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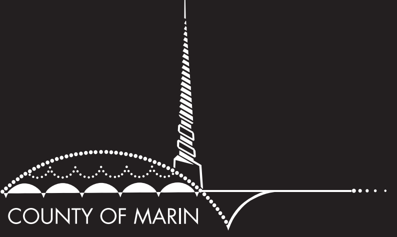
DEPARTMENT OF HEALTH AND HUMAN SERVICES STRATEGIC PLAN TO ACHIEVE HEALTH AND WELLNESS EQUITY 2018



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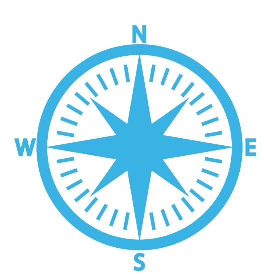
LETTER FROM THE DIRECTOR



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

HEALTH & WELLNESS EQUITY

Racial inequities are addressed

All Marin County's residents are healthy, safe, and resilient

People receive the right services when and where they need them	HHS is more responsive to communities	Policies, systems, and environments are more just	Programs and services are more effective
2023 TARGET	**2023 TARGET**	**2023 TARGET**	**2023 TARGET**
At least 85% of HHS clients report that their interactions with staff were positive	At least 75% of HHS programs elicit meaningful input on program development and evaluation	At least 75% of collaborative community partners report that HHS contributes meaningfully to efforts to change conditions	At least 85% of programs review data once (or more) each year and use it to improve
CLIENT	**COMMUNITY**	**CONDITIONS**	**QUALITY**
Embrace a culture where client perspectives and needs through the life span come first	Ensure change is co-created and driven by community members	Transform inequitable conditions	Strengthen effectiveness of our work with data and innovation

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.**

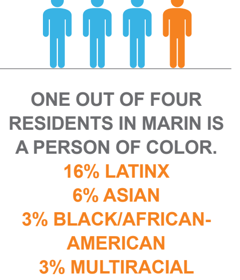
While HHS programs generally function well and usually are responsive to the needs of clients, until now the Department has had no unifying strategy to support, improve, and integrate service delivery and measure meaningful outcomes. Furthermore, while some programs have a history of actively engaging 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) (/ləˈtiːnɛks, 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.

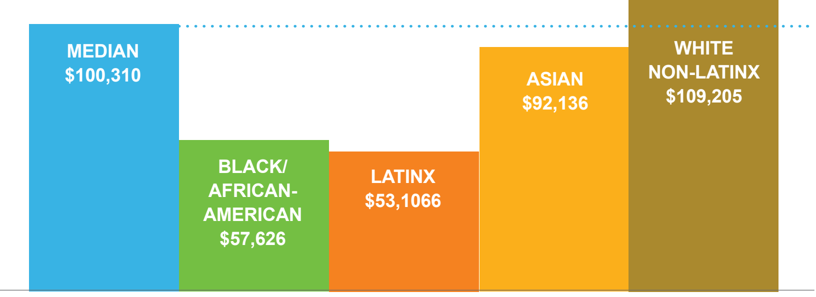
WHY FOCUS ON RACE?

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.

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[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]

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[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?

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, 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

CLIENT

COMMUNITY

CONDITIONS

QUALITY

All in Marin Flourish: HHS' Plan to Achieve Health & Wellness Equity

Let's Get Healthy, California

County of Marin 5 Year Business Plan

County of Marin Racial Equity Plan

Area Agency on Aging

First 5 Marin Childrens & Families Commission

Mental Health Services Act

Continuum of Substance Use Services

Marin HHS Internal Strategic Plan 2017

ACKNOWLEDGMENTS

COMMUNITY LEADERS WHO PROVIDED INPUT ON PLAN

Name	Affiliation
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Maria Arnao	Marin Community Clinic
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Armando Cerros	Marin Community Clinic
Alexandra Danino	SF-Marin Food Bank
Lori Davis	Sanzuma
Mary Denton	Sunny Hills Services
Teri Dowling	Marin County Commission on Aging
Balandra Fregoso	Parent Services Project
Donna Garske	Center for Domestic Peace
Maya Gladstern	Marin Advocates for Mental Health
Terrie Green	Marin City Parent and Leadership Academy
Linda Jackson	Aging Action Initiative
Salamah Locks	Marin County Commission on Aging
Vinh Luu	Marin Asian Advocacy Project (MAAP)
Jennifer Malone	The Spahr Center
Ricardo Moncrief	ISOJI
Nicole Nelson	Seneca Family of Agencies
Joe O'Hehir	Whistlestop
Florencia Parada	Marin Community Clinics
Tamara Player	Buckelew Programs
Sandy Ponek	Canal Alliance
Mitesh Popat	Marin Community Clinics
Ilene Pruitt	Golden Gate Regional Center
Amy Reisch	First 5 Marin
Amy Rudkin	Seneca Family of Agencies
Chris Shaw	County of Marin
Jody Stamps	Marin Child Care Council
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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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Shirin Vakharia	Marin Community Foundation
Cheryl Paddack	North Marin Community Services *(formerly Novato Youth Center & Novato Human Needs Center)*

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