project are on time and of high quality.

#1 APPROACH AND PROCESS

Below we outline key elements of our approach:

- **Leveraging our experience working in San Francisco with SF DPH and organizations to improve health.** We bring considerable experience working with SF DPH on a range of assessment, evaluation, and planning projects that focus on improving the health of San Francisco's most vulnerable residents. We will leverage our experience and build on our long-time relationships with key leaders throughout San Francisco for this project.

- **Using data to guide decision-making:** An important component of a successful strategic planning process is the careful use of data. We work closely with our clients to determine both the best sources of data, and the best uses of that information. We expect to work collaboratively with SDDTAC to establish a formal prioritization process and use best practices that will guide the development of the SDDTAC Strategic Plan.

- **Centering equity:** Our team has a long history of centering racial equity in our work, and we understand that we need to reduce (and ultimately eliminate) inequities in order to make significant and sustainable improvements to population health and well-being. We also know that achieving racial equity requires significant changes to how institutions and systems operate (including changing policies, organizational culture, and decision-making processes), as well as the meaningful engagement of diverse community members and other stakeholders. Within R+A, we regularly reflect on how to strengthen our practice and more effectively address equity.

- **Facilitating transparent and inclusive planning processes.** Our team brings extensive experience leading planning processes, including facilitating planning meetings with diverse stakeholder groups for strategic and community planning processes, as well as for evaluation projects. Our planning processes are transparent, inclusive, and accessible for a wide range of audiences. We structure meetings using a variety of facilitation techniques, including small and large group discussions, and other approaches that consider literacy, culture, and diverse learning and communication styles. We structure each engagement so that participants feel comfortable participating in meaningful ways with the aim of creating shared understandings, strong buy-in, and innovative and implementable action steps. We are also skilled at navigating challenging group dynamics. By being clear about the goals, key decision-makers, and decision-making process, we are responsive to unanticipated challenges and opportunities, while maintaining our focus on a high-quality final product.

- **Collaborating with clients and stakeholders.** Our team values working closely with our clients to ensure shared goals and a tailored approach to our planning projects. We prioritize clear communication and make our team members available for discussion and feedback at all stages of an engagement, beginning by clarifying timelines, expectations, and the appropriate level of engagement for stakeholders.

- **Balancing aspirations and actionability.** We create strategic plans that are innovative and easy to use, with a clear outline for how the plan will be implemented. We ensure that the final plan reflects the input of staff and key stakeholders by incorporating relevant feedback along the way. Our collaborative approach is embedded throughout the process in order to ensure that the plan includes achievable and relevant metrics—both outcome measures ("the what") and process measures ("the how"). These metrics help staff monitor day to day implementation of the plan and to develop reports on progress and milestones in the future.

We will employ a highly collaborative approach to develop the SDDTAC Strategic Plan, beginning with close engagement of SF DPH staff to clarify the vision for this planning process. This high level of collaboration will ensure that Strategic Planning process is realistic.

PROPOSED SCOPE OF WORK

Below we outline our proposed strategic planning process based on existing resources. We are happy to discuss an expanded strategic planning process (see proposed optional tasks below) should additional resources become available. We are also happy to negotiate modifications to the proposed scope (below).

Task 1. Project Management. We will hold an initial meeting with SF DPH staff (and a subset of SDDTAC members if appropriate/available) to review and finalize the work plan and timeline. We will also establish up to six (6) additional project check in meetings (note that these meetings will be held on the phone). We will also discuss relevant documents to review for the project.

- ✓ Deliverables: Final scope of work and timeline

Task 2. Conduct Rapid Environmental Scan. We propose to work closely with SF DPH staff to conduct a rapid environmental scan that includes the following:

- 2.1. Review key data from extensive community engagement and identify cross cutting key takeaways. For this component of the environmental scan, we will review SDDT funding priorities, key findings from focus groups and Town Hall, as well as the SDDTAC 2019 Report and identify cross-cutting key takeaways to inform the selection of goal areas and strategies.
- 2.2. Review goals from other coalitions/committees that align with SDDTAC. We propose to support SF DPH staff to identify relevant goals from SF coalitions/collaborations and initiatives that align with SDDTAC and we will then create a visually engaging crosswalk summary.
- *Optional task*: With additional resources, we propose to conduct a crosswalk of relevant strategies used in other SF coalitions/collaborations that align with SDDTAC.
- 2.3. Conduct brief review of evidence-based strategies. We will identify approximately 3-7 culturally appropriate, evidence-based strategies for each of the goal areas.
- *Optional task:* Conduct and analyze brief key decision maker survey: With additional resources, we propose to develop a brief survey for key decision makers to provide input on the goals and strategies identified for this Strategic Plan.

- ✓ Deliverables: Cross cutting key takeaways from Community Engagement; Cross walk of relevant aligned coalition goals; 3-7 evidence-based strategies for each of the goal areas.

Task 3. SDDTAC Strategic Planning Meetings

- **Meeting #1 - SDDT Advisory Committee Strategic Planning Meeting.** In the first strategic planning meeting, we propose to review the overall process and draft decision-making matrix to ensure that key decision points and roles are clear, and the process for decision making is transparent. We will also ask Committee members to identify key considerations and priorities/outcomes for the strategic planning process (e.g., what has worked well in decision making in the past, challenges, and to identify key priorities/outcomes for this strategic planning process). With the aim of lifting up common goals and collaborative work, we will also present a draft list of coalitions/committees that have similar aims and ask the Committee to identify any additional coalitions. Finally, we will confirm key data that will inform the strategic planning process as well as the timeframe for the strategic plan.
    - ✓ Deliverables: Decision-making matrix, meeting agenda, and summary of action steps.
- **Meeting #2 - Strategic Planning Subcommittee Meeting.** Based on the input from meeting #1, we will review and update the SDDTAC principles. We will also review a draft SDDTAC mission and vision. We will then review the cross-cutting findings from the rapid environmental scan (see Task 2, Part 1a above). Using the data to guide the conversation, we will then review and discuss key outcomes for the SDDTAC. Finally, we will discuss criteria for prioritizing 3-5 goal areas and corresponding strategies.
    - ✓ Deliverables: Draft updated principles, draft SDDTAC mission, vision, and outcomes; criteria for selecting 3-5 goal areas.
- **Meeting #3 - Strategic Planning Subcommittee Meeting.** During this meeting, Subcommittee members will review and confirm revisions to a final draft of the principles, mission, and vision. The group will also provide feedback on the outcomes and use the criteria (identified in meeting #2) to draft the 3-5 goal areas. The group will then prepare a final set of draft goal areas for the SDDTAC to review and approve. The group will also review and confirm the criteria (e.g., evidence-based and equity-focused) for selecting strategies/approaches.
    - ✓ Deliverables: Final draft principles, mission, vision, goals, and outcomes for SDDTAC to review; criteria for selecting strategies.
- ***Optional Meeting* - Strategic Planning Subcommittee Meeting:** Subcommittee members will present the draft principles, mission, vision, goals, and outcomes at a SDDT Advisory Committee Meeting for feedback and approval. With additional resources, R+A staff can attend and/or assist with facilitation. This will ensure that the SDDTAC is involved and can provide feedback early in the strategic planning process.
- **Meeting #4 - Strategic Planning Subcommittee Meeting:** Subcommittee members will have an opportunity to review the results of the rapid environmental scan (see Task 2.3) and then participate in an exercise using the criteria to select key strategies. The group will then discuss the results and make final recommendations for the SDDTAC to review and consider.
    - ✓ Deliverables: Draft strategies for each goal area.
- ***Optional Meeting* - Strategic Planning Subcommittee Meeting:** Subcommittee members will present key results from the rapid environmental scan to the SDDT Advisory Committee to set the stage for finalizing the goals and reviewing draft strategies. The SDDTAC will then provide feedback on the updated goals and draft strategies. With additional resources, R+A staff can attend

and/or assist with facilitation. This will ensure that the SDDTAC is able to provide feedback on the goals and strategies.

- **Meeting #5 - SDDT Advisory Committee Strategic Planning Meeting.** At this meeting, we will present a final draft of the strategic plan and gather feedback from the Advisory Committee. We will begin with a brief reminder of the process used to identify the key components of the strategic plan and will then ask Advisory Committee members to review and provide final feedback on the goal areas, outcomes, and strategies. In this meeting the Advisory Committee will approve the goal areas, outcomes, and strategies (if ready).
  - ✓ Deliverables: Draft or Final goal areas, updated outcomes and strategies for each goal area.
- ***Optional Meeting* - Strategic Planning Subcommittee Meeting:** If the SDDTAC is not ready to approve the strategic plan in meeting #5, this meeting would provide an opportunity to review the feedback, and update the goal areas, outcomes, and strategies for final review and approval.
  - ✓ Deliverables: Updated goals, outcomes, and strategies
- ***Optional Meeting* - SDDT Advisory Committee Strategic Planning Meeting.** If necessary, an additional strategic planning meeting will be scheduled to review and approve the final SDDTAC Strategic Plan.
  - ✓ Deliverables: Final goals, outcomes, and strategies

Task 4. Finalize the SDDTAC Strategic Plan. Once the goal areas, outcomes, and strategies are approved, we will compile the final Strategic Plan. The final SDDTAC Strategic Plan will be compelling and visually dynamic (using visualization techniques to present information), and will include a brief introduction and description of the process, a brief overview and purpose for each of the three to five goals, key strategies for each of the goals, outcomes, and selected metrics for tracking progress over time.

- ✓ Deliverables: Final SDDTAC Strategic Plan

#2 RECOMMENDED STAKEHOLDERS TO INCLUDE

Based on the extensive community engagement conducted to date as well as the available resources allotted for this planning process, we recommend focusing on the SDDTAC membership to develop this strategic plan. The SDDTAC members are critical stakeholders in the development and success of this strategic plan. Additional stakeholders could be identified and included as additional resources become available.

#3 SAMPLE AGENDA

Please see Appendix A for the Sample Agenda.

#4 TIMELINE

We estimate that the Strategic Planning Process will begin in June 2019 and will be completed by March of 2020.

#5 HANDLING CONFLICT

We bring 20 years working on projects facilitating decision-making processes, and greatly value diverse community member and stakeholder input and create decision-making processes that strive to make

participation—including sharing diverse perspectives and even conflict—part of the process. We do this by 1) building trust; 2) creating a transparent decision-making process; and 3) developing criteria for decision-making that are focused on achieving project goals. We believe that developing clear project principles and goals and establishing group agreements helps build trust from the outset of a project. Some examples of creating transparent processes include setting up a clear project scope, timeline, and decision-making process so that all project participants are clear in advance about how decisions will be made and by whom. We have also found that when we work on projects with people we have worked with before (e.g., SF DPH staff and community partners), trust is established more quickly because they are familiar with our work. We create decision-making processes that are based on striving for group consensus and have found that this is effective. By developing criteria for decision-making that is focused on achieving project goals, participants are typically able to come to agreements and move forward. We also establish clear "fall back" methods, like voting or establishing a clear decision maker if the group is unable to come to agreement. Overall, we believe that when diverse perspectives are included in the decision-making process, the final recommendations and products are stronger and have broader buy-in. Ultimately, we believe that setting up a clear process for incorporating input results in more effective future action.

#6 SELECTED EXPERIENCE WORKING WITH CBOS SERVING B/AA, LATINX, API, NATIVE AMERICAN COMMUNITITIES

Our team brings over 20 years working closely with diverse and vulnerable populations in San Francisco, across California and throughout the US. Selected examples of our work include:

San Mateo County's Community Collaboration for Children's Success (CCCS) Planning Process. Raimi + Associates is currently facilitating a participatory, trauma-informed, and place-based planning process for the CCCS initiative in four neighborhoods within San Mateo County. Partly inspired by the trauma-informed community planning work done with HOPE SF residents, this initiative engages County decision-makers, local stakeholders, and neighborhood residents. This process is designed to identify community assets, the primary issues that families in these neighborhoods are dealing with, barriers that keep children and youth in these neighborhoods from flourishing, and community hopes. This information is being used to identify data- and community-supported strategies that align with and build on existing efforts and community strengths and that address barriers, gaps, and opportunities. At the end of the planning process, each neighborhood will have an action plan to implement prioritized policy, programmatic, and systems changes that will make opportunities and experiences more equitable for the children, youth, and families in these neighborhoods. (To see one of the neighborhood action plans, visit: https://www.gethealthysmc.org/sites/main/files/file-attachments/cccs_nfo-rwc_neighborhood_action_plan.pdf)

REACH Ashland Youth Center Evaluation and Technical Assistance. For the last three years, R+A has been working with the Alameda County Center for Healthy Schools and Communities (CHSC) to evaluate program quality and effects of REACH's programming on the vulnerable youth who visit REACH. REACH operates as a collaborative of multiple agencies within and outside of County government that support five program areas (recreation, education, arts & creativity, career, and health & wellness). During this time, we have worked closely with REACH and HCSA staff to design and implement an evaluation approach that is based on the Results-Based Accountability framework, responsive to REACH staff, CHSC/HCSA and other stakeholders, and provides data that is useful for ongoing learning.

Santa Clara County Children's Health Assessment. R+A worked with staff from the SCC Public Health Department to conduct the qualitative assessment of children's health in Santa Clara County. As part of

this project, we worked closely with a steering committee made up of key leaders from across the county. We also conducted 19 focus groups with youth and parents (held in English, Spanish, Mandarin, and Vietnamese) and 30 key leader interviews to gather data on a range of factors, including the social determinants that affect children's health. Focus groups were conducted with youth in Juvenile Hall, foster youth, foster and adoptive parents, and participants included teen parents, undocumented immigrants, and gang-involved youth. R+A analyzed the qualitative data and presented the findings in a report, with chapters on Structural Racism & Discrimination (incorporating the racial equity framework from the Government Alliance on Race & Equity), Economic Inequality & Housing Instability, Barriers to Accessing Services, and Early Learning & the Educational System. R+A also successfully provided capacity building and training for Santa Clara staff and community member survey administrators and collected more than 1,100 intercept surveys (in English, Spanish, and Vietnamese) with parents or primary caregivers of children ages 0 to 17 over 5 weeks. In addition, R+A planned and facilitated a community meeting to identify priority health issues and a "Call to Action" forum with over 80 community stakeholders where we presented qualitative findings and identified action steps. During this meeting, we organized and facilitated small group discussions to identify strategies and recommendations related to each broad area. The project culminated in a written report of findings and action plan that is being used to align community resources and inform systems change efforts.

Asian & Pacific Islander Wellness Center (A&PI WC) Clinic Needs Assessment. Kym Dorman (while at Harder+Co.) led the A&PI WC health needs assessment of residents in the Civic Center/Tenderloin neighborhood of San Francisco. Specifically, many low-income A&PIs, including members of the local Chinese, Vietnamese, Thai/Lao, South Asian, and Arab communities, face difficulties accessing health care due to lack of insurance coverage, language barriers, concerns regarding immigration status, and lack of culturally competent care. In response to this need, A&PI WC took steps to expand their medical services with the ultimate goal of developing a free clinic. As Project Director, Kym oversaw all aspects of this project, including the training of A& PI Wellness Center staff to conduct the intercept survey in multiple languages. The project also included conducting focus groups in multiple languages and writing a summary report of findings to inform program development at the A& PI Wellness Center.

San Francisco HIV Prevention and Planning Council (HPPC). For over a decade, Kym Dorman (while at Harder+Co) worked closely with SF DPH staff to provide ongoing technical assistance for the San Francisco HPPC. HPPC was comprised of community members and service providers and was charged with setting priorities for HIV prevention in San Francisco. Technical assistance support included leading and supporting multiple HPPC committees including providing planning, research, and facilitation support and training for the HPPC Bylaws, Policies and Procedures committee, and overseeing the production of the 2010 SF HIV Prevention Plan.

University of California, Berkeley School of Public Health, Best Babies Zone Initiative Evaluation. Kym Dorman led the team that developed and conducted the evaluation for the national place-based Best Babies Zone Initiative (BBZ) during its first years (while at Harder+Co.). Funded by the W. K. Kellogg Foundation, BBZ uses a collective impact approach to reduce health disparities and create an environment in which every baby is born healthy and grows up thriving. Three cities were selected to develop prototype BBZ communities across the United States: Cincinnati, New Orleans, and Oakland. Using a participatory and developmental evaluation approach, the team worked with the BBZ leadership team, policy leaders from across the country, and stakeholders from each site to develop evaluation tools and systems for a process and outcome evaluation, and developed the first evaluation report on the Initiative's important cross-sector work during its first three years.

#7 SELECTED EXPERIENCE WORKING WITH COMMISSIONS/COMMITTEES

Many of our projects include working closely with commissions/committees. For this reason, we have extensive experience planning and facilitating participatory meetings with key stakeholders as part of the strategic planning, assessment, or evaluation project. Selected examples of our work include:

Napa County Public Health Division, Assessment, Planning, and Evaluation for Live Healthy Napa County. Working closely with the Napa County Public Health Division, members of our team led and facilitated the countywide Mobilizing for Action through Planning and Partnerships (MAPP) process for a consortium of public, private, and nonprofit organizations in Napa County over a two-year period. The Steering Committee included key leaders from across the county and Karen Smith, who was then Napa County's Health Officer. The process consisted of three components: a Community Health Assessment (CHA) to collect, analyze, and interpret community data; a Community Health Improvement Plan (CHIP) to identify ways to address the issues identified by the CHA by identifying specific action steps and related measures; and a Community Health Action Plan (CHAP) to identify strategies and measures for each participating partner. The CHIP and CHAP include process and outcome measures for implementation and population-level metrics to track overall impacts over time. We also conducted the process evaluation and produced a report summarizing findings.

California Partnership to End Domestic Violence (CPEDV), Strategic Planning Process. CPEDV is a statewide nonprofit that seeks to advance policy advocacy and organizational capacity building on issues of domestic violence. Kym Dorman (while at Harder+Co.), guided CPEDV in a comprehensive strategic planning effort that engaged the board, staff, member organizations, and key stakeholders in thinking proactively about critical issues in the field of domestic violence—and the role that the organization could play in addressing those challenges. Using stakeholder surveys, community input meetings, and a series of planning sessions with a planning committee, Kym helped CPEDV develop a practical multi-year roadmap for the future. The strategic plan described CPEDV's goals, strategies, objectives, and resources for three years to ensure that it would continue to be an important statewide and national leader in the domestic violence field.

SF HIV Health Care Reform Task Force (San Francisco Department of Public Health). The SF HIV Health Care Reform Task Force ("Task Force") was charged with planning for the transition of San Franciscans living with HIV into broader systems of care as the ACA was first implemented in 2014. Comprised of representatives from the San Francisco Department of Public Health, the City's HIV prevention and care service provider networks, the HIV Prevention Planning Council, and the HIV Health Services Planning Council, the primary goal of the Task Force was to develop recommendations for a transition plan that minimized disruption in client care, ensured access to essential HIV services, guided HIV services organizations in planning for a changing healthcare landscape, and prepared the broader healthcare system to deal with the integration of high-utilization, high-cost clients living with HIV into a larger system of primary care. Kym Dorman (while at Harder+Co.) facilitated the planning process and oversaw the development of the final recommendations report. (For the full report, please go to: www.sfhiv.org/wp-content/uploads/HCRTF-Recommendations_Version-1_072913_final31.pdf).

Integrated Delivery Systems (IDS) Planning, San Francisco Department of Public Health. Kym Dorman (while at Harder+Co.) co-led and facilitated a San Francisco Department of Public Health (SF DPH) strategic effort to examine the provision of population health services within the context of health care services, to consider ways to reduce the burden of chronic diseases, and to develop strategies that strengthen disease prevention, health promotion and community wellness. Kym worked with community

stakeholders including health care delivery service providers and a range of community leaders and decision makers to develop systems level recommendations to inform actionable change that aligned with the National Prevention Strategy to establish a set of common quality measures within a "triple aim" framework in preparation for health reform.

Program Collaboration and Service Integration (PCSI), San Francisco Department of Public Health. PCSI aimed to expand DPH systems and capacity to monitor "real time" disease trends in order to scale-up and support the implementation and sustainability of a syndemic approach to the prevention of HIV/AIDS, STDs, Viral Hepatitis, and Tuberculosis infections. By working together more closely, these systems would allow the jurisdiction to maximize resources and provide integrated services to populations at high-risk for co-morbid conditions. Kym Dorman (while at Harder+Co.) co-directed the project and was in charge of providing technical assistance and research support to the PCSI planning process, including the analysis of secondary data, organizing and facilitating steering committee and work group meetings, gathering and analyzing stakeholder input, and ultimately drafting recommendations to inform systems change and future collaborative efforts.

Enhanced Comprehensive HIV Prevention Plan (ECHPP), San Francisco Department of Public Health. This project culminated in the development of a comprehensive plan for San Francisco that integrated HIV/AIDS surveillance and service delivery data within DPH. This planning process focused on a) planning and facilitating ECHPP steering committee and workgroups meetings, b) conducting a situational analysis for required and recommended interventions, c) developing a vision for the future in the form of goals, strategies, and objectives, and d) developing an ECHPP plan for CDC and community dissemination. Kym Dorman (while at Harder+Co.) served as a project director and oversaw all aspects of the project.

#8 SELECTED EXPERIENCE WORKING WITH PUBLIC HEALTH DEPARTMENTS

Our team at Raimi + Associates has extensive experience working with public health departments to address disparities and community health issues (e.g., chronic disease) using a variety of approaches including policy, systems, and environmental change and health in all policies. Selected project examples include:

CHRONIC DISEASE

Process Evaluation of the Implementation of Santa Clara County's Partners for Health Community Health Improvement Plan. Raimi + Associates successfully facilitated the process evaluation for the Santa Clara County Public Health Department cross-sector collaborative Partners for Health which has two key priorities: 1) chronic disease/Healthy Eating & Active Living and 2) Behavioral Health. Using a collective impact approach, the evaluation included providing technical assistance and training for collaborating organizations, conducting a Collaborative Partnership survey and key leader interviews to explore partners' motivation for continued engagement, as well as early achievements. The evaluation report presented key findings related to collaborative meetings, progress towards achieving goals, and recommendations for the coming year.

DIRECT SERVICE AND PSE

Monterey County Health Department, Equity-Focused Action Planning. R+A collaborated closely with staff from MCHD to refresh their strategic plan with clear, equity-focused action steps. The updated strategic plan includes strategies, activities, and metrics that align with the four priority areas, corresponding objectives, and prioritized strategies that support health equity. The MCHD four goal areas

include: 1) empower the community to improve health; 2) enhance public health & safety through prevention; 3) ensure access to culturally & linguistically appropriate, quality health services; 4) engage MCHD workforce & improve operational functions. The final MCHD strategic plan for 2018 -2022 provides inspiration and clarity for MCHD and its county-wide collaborative partners related to providing high-quality health services and programs with an equity focus over the next five years. (For the full plan, please go to: http://www.co.monterey.ca.us/home/showdocument?id=65689)

San Mateo County Health System's Racial Equity & Multicultural Organizational Development Plans. R+A is currently providing consulting services to the San Mateo County Health System to support the implementation of their Behavioral Health & Recovery Services' Multicultural Organizational Development Plan. Services include assessing alignment between the Racial Equity Plan developed by the Health System's Government Alliance for Race & Equity (GARE) cohort and the Behavioral Health & Recovery Services' Multicultural Organizational Development Plan, developing key messages for managers and leadership, facilitating meetings with the leaders of multiple divisions within the Health System, and identifying meaningful metrics to track the implementation and overall effectiveness of the plans.

Race Equity Consultant for the City of Berkeley Public Health Division. Raimi + Associates was recently selected to work with staff from the City of Berkeley Public Health Division to promote equity, diversity, and inclusion. As part of this project, our team will assess the strengths and needs of Berkeley Public Health Division (BPHD) staff, conduct training sessions, identify performance measures using the Results Based Accountability framework, and provide technical assistance.

California Department of Public Health (CDPH), Health in All Policies (HiAP) Process Evaluation
Kym Dorman (while at Harder+Co.) led the process evaluation of the statewide HiAP collaborative process to identify successful elements of this collaborative, as well as challenges and early outcomes. Evaluation methods included designing and implementing a stakeholder survey and conducting key leader interviews with members from the HiAP Task Force and HiAP staff. Findings were presented to the Strategic Growth Council and informed the development of Health in All Policies: A Guide for State and Local Governments (created by the Public Health Institute, California Department of Public Health, and the American Public Health Association, 2013).

#9 PROPOSED BUDGET

		Raimi + Associates Staff			
		Project Director (Dorman)	Project Manager (Kruza)	Assistant	Labor Cost per Task
Tasks					
1	Project Management (i.e., up to 6 mtgs with SF DPH staff, internal team mtgs) and final scope of work	12	10	3	$4,540
2	Conduct Rapid Environmental Scan	8	16	16	$5,640
3	Prepare and facilitate up to 5 Strategic Planning Meetings	42	48	24	$19,050
4	Finalize SDDTAC Strategic Plan	20	24	12	$9,300
TOTAL DIRECT LABOR					
	Total Hours	82	98	55	
	Hourly Billing Rate	$225	$160	$80	
	Labor Cost Per Team Member	$18,450	$15,680	$4,400	
				Total Labor Cost	$38,530
INDIRECT COSTS					
	General Office Expenses (3% of labor)				$1,156
	Travel + Bridge Toll				$300
				Total Indirect Costs	$1,456
GRAND TOTAL					**$39,986**

#10 SELECTED EXAMPLE STRATEGIC PLAN

Our example strategic plan is the Marin Health & Human Services (HHS) Department, Strategic Plan to Achieve Health and Wellness Equity. Raimi + Associates recently led the development of Marin HHS' first strategic plan, under the leadership of Grant Colfax. R+A worked closely with HHS staff to identify culturally responsive, evidence-based, and promising strategies and interventions from multiple disciplines (e.g., social services, behavioral health, public health) to address key disparities in the county. The R+A team planned and facilitated a highly engaged participatory process involving HHS staff meetings with the Community Facilitation Team, Data Team, Strategic Planning Team, and Executive Team to review county-level data and identify focus areas, strategies, actions, outcomes, indicators of success and metrics. As part of the development of the strategic plan, our team also engaged in an extensive community data collection process, including conducting 10 community focus groups in English, Spanish, and Vietnamese, and developing an online comment form. Findings from these data were summarized and presented at multiple

community stakeholder meetings where participants had an opportunity to provide feedback on draft focus areas and identify possible strategies for future collaboration. As part of the process, the R+A team worked closely with HHS staff to review county level data, lead the extensive community engagement process, and facilitated the identification of focus areas, strategies, actions, outcomes, indicators of success and metrics. The final plan outlines a 5-year roadmap for the Department. (To see the full strategic plan, please see Appendix B or visit:
https://www.marinhhs.org/sites/default/files/libraries/2019_02/mc_hhs.stratplan18_v7.pdf)

#11 REFERENCES

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San Francisco Department of Public Health
Dr. Grant Colfax
Director of Health

Sugary Drinks Distributor Tax Advisory Committee

DRAFT AGENDA

June 12, 2019
5:00pm
25 Van Ness Ave, Room 70
San Francisco, CA 94102

Order of Business:

1. Call to Order/Roll Call
2. Approval of Minutes for previous meeting
3. Review and Consideration of Regular Agenda
4. Public Comment
5. DPH Staff Report

Timing	Agenda Item #6	Roles
5:45-7:15pm (15 min) (30 minutes) (15 minutes) (5 minutes) (10 minutes)	**6a. Welcome, Introductions, and Overview of the Strategic Planning Process** • Welcome and overview of the strategic planning process • Review decision-making matrix and key decision points in ppt presentation; Ensure roles and decision-making is clear **6b. Engage SDDTAC members in exercise to identify key considerations and priorities/outcomes for the strategic planning process** • We are going to ask the SDDTAC to engage in a three-part discussion in pairs. Each question will be discussed with a different pair. Each pair will have 5 minutes to discuss their responses, and then 5 minutes to write down their answers on post it notes. • Pair share #1: Discuss what has worked well with decision making as the SDDTAC in the past • Pair share #2: Discuss what challenges have emerged in decision making and what has helped to address the challenges • Pair share #3: Discuss key priorities/outcomes for this strategic planning process • Large Group discussion and debrief to identify themes **6c. Review and confirm other relevant coalitions and data to inform the strategic planning process** • Review slide with other coalitions and add any additional coalitions • Review slide with example data and add any additional data **6d. Next steps, Q+A, and contact information** • Review slide with next steps and contact information for R+A staff	Kym

SUPPORT

TRUST

UNITY

EXCELLENCE

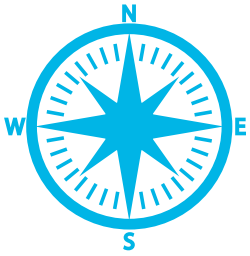
ALL IN MARIN

DEPARTMENT OF HEALTH AND HUMAN SERVICES STRATEGIC PLAN TO ACHIEVE HEALTH AND WELLNESS EQUITY 2018

COUNTY OF MARIN

CONTENTS

LETTER FROM THE DIRECTOR



This strategic plan is a roadmap for Marin County, Health and Human Services (HHS). It demands bold action, radical inclusion, and accountability. Historically, HHS has functioned effectively as the executor and funder of services – often within the confines of mandated services as delivered through our public health, behavioral health, and social services divisions. Herein, we are challenging ourselves to do better across a wide spectrum of areas that influence health and wellness, from focusing on direct customer service to climate change. Our goals are specific, measurable, and realistic. Mandated services will continue, but with a renewed emphasis on quality and outcomes that will help build greater equity in our communities.

The plan's focus on equity stems from the fact that Marin is the most inequitable county in the state. The plan recognizes that this status quo is unacceptable. It also recognizes that while service delivery is key to helping individuals and their families, we have the responsibility to understand and address the systemic causes of inequities. Given the state of our national struggle to address honestly the current and historic racial and ethnic dynamics in the U.S., bringing a focus on race to the core of our work is especially timely.

When we lead with race we are acknowledging and confronting the policies, programs, and practices that are critical to achieving not only an equitable county but society as a whole. Challenging institutional and structural racism that is pervasive in our everyday work and lives is fundamental and key to addressing the inequities that are driven by these dynamics.

This plan reflects the multiple perspectives gathered from clients, other community members, community organizations, as well as County-level data and information from evidence-based, best, and promising practices. The plan identifies key conditions, including some typically outside the scope of HHS Departments and Programs, where we are committed to effecting change with engagement of stakeholders with similar goals. Indeed, the plan recognizes that HHS must work with partners in new ways to optimize the chances for success. To that end, the strategy outlines how HHS will work collaboratively across sectors and with community partners to measure progress.

This strategy sets priorities and metrics, but an institution's culture determines whether goals are realized and maintained. The cultural shift this plan requires is considerable, and already underway as HHS strives to uphold and exemplify our core values of Unity, Support, Trust, and Excellence. As outlined in the HHS operational plan (http://marinhhs.org/operational-plan), HHS is committed to shifting our own internal culture to be more equitable, diverse, and transparent.

(continued)

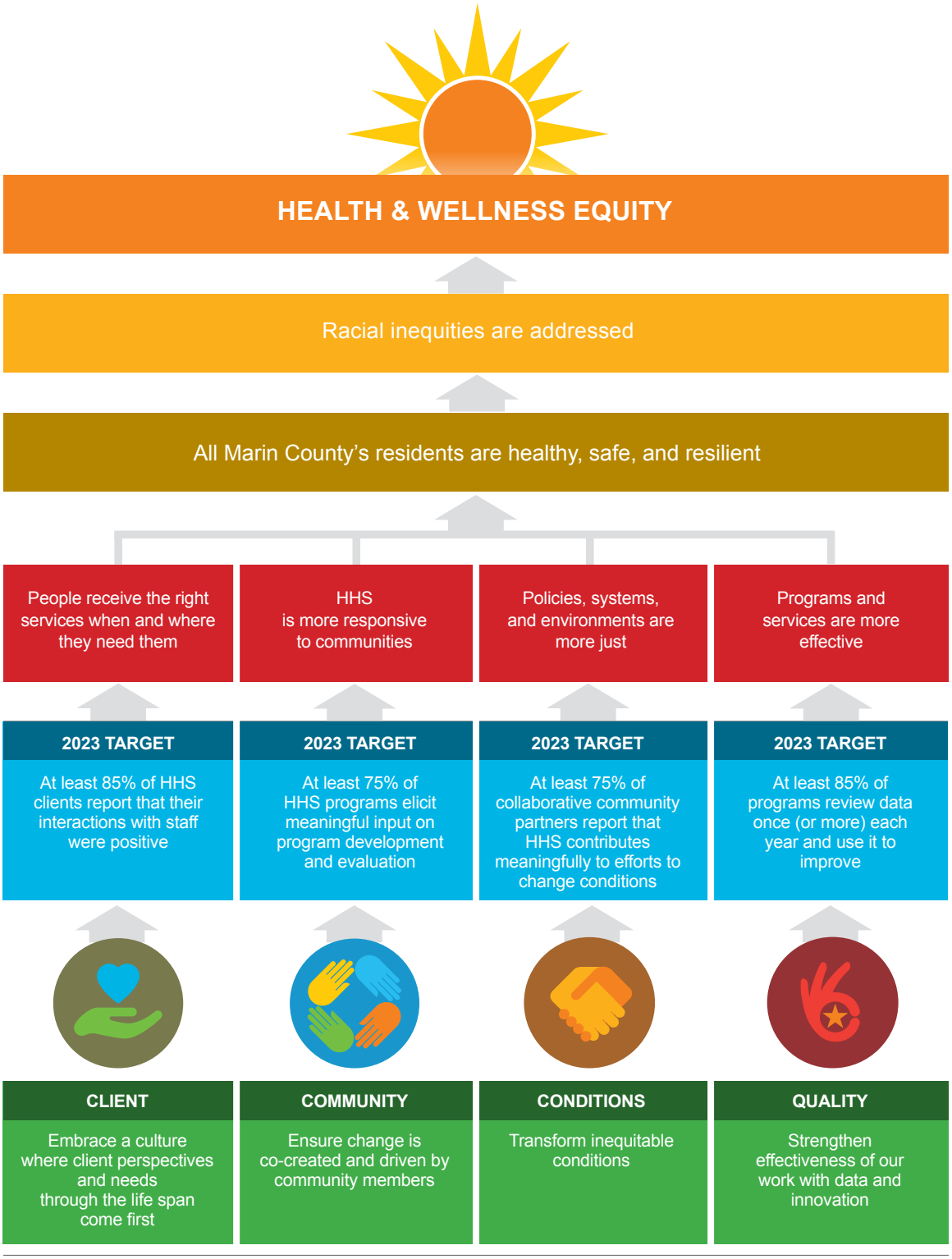
LETTER FROM THE DIRECTOR
CONTINUED

Investment and institutional support is also required for success. This plan aligns with the County's 5-year business plan and other equity efforts throughout the county. HHS is allocating personnel and infrastructure resources to implement the strategy. This includes hiring an executive-level Chief Strategy Officer who is responsible for overseeing the execution of the strategy, as well as creating organizational structures and systems within the department to ensure work is coordinated, integrated, and aligned with shared goals.

For this plan to be effective, our work will need to be challenging, and at times uncomfortable. Testing new initiatives, and new ways of engaging together, will inevitably create tension and face the systemic barriers of bureaucracy. Through embarking on this important process, however, the work will also create new partnerships, innovative programs, and better outcomes to increase health and wellness equity in our communities. Core to realizing these outcomes is a shared vision and priorities, as well as a learning culture that honestly and effectively creates change. While the journey will be long, we have already begun. Let's continue…

Dr. Grant Colfax
Director, Department of Health and Human Services
County of Marin

GOAL AND FOCUS AREAS FOR HHS STRATEGIC PLAN TO ACHIEVE HEALTH AND WELLNESS EQUITY



OVERVIEW OF HHS

The Marin County Department of Health & Human Services (HHS) is charged with protecting the health and well-being of all County residents. HHS strives to ensure that all residents can achieve optimal health, while allocating resources to improve health and wellness equity.

Vision of Marin Health & Human Services Department:
All in Marin Flourish.

The Department has approximately 700 employees and a budget of $180 million, much of which is mandated to be spent on core services, from Medi-Cal enrollment to disease surveillance. Social Services provides care and support to County residents most in need. Programs include those for older adults, foster care, nutrition, employment training, as well as disability and medical care coverage. The Behavioral Health and Recovery Services Division delivers mental health and substance use treatment services, primarily through Medi-Cal. It also has an extensive portfolio that focuses on prevention and early interventions. Public Health's scope of work ranges from maintaining vital statistics, tracking and managing disease outbreaks, to addressing cross-cutting issues such as the opioid epidemic. Further details and specifics of the work of these divisions can be found on our website: https://www.marinhhs.org/content/government.

Mission of Marin Health & Human Services Department:
To promote and protect the health, well-being, safety and self-sufficiency of all people in Marin County.

While HHS programs generally function well and usually are responsive to the needs of clients, until now the Department has had no unifying strategy to support, improve, and integrate service delivery and measure meaningful outcomes. Furthermore, while some programs have a history of actively engaging community to set priorities and better deliver services, this has been the exception, rather than the rule. While an equity focus is generally embraced, there is not a shared common understanding of how to operationalize equity-related work or how to measure progress. This strategy provides a comprehensive framework to address these challenges over the next five years.

OVERVIEW OF HHS

As part of the County government's priority on increasing equity, including its partnership on the Government Alliance on Racial Equity (GARE)[ii], this plan will focus on actions to improve racial equity in the areas of health and wellness. The goal of such "targeted universalism" is not only to improve conditions for those of a specific race or ethnic groups, but to benefit the greater good and society as a whole.[iii]

Equity: *Just and fair inclusion in the County where all can participate, prosper, and reach their full potential. Equity efforts seek to rectify historic patterns of exclusion.*

MARIN COUNTY BOARD OF SUPERVISORS, 2017

ONE OUT OF FOUR RESIDENTS IN MARIN IS A PERSON OF COLOR.
16% LATINX
6% ASIAN
3% BLACK/AFRICAN-AMERICAN
3% MULTIRACIAL

Our ranking as one of the healthiest counties in California[iv] correlates with our top state county rank in median per capita income, reflecting the association of affluence with health. Further exploration of county data reveals significant concerns. In 2017, Marin had the highest level of racial and ethnic inequities of all California counties.[v] These inequities are the result of historic, deep and pervasive inequitable systems, including exclusionary policies and practices.

With a population that is nearly three-quarters white, the relative lack of racial and ethnic diversity in the county further exacerbates the equity divide. Indeed, it could be argued that precisely because the racial inequities are so large, in such a modest population, that it is even more unacceptable that they exist at all. It also suggests that improving race equity outcomes is not an insurmountable challenge. By 2030, one in five Marin residents will be Latinx, suggesting that these issues may be even more pronounced in the near future.

For persons of color in Marin, inequities mean less access to opportunity, which, in turn, are associated with poor outcomes. For example, Latinx children in Marin are less likely to enroll in pre-K education, a key indicator of success, than Whites (35% vs. 85%[vi]). Only 5% of White students do not graduate from high school in comparsion to 18% of Black/African-American students.[vii] Median household income in Marin is $100,310; in Black/African-American and Latinx households, it is nearly half of the median, at $57,626 and $53,106, for Asians it is nearer, but still below, the median, at $92,136, and in White Non-Latinxs it is above the median, at $109,205.[viii] People of color in Marin die younger than Whites. Life expectancy for Black/African-Americans, Latinxs, and Asians in Marin is 75, 80, and 81 years respectively; for Whites, it is 83 years[ix], one of the highest ages in the nation.

Latinx (la-teen-ex) (/lə'ti:nɛks, læ-/) is a gender-neutral term sometimes used in lieu of Latino or Latina (referencing Latin American cultural or racial identity). The plural is Latinxs.

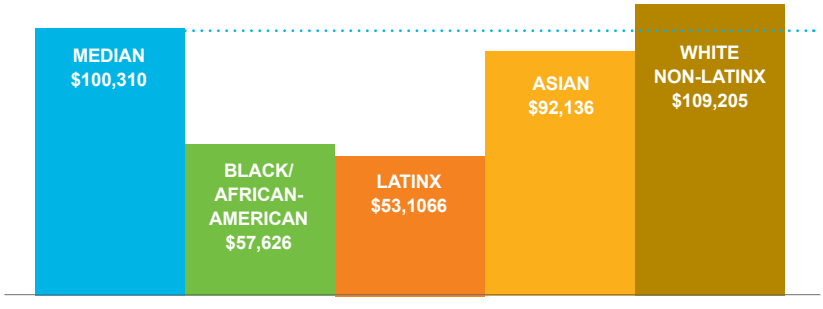
WHY FOCUS ON RACE?

While income, education, and other socioeconomic and cultural factors play key roles in shaping outcomes in our communities, the direct effects of racism – whether covert or overt, intentional or unintentional, systemic or individual – must be acknowledged and addressed to achieve equity. Research demonstrates independent associations of racial discrimination on driving inequities, including downward mobility.[x]

Systems that are failing communitites of color **are failing all of us.**

Our focus on racial equity has effects beyond improving the lives of communities of color. As outlined by GARE and others, efforts to improve access for one group have brought broader benefits to communities.[xi] Thus, we expect this plan to not only address racial and ethnic inequities, but in doing so also improve outcomes for the Marin community as a whole, including those in other historically marginalized or underrepresented groups including, but not limited to: those of different genders, abilities, advanced age, and sexual orientation. Our collective efforts to address racial discrimination directly and honestly, in conjunction with other work across the county, may help move ourselves and the communities in which we live and work closer to reconciliation and healing.

To achieve this goal, we must work differently across sectors, and embrace the disruption that such work requires. New and non-traditional partnerships can help remove barriers to opportunity, and direct resources towards evidence-based efforts that address historic inequities. Marin HHS' strategy to achieve equity – to realize the Department's vision that *All in Marin Flourish*—identifies four focus areas and corresponding strategies to do just that.



HOUSEHOLD INCOME IN MARIN COUNTY

HISTORY HAS SHAPED RACIAL INEQUITIES IN HEALTH AND WELL-BEING IN MARIN

To be effective in reducing inequities, we need to understand historic factors that have shaped them throughout the County. Marin City, historically a predominantly African-American/Black community but now ethnically diverse, and the Canal district of San Rafael – a majority Latinx community – are good examples. While both communities demonstrate great resiliency and strength, social and structural factors have created profound inequities along racial and ethnic lines.

In the 1940s, Marin City was created by the federal government for the Sausalito-based Marinship Shipyards workers and their families to support World War II defense industries. Thousands of Black/African- Americans moved from the Midwest and the South to Marin for employment. When World War II ended, many Marinship workers lost their jobs. Most of Marin City's White residents relocated—but racially discriminatory laws and policies severely limited housing and employment opportunities for Black/African-American residents.[xii, xiii, m] Over decades, unequal educational opportunities, unjust application of law enforcement, lack of access to healthcare, and inadequate access to healthy food, along with broad and overarching overt and covert racial discrimination, correlated with poor outcomes.[xiv]

San Rafael's Canal District was developed as an industrial and residential neighborhood in the 1950s and 1960s with small housing units in multi-family buildings. The neighborhood's population is increasingly Latinx as families find lower-cost rents and proximity to manual job opportunities. Lack of access to pre-school education, adequate housing, healthy food, and healthcare coverage contribute to poor health and other detrimental outcomes among residents. While employment rates are high, low-wage jobs often lack critical benefits like paid sick leave and have limited opportunities to advance.[xv, xvi] In addition, increasing numbers of residents are from Central American countries where violence is prevalent, increasing the risk that many families will suffer from trauma and adverse childhood experiences. The systemic marginalization of Latinx communities in Marin – whether due to overcrowded housing, poor pay, federal immigration policies, or lack of culturally appropriate behavioral health care, among other factors – contribute to poor outcomes.

While racial and economic segregation are not unique to Marin, they perpetuate inequities for people of color by dictating where they can live and limiting long-term social and economic mobility. Residential segregation limits residents' social and professional networks, denying them relationships and knowledge needed to advance professionally.[xvii] The cumulative and continued effects of structural racism in the County and throughout the U.S. have shaped our communities, and have resulted in specific negative effects felt by many residents of color today.

[1] From the Government Alliance on Race & Equity (2016): **Structural racism** encompasses a history and current reality of institutional racism across all institutions, combining to create a system that negatively affects communities of color. Structural racism is racial bias among interlocking institutions and across society, causing cumulative and compounding effects that systematically advantage white people and disadvantage people of color. **Institutional racism** includes policies, practices and procedures that work better for white people than for people of color, often unintentionally or inadvertently.

HOW TO NAVIGATE THE PLAN

This section outlines components of the plan and how they work together to support action.

HOW HHS WILL IMPLEMENT THE PLAN	
FOCUS AREA	Strategic area that is prioritized in the plan to reach the goal
STRATEGY	How HHS will accomplish the outcomes
ACTION	The tactic that supports execution of the strategy
OUTCOME	The condition that actions are intended to create

HOW HHS WILL MEASURE PROGRESS	
INDICATOR OF SUCCESS	What will be different if the focus area and strategies are successful
METRIC	The specific measures used to determine progress

FOCUS AREA 1: CLIENT

EMBRACE A CULTURE WHERE CLIENT PERSPECTIVES AND NEEDS THROUGHOUT THE LIFE SPAN COME FIRST

Why Focus on the Client?

Central to our efforts on leading with race to achieve equity is treating clients respectfully and with cultural humility. This work will build on existing efforts throughout HHS to increase the cultural responsiveness of services, improve customer experience, and coordinate services across programs. Over the next five years, HHS commits to systematically expanding this work throughout the Department and to supporting contracted service providers to do the same.

By deepening our understanding of how individuals experience accessing and receiving services, HHS will identify opportunities to improve service delivery. This includes ensuring that services focus on the client's[2] immediate needs first, and by asking "how can I help you," rather than focusing immediately on whether an individual meets specific eligibility requirements. Gathering consistent client feedback will ensure that services are responsive and will enable us to better address their needs. Ensuring that services consider client perspectives will also require addressing the complex factors that shape people's health and wellness.

In addition, HHS services are often siloed and disconnected, making it challenging for clients to navigate and access multiple types of support.[xviii] This inefficient fragmentation may result in lower quality of care and higher costs. HHS' focus on integrating service delivery will help connect clients to timely and appropriate services.

We believe that providing the right services when and where community members need them will result in improved health and wellness. For these reasons we are strengthening our commitment to this work.

[2] For this plan, clients are defined as people who are eligible receive benefits and/or direct services from HHS programs (e.g., case management services, behavioral health services, WIC services) within Marin County.

FOCUS AREA 1: CLIENT

HOW HHS WILL IMPLEMENT FOCUS AREA 1: CLIENT

STRATEGIES	ACTIONS	5-YEAR OUTCOMES
Strengthen accessibility and cultural responsiveness of services	■ Incorporate client needs and perspectives into program development and evaluation ■ Support community members to make informed choices about benefits and services ■ Require implicit bias and cultural humility trainings for HHS and contracted providers ■ Ensure managers, supervisors, and executives engage directly with clients on a regular basis to better understand challenges	**More people receive the right services when and where they need them**
Integrate service delivery to support clients	■ Implement systems that reinforce coordinated service delivery and information sharing ■ Adopt policies and procedures that support integrated service delivery services	

FOCUS AREA 1: CLIENT

HOW HHS WILL MEASURE THE EFFECT OF THE STRATEGIES

STRATEGIES	INDICATOR OF SUCCESS	METRIC
Strengthen accessibility and cultural responsiveness of services	Improved access to services	Increase in HHS clients whose primary language is not English who receive services in their primary language
		Increase in client satisfaction and culturally responsive services (also in Focus Area 4: Quality)
Integrate service delivery to support clients	Improved cross-program data sharing	Increase in HHS programs that use a common screening tool
		Increase in HHS programs that share client data

FOCUS AREA 2: COMMUNITY

ENSURE CHANGE IS CO-CREATED AND DRIVEN BY COMMUNITY MEMBERS

Why Focus on Community?

HHS recognizes that leading with race to achieve health and wellness equity also requires working with our partners in new ways. This focus area highlights opportunities to deepen HHS work not only with community organizations, but also with individual community members to ensure that programs and services reflect their needs and priorities. We must move beyond the status quo of expecting people to "come to us," and instead partner fully with members of the community to catalyze shared efforts to effect meaningful, lasting change. These collaborations will amplify efforts on leading with race to advance health and wellness equity by aligning and coordinating work, accomplishing more than HHS or any other single organization could do alone. Co-creating programs with community has the potential to increase efficiency, effectiveness, innovation and sustainability, while also making the distribution of resources more equitable.[i], [ii], [iii], [iv]

Trust between HHS and communities that are most burdened by racial inequities is necessary for direct, honest and effective collaboration. Historically, government has created structural barriers that have discriminated against many communities which contributed to differences in health and wellness outcomes.[xix] For these communities to trust HHS, staff must listen, be responsive, follow-through, and deliver meaningful results.

FOCUS AREA 2: COMMUNITY

HOW HHS WILL IMPLEMENT FOCUS AREA 2: COMMUNITY

STRATEGIES	ACTIONS	5-YEAR OUTCOMES
Engage community to effect meaningful change	■ Support initiatives led by community members ■ Align with leadership within communities of color and low-income communities ■ Foster emerging leadership and develop workforce pipeline from key communities	**HHS is more responsive to communities**
Co-design and collaboratively implement services	■ Create Depatment-wide Community Engagement and Communications Team ■ Expand use of Community Advisory Boards (CABs)	

FOCUS AREA 2: COMMUNITY

HOW HHS WILL MEASURE THE EFFECT OF THE STRATEGIES

STRATEGIES	INDICATOR OF SUCCESS	METRIC
Engage community leadership to effect meaningful change	Improved alignment of HHS with leadership from disproportionately affected communities	Increase in community members who report HHS collaborations support community priorities
		Increase in effectiveness of community-led programs that address drivers of health inequities
		Increase in HHS staff at all levels from disproportionately affected communities
Co-design and collaboratively implement services	Improved HHS services shaped by community member input	Increase in programs, strategies, and services developed in partnership with Community Based Advisory Boards (CABS)/ collaboratives from underserved communities
		Decrease in racial/ethnic inequities in chronic diseases.

FOCUS AREA 3: CONDITIONS

TRANSFORM INEQUITABLE CONDITIONS

Why Focus on Conditions?

Historically, HHS departments have emphasized direct services, rather than also addressing the broader psychosocial and environmental factors that contribute to health and wellness outcomes.[xx] To optimize our effectiveness, HHS must address such important conditions. Our goal is to assume a leadership role to help effect change in inequitable conditions that lead to poor racial health and wellness outcomes.

HHS will align and work with partners throughout the county to amplify the work of addressing key conditions that help drive, maintain, or worsen racial inequities. HHS will draw on the collective impact framework to align diverse, cross-sector entities around a common agenda, shared measurement, and coordinated efforts. Partnerships will involve community-based organizations, non-governmental service providers, resident groups, community coalitions, non-county government agencies, and county government agencies outside of HHS.

Conditions within Marin County that shape health and wellness racial inequities, and where the key racial differences exist, are identified below. There are many factors that influence health and wellness. However, after a thorough data review, combined with many conversations with staff and community members, the following conditions were identified consistently as key areas to address. While the scope of these conditions varies widely, each represents important work to be done about the health and well-being of Marin residents.

ECONOMIC AND HOUSING INSECURITY

EDUCATIONAL ATTAINMENT

TRAUMA

CLIMATE CHANGE

FOCUS AREA 3: CONDITIONS
TRANSFORM INEQUITABLE CONDITIONS

How Do These Conditions Affect Health and Wellness in Marin County?

ECONOMIC AND HOUSING INSECURITY

Extensive research has shown that economic disparities are correlated with poorer population health outcomes.[xxi] In addition to the challenges faced by Marin residents with incomes below the federal poverty level, the high cost of living in the County burdens residents who make less than the self-sufficiency standard.[3] It has become increasingly difficult for low-income families to afford basic necessities, including shelter and affordable housing. Housing insecurity negatively affects health and well-being. People who experience housing insecurity may spend more than half of their income on housing costs. They may also have difficulty paying rent, live in overcrowded units, or experience homelessness.

What are examples of inequities in Marin related to economic and housing insecurity?

- Over half of Black/African-Americans and Latinxs and nearly one-third of Asian-Pacific Islanders do not have enough income to afford food, housing, transportation, and other necessities, compared to one-quarter of whites.[xxii]
- Black/African-Americans and Latinxs own their homes at slightly more than one-third the rate of whites.[xxiii]
- Among adults over 65, whites have twice the family income of Latinx or Black/African-Americans.[xxiv]
- On average between between 2010-2014, 26% of Marin's non-institutionalized population lived below 250% of the federal poverty level, including:[xxv]
  - 61% of the Latinx population
  - 51% of the Black/African-American population
  - 25% of the Asian population
  - 18% of the white population
  - 52% of children of color ages 0-17 in Marin live in such households, compared with 15% of white, non-Latinx children.[xxvi]

(continued)

[3] The **Self-Sufficiency Standard** defines the minimum income needed to meet basic needs for California's working families without the help of public or private assistance, and incorporates a county's cost of living.

FOCUS AREA 3: CONDITIONS
TRANSFORM INEQUITABLE CONDITIONS

How Do These Conditions Affect Health and Wellness in Marin County?

EDUCATIONAL ATTAINMENT

A half century of research has shown that earlier and longer education is a strong predictor of adult health and wellness.[xxvii, xxviii] In part, higher **educational attainment** increases people's access to expanded employment opportunities, greater income, health insurance coverage, and loan opportunities. Increased educational attainment is also correlated with health literacy and healthier behaviors.[xxix]

What are examples of the educational inequities in Marin?

- 35% of Latinx 3 and 4-year-olds attend pre-school compared with 84% of non-Latinx Whites.[xxx]
- 39% of Black/Black/African-American and 45% of Latinx third graders read below grade level, compared to 10% of white children.[xxxi]
- 10.8% of Black/African-American students were suspended from school compared to 1.4% of white students.[xxxii]

TRAUMA

Trauma, including adverse childhood experiences, negatively affect health and well-being throughout the life span.[xxxiii] It includes exposures such as physical violence, incarceration, sexual abuse, emotional abuse, and neglect. Trauma related to institutional racism is associated with greater risk of heart disease, obesity, substance-use disorders, and learning and behavioral issues.[xxxiv, xxxv] Becoming a trauma-informed system starts from the recognition that trauma has a profound impact on people, and their ability to be successful in all aspects of their lives. Therefore, it is necessary to create spaces and places where people can get help and healing but more importantly to create policies, practices, procedures and programs that prevent and support people from experiencing trauma.

What are examples of current inequities related to trauma?

- In a nationally representative sample of adolescents, the prevalence of experiencing trauma was 70%, but highest among Black/African-American and Latinx youth.[xxxvi]
- Despite making up less than 3% of the total population in Marin, Black/African-Americans make up nearly 20% of adult and juvenile felony arrests.[xxxvii]
- While they make up only 6.8% of children in Marin, 27% of children entering the foster care system are Black/African-American.[xxxviii]
- 30% of Latinx migrants experience migration-related trauma.[xxxix]

(continued)

FOCUS AREA 3: CONDITIONS
TRANSFORM INEQUITABLE CONDITIONS

How Do These Conditions Affect Health and Wellness in Marin County?

CLIMATE CHANGE

Climate change is here and has already caused property damage from flooding and wildfires in and near Marin County, causing massive system-wide disruptions and costing billions of dollars.[xl] Increases in temperatures have led to increased heat advisories. Shifting regional temperatures and weather patterns have increased the range and frequency of infectious diseases (e.g., Zika, West Nile virus). Climate change magnifies existing racial health and wellness inequities. Communities that disproportionately bear the burden of climate change include people without means for evacuation (e.g., no access to public transit or private motor vehicles), and people who are linguistically isolated.[xli]

What are examples of inequities related to climate change?

- The low-lying coastal communities of Marin City and the Canal District in San Rafael are more vulnerable to the harms of sea level rise and flooding compared to whiter and wealthier Marin jurisdictions.[xlii]
- The effects of climate change, such as extreme heat, flooding, and diminished air quality, are disproportionately concentrated among communities of color.[xliii]
- Climate change also magnifies existing health and wellness inequities. Communities that disproportionately bear the burden of climate change include people without means for evacuation (e.g., no access to public transit or private motor vehicles), and people who are linguistically isolated.[xliv]

FOCUS AREA 3: CONDITIONS

HOW HHS WILL IMPLEMENT FOCUS AREA 3: CONDITIONS

STRATEGIES	ACTIONS	5-YEAR OUTCOMES
Catalyze partnerships to improve conditions that affect health and wellness	■ Use a collaborative approach to align resources and create change ■ Advocate for the health and wellness benefits of equitable policies, systems, and environments ■ Develop shared messaging around how conditions affect health workforce pipeline from key communities	**Policies, systems, and environments are more equitable**

FOCUS AREA 3: CONDITIONS

HOW HHS WILL MEASURE THE EFFECT OF THE STRATEGIES

STRATEGIES	INDICATOR OF SUCCESS	METRIC
Catalyze partnerships to improve conditions that affect health and wellness	Improved ability to meet basic needs	Increase in individuals who exit our services and have an income at or above the self-sufficiency standard for Marin County
		Ending chronic homelessness by 2022
	Improved educational opportunities	Increase in 3-4-year old Latinxs in pre-school
		Increase in college readiness for young people of color
	Decrease exposure to trauma and increase resilience*	Increase in individuals who demonstrate resilience or have fewer adverse childhood experiences (ACES)
		Develop a unified trauma informed system of care
	Improved community resilience to climate change	Increase in disaster planning and response that address the needs of vulnerable communities
		Increase in access to healthy, safe, and energy efficiency of homes of low-income residents

FOCUS AREA 4: QUALITY

STRENGTHEN EFFECTIVENESS OF OUR WORK WITH DATA AND INNOVATION

Why Focus on Quality?

To optimize our equity work, program effectiveness, and ensure taxpayer dollars are allocated with accountability, we commit to expanding our data-driven work and use of evidence-based and innovative approaches. To ensure that HHS provides consistent high-quality programs and services we will embrace a culture of continuous improvement by engaging staff at all levels as problem solvers in developing solutions for change and respect for people which is the foundation of a Lean Organization. A culture of continuous learning is created when meaningful data is collected, reviewed, and used to inform improvements and change the way programs and services, are delivered. **Data-driven work** is supported by quantitative and/or qualitative data that measure efforts and determine success or failure. **Evidence-based approaches** are supported by research in peer-reviewed literature. **Innovative approaches** attempt to meet needs in new ways based on quantitative and qualitative data from the community served.

While HHS programs already collect much data, too often that information is tracked to meet legislative or funding requirements and is not used to improve outcomes. This plan proposes a systematic approach to collect, review, and use data to inform program and service improvements by staff at all levels. Indeed, HHS will become a Lean organization to increase efficiencies and optimize outcomes. By gathering, reviewing, and using data in new ways, HHS will strengthen and improve programs and services with the goal to inform ongoing improvement. This focus area outlines approaches to further understand what is working, how to improve over time, and how to tailor innovative approaches to fill gaps and more effectively meet the needs of our diverse clients.

FOCUS AREA 4: QUALITY

HOW HHS WILL IMPLEMENT FOCUS AREA 4: QUALITY

STRATEGIES	ACTIONS	5-YEAR OUTCOMES
Implement evidence-based and data-driven work	■ Create data collection systems that routinely and systematically assess operations and services ■ Analyze data by racial/ethnic demographics to prioritize practices and approaches that improve health and wellness equity ■ Realign resources to support evidence-based policies, practices, and services ■ Promote outcome-based approaches and measures in contracts with partners ■ Collect and use client feedback for quality improvement	**Programs and services are more effective**
Champion innovation	■ Create and provide support to innovate and take informed risks ■ Ensure HHS staff and contracted partners have opportunities for continuous learning ■ Identify and test technological innovations to improve information sharing and customer service ■ Optimize available revenues and use braided funding to support creative approaches	

FOCUS AREA 4: QUALITY

HOW HHS WILL MEASURE THE EFFECT OF THE STRATEGIES

STRATEGIES	INDICATOR OF SUCCESS	METRIC
Implement evidence-based and data-driven work	Improved use of data and evidence for quality improvement	Increase in HHS direct services and contracts that use evidence-based approaches and measurable outcomes pertaining to health and wellness
		Require HHS programs and contracted programs to include equity-related outcome metrics
Champion innovation	Improved culture of learning and informed risk-taking	Increase in HHS staff who report that they have opportunities to learn at work to test new ideas
		Increase in contractors who report that HHS is adaptive and meeting changing service needs

NEXT STEPS

1 Disseminate plan across Community and HHS	**2** Establish implementation priorities	**3** Identify internal leads and champions
4 Engage community in dialogue for prioritizing HHS efforts	**5** Develop a community feedback loop and accountability mechanism	**6** Create systems to measure progress and continuous improvement

ALIGNMENT WITH MARIN HHS CORE VALUES

Strategic Approach to Achieving Equity		HHS Core Values
We will improve the **client** experience by prioritizing user perspectives and holistic care.		*Integrated services informed by client perspectives will better **support** clients.*
We will support **community** leadership and deepen relationships that improve our services and the conditions in which we live.		*To earn the **trust** of community members, we must change how we work with community.*
We will address the **conditions** in which we live, work, learn, and play—factors that shape our ability to be healthy and self-sufficient.		*To transform conditions, we must work in **unity** with community and cross-sector partners.*
We will strengthen the **quality** of our work by supporting innovation and reflecting on existing data and evidence.		*To achieve **excellence** throughout HHS, we must use data to learn what is working.*

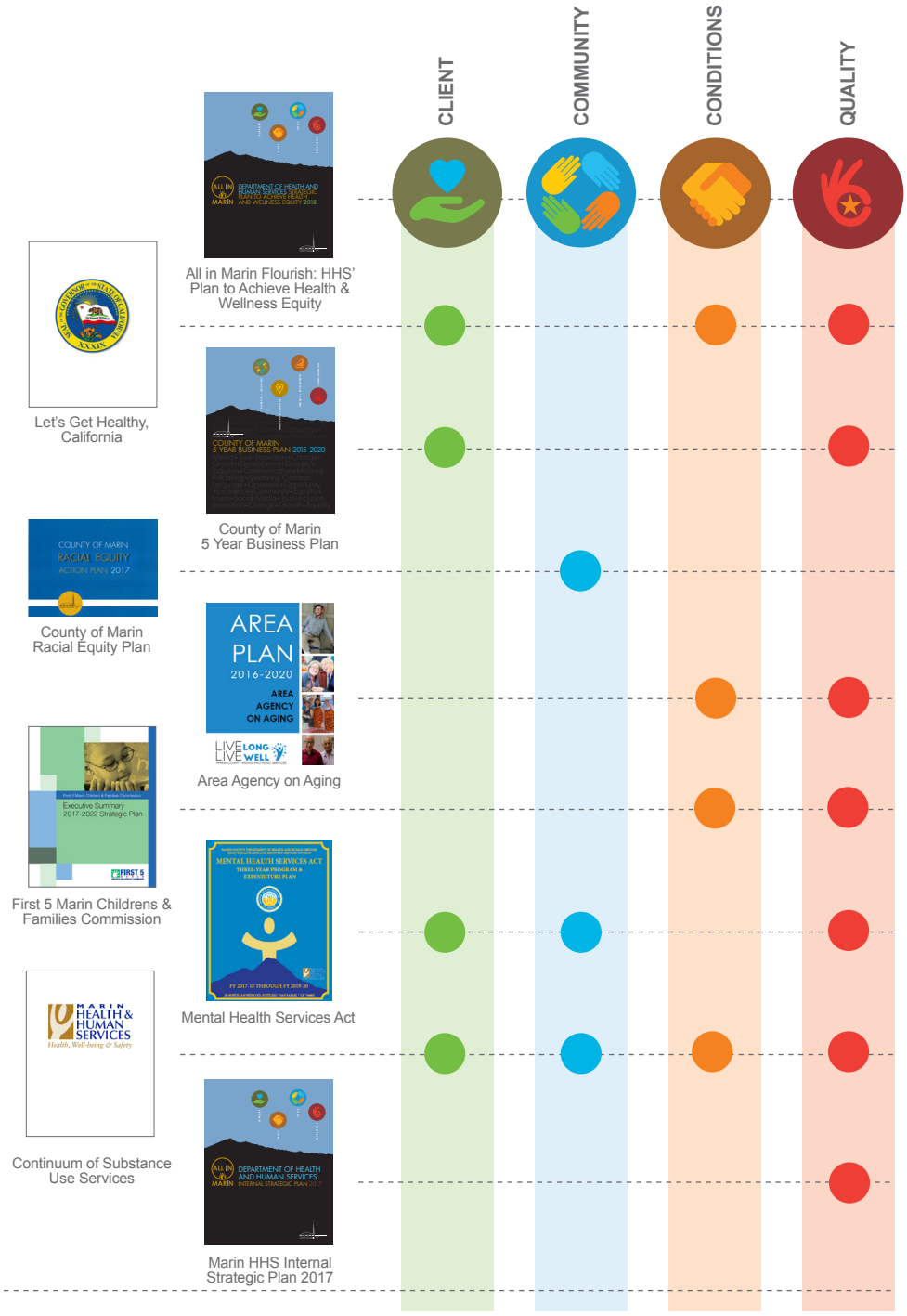
APPENDIX 1
OVERVIEW OF THE PLANNING PROCESS

This plan's strategies and actions were identified through review of data, input from community members and stakeholders in Marin County, and consideration of evidence-based, promising, and innovative practices from multiple disciplines.

Data Review	
■ Reviewed County Wide Data including: ● Census data ● Portrait of Marin ● Marin County Community Health Assessment ● Marin County/San Rafael Community Health Needs Assessment 2016 ■ Reviewed plans and reports by age including: ● First 5 Strategic Plan ● Area Plan on Aging ■ Reviewed plans and reports by topic including: ● Mental health ● Alcohol and substance use ● Food insecurity	Oct 2016- Feb 2018
Engagement with HHS Clients and Community Members who are not Clients but who are Eligible for HHS Services	
■ 10 focus groups with 144 clients and community members (for more details, see Appendix) ■ Online and paper comments elicited from community members unable to attend focus groups	April-June 2017
Stakeholder Engagement	
■ 4 meetings with more than 55 stakeholders representing more than 50 community partners, including, service providers, government agencies, and resident groups ■ Online and paper comment form elicited from stakeholders unable to attend stakeholder meetings	June-Nov 2017
HHS Staff Engagement	
■ Held meetings every two weeks with the HHS Strategic Planning Executive Team ■ Held monthly meetings with the Strategic Planning Team, Strategic Planning Data Team, and Community Facilitation Team and provided regular updates to the HHS Executive Team ■ Held two Leadership Council meetings with HHS managers and supervisors ■ Provided ongoing communication about strategic plan development with opportunities for HHS staff to ask questions and provide feedback	Oct 2016- Feb 2018

APPENDIX 2

ALIGNMENT WITH COUNTY AND STATE PLANS



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Marianne York	Marin County Commission on Aging
Patti D'Angelo Juachon	Marin Community Foundation
Wendi Kallins	Safe Routes to Schools Marin *
Kiki La Porta	Marin Environmental Housing Collaborative
Christine O'Rourke	Marin Climate and Energy Partnership

(continued)

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ENDNOTES

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