



HEALTH EQUITY AND COMMUNITY ENGAGEMENT REPORT

MARIN COUNTY



Project Description

The Bay Area Regional Health Inequities Initiative (BARHII) is a collaboration of public health directors, health officers, senior managers and staff from eleven of the San Francisco Bay Area local health departments (LHDs), including Marin County. The BARHII LHD membership formed to collectively address the factors that contribute to egregious differences in life expectancy and health outcomes between different socio-economic groups in the region. The mission of BARHII is to: Transform public health practice for the purpose of eliminating health inequities using a broad spectrum of approaches that create healthy communities. As Margaret Whitehead of the World Health Organization defines it, “Health inequities are differences in health status and mortality rates across population groups that are systemic, avoidable, unfair, and unjust.” BARHII focuses its work on how public health departments can address

upstream, structural and social factors that perpetuate health inequities. The BARHII Framework¹ describes the problem areas addressed by a continuum of public health practice ranging from cataloguing causes of mortality and disease management on the right side to addressing more upstream social inequalities such as racism and class inequality on the left side.

BARHII’s goal of transforming public health practice is carried out by a LHD staff, in-kind committee structure, one of which is the Community Committee (CC). The CC supports member health departments as they attempt to forge new strategies for community engagement and capacity building to address the broad range of conditions that contribute to poor health, and to establish relationships that can be sustained over time. This project was developed in order to assess the perceptions of existing health inequities, current best practices to engage community in public health and

¹ BARHII Framework in Action: http://www.barhii.org/programs/download/conceptual_framework.pdf

shared opportunities for advancing health equity.

From 2009-2011, BARHII staff and LHD members of the CC conducted qualitative assessments in seven local health jurisdictions (LHJs), including focus groups with public health department staff and leadership as well as site visits and focus groups with a few LHD-selected community agencies that have experience working with the LHD. This report summarizes the analyzed results from qualitative data collected in the County of Marin in April 2009 at 7 focus groups with the following agencies:

- Canal Alliance: <http://canalalliance.org/>
- Canal Welcome Center: <http://www.cwcenter.org/>
- Marin City Health and Wellness Clinic: <http://www.marincityclinic.com/>
- Marin Community Clinics-Novato: <http://www.marinclinic.org/>
- Marin County Health and Human Services – Leadership and Program Staff: <http://www.co.marin.ca.us/depts/HH/Main/index.cfm>
- Marin County Health and Wellness Campus: <http://www.co.marin.ca.us/campus/>
- Novato Youth Center: <http://www.novatoyouthcenter.org/>
- San Geronimo Valley Community Center: <http://www.sgvcc.org/>

This report describes perspectives of both LHD and community agency staff on key themes that emerged in discussions from the focus groups and site visits conducted. The data results presented show local priorities in health inequities and social conditions as well as highlight best practices and lessons learned related to (1) public health and community agency collaborations and (2) how health inequity concerns are being addressed by both LHDs and community agencies in Marin County.

Social Determinants of Health Inequities in Marin County

A clear picture of some of the persistent environmental and social conditions that impact health inequities in Marin County emerged from focus groups held with Local Health Department (LHD) staff and leadership, as well as site visits and lengthy discussions with LHD-selected community-based organizations (CBOs). The description of these health inequities put forth by LHD employees was more health issue focused, while the CBOs described more of the social, environmental and policy inequities faced by specific groups and communities. Strong agreement was found in the geographic distribution of inequities; Marin City, Canal, and certain isolated parts of West Marin and Novato were named as the areas of greatest concern.

Geographic Division and Lack of Transportation

Marin's rural and agricultural communities shared their concerns regarding transportation access issues related to community members' lack of cars, inability to drive due to physical or other reasons, or limited availability of the public transportation system. Additionally, Novato participants noted challenges by the distances one has to walk to access the bus system as well as the bus schedule itself, which often takes many hours to navigate one trip to Central San Rafael. Residents of the Canal neighborhood were challenged by lack of transportation and mentioned issues related to towing, car ownership, and difficulty with changes to the bus routes. Some participating communities, such as Marin City and the San Geronimo Valley, are also geographically isolated from services by distance, highways and hills. San Geronimo representatives spoke to their community center human services development coming out of the storm disaster and flooding in the early 1980s which left many trapped and isolated. A Marin City CBO representative stated *"Most of our patients do not have cars so they can't go*

to Marin Community Clinic or the County's campus in the Canal without taking two buses. And if you're sick, that's the last thing you want to do is take two buses to see a doctor, and then sit and wait your turn for hours, and then have to go home on the bus, maybe in the dark. It's the last thing you want to do." Although there is a high level of need, the relatively small population numbers in Marin City make it harder to obtain needed services compared to other areas of the County. In addition, Marin City participants mentioned a social isolation via discrimination with businesses not wanting to be associated with Marin City. One CBO participant explained, "Every time I say that racism is the number one health issue of Marin City, they're like 'Oh, you mean internalized racism, right?'. I'm like 'No, I mean, real, external, blatant racism, down to even getting a pizza'... you have to go to Long's parking lot to pick up the pizza to bring back to Marin City."

Wealth Gap and Cultural Divides

Marin's cost of living is a health equity issue which was raised in most of the focus groups. For a family of three to live at a level of self-sufficiency in Marin requires an average of \$68,000 or three minimum wage jobs.² Increasing income gaps also create cultural divides that result in "two worlds" in Marin which are distinctly different from each other. A CBO participant explained, "We were getting this increased income inequality. And, similarly we've got this big gap, this increasing gap between folks who are struggling and folks who are moderate income and feel

fairly secure. And everybody is affected by this economic downturn, but there's kind of a cultural gap between these segments of our population." This wealth gap creates different daily realities that impact people's opportunities and behaviors and can foster division rather than integration in Marin County. For example, one Novato participant explains a culture clash resulting from a lack of affordable housing: "I grew up in Novato and my mom's neighbors are about four families living in a single-family home... there are a bunch of vehicles and stuff like that... there are lots of folks in Novato that are very resentful of that kind of lifestyle. But it's really just an example of lack of affordable housing, so people do what they need to do to get by. They share their resources."

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In addition, in an effort to meet the needs of the changing demographic of Novato public school students, schools are implementing Spanish speaking programs or other innovations. Some community members indicated that there are influential voices which are not in support of these changes; one reason being the sentiment that increasing services and programs that address the needs of certain children takes away resources from others. According to one CBO participant, "In Novato we do have some building resentment among the population at large, as they're witnessing this demographic shift. And we have had some white flight... one school in particular had a really rapidly growing Latino population and also is positioned in a more affluent area... many families pulled their children out of the public school system altogether and put them into private schools... so there is some of that tension." These examples show how resident reactions to increasing diversity and the impact of income gaps can further intensify social and cultural divides.

² Insight Center for Community Economic Development 2008

Immigration

Immigration status was an important determinant of health for community participants representing the Canal neighborhood. According to CBO representatives, immigration status contributes to fear of government and institutions, ultimately decreasing one's ability to advocate for oneself effectively, therefore creating less social power and opportunities. For example, one community participant explained, *"we have an opportunity to get everybody new (energy-efficient) appliances through PG&E...nobody wants to sign up for this program, even if they're going to get a new fridge and a new stove...they don't want their name anywhere, they don't want any official contact."* This fear, which intensified after the Immigration and Customs Enforcement (ICE) raids in Marin County, and continued concerns regarding possible risk of deportation and other consequences of lack of documentation, contribute to increases in stress and anxiety, grief and loss, and other mental health challenges. However, low-cost, bilingual mental health resources are very difficult to access, if existent at all. According to community representatives, these fears hold people back from addressing public health and safety issues like reporting domestic violence due to fear of law enforcement or deportation. A lack of access to health care, including services provided in other languages and with diverse cultural sensitivity, were also mentioned as barriers – particularly for immigrant groups.

Affordable Housing and Homelessness

The high cost of living in Marin County contributes

to a lack of affordable housing and is an underlying factor in why more than half (60%) of Marin's workforce commutes from out of the County.³ Participants shared some of the history of their communities and how certain policy decisions have had lasting, detrimental effects on affordable housing, community development and displacement to this day. For example, a Marin City participant explained, *"in San Rafael or San Anselmo or in other areas of the County, they did not sell (homes) to Blacks or Jews... it was a multicultural community at the time... what wound up happening is...primarily African Americans remained... and everyone else moved out to different parts of Marin or to other counties...we had stores, a post office, we had a pretty vibrant community, but after (World) War (II) all those things were torn down...and so we're fighting that issue even today, because there are a lot of forces that say let's tear down public housing. So that's a big issue that we are being confronted with right now. They want to put workforce housing in its place. Well, you have to make a minimum of \$68,000 to even qualify for workforce housing. So what that does, it does not just mean that Black and poor people will be moved out of public housing."*

Overcrowded living conditions and precariously housed individuals are sometimes missed when assessing the needs of the community, since they do not have their own independent residence. Another community representative mentioned how *"people (are) renting a living room, that's where they are living with their families. Or there is a family in a room together, so*

We were getting this increased income inequality. And, similarly we've got this big gap, this increasing gap between folks who are struggling and folks who are moderate income and feel fairly secure. And everybody is affected by this economic downturn, but there's kind of a cultural gap between these segments of our population.

3 Non Profit Housing Authority of Northern California 2010: http://www.nonprofithousing.org/pdf_pubs/Miles_from_Home_LowRes.pdf

they don't have space." These stories represent the need for affordable housing and community development in order for the distribution of housing, food, and other resources to be more equitable.

Foreclosures in Marin were reported as having increased by 603%, with Novato having the highest rate in the County. Simultaneously, the number of homeless families in Novato was reported as increasing. Participating community agencies noted that: *"We have new data from the Novato Unified School District that tells us there are 182 identified homeless students and that in just this school year the number of students living in a homeless shelter has gone from two to ten, and they haven't ever experienced that before... And it's also important to note here that the homeless shelter is in San Rafael. There is not a temporary homeless shelter in Novato. And there's not a shelter for children at all."* Therefore, the recent increase in foreclosures and homelessness only add to affordable housing being a key inequity in Marin County.

Inequities in Policy and Leadership

Both CBOs and LHD personnel discussed the importance of the role of leadership in promoting an understanding of what health equity is, as well as offering potential global and micro solutions to address inequities. Additionally, broader political will to embrace equity as a priority is seen as key to sustainable change. Community members expressed that they are less empowered to engage and mobilize to help meet their area's needs when they do not feel supported by those in power. There is a dynamic that exists in most government leadership where politicians weigh the differing opinions and needs of a diverse group of voting constituents. It generally takes strong actions and institutional backing in order to build the

political will to advocate for low-income communities of color, which have small numbers and little social power, but very high need. This issue of political power was further discussed as it relates to considerations of age, particularly in creating environments that are welcoming to children and families as well as our aging populations. One community participant explained how these ideological tensions can affect community and political risk-taking: *"I think because of the different world views in our little community, it's been hard to build the capacity necessary to take risks, the risks required to really invest in programs that can advance the social, emotional and overall health of our community."*

Best Practices in Health Equity and Community Engagement of the County of Marin's Health and Human Services Department

Focus groups and site visits with LHD staff and CBOs described the following successful community engagement and health equity LHD strategies:

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Relationship Building

Both community agency representatives and LHD staff reported that having a specific, identified person to talk to makes it easier to successfully build community capacity and promote community engagement with the support of Marin's Health and Human Services (HHS).

It was mentioned that this role that the HHS staff play helped to provide information to community members, link individuals to resources, communicate community needs in culturally appropriate language, and translate institutional language and community language interchangeably.

Physical presence in the communities served was among the keys to success discussed by both community representatives and LHD staff alike. One community representative stated that it is important when the LHD is *“Being present, accountable, and genuine when ‘showing up’ and actually doing what is said that will be done.”* Another community member shared that, the LHD *“Showing up consistently on ‘non-health’ events, makes a lot of difference.”* Some of these non-health events include food banks, PTA meetings and school registration nights.

In addition to LHD staff showing a consistent presence in the community, developing trust and engaging the community in decision-making were also seen as strengths by both LHD and community participants. Several LHD members mentioned Marin’s local approach to implementing the statewide Binational Health Week Initiative (BHWI) as a model for understanding community issues and strategizing ways to improve community health. Starting in 2002, Marin first implemented BHWI via the County Board of Supervisors Aides and representatives from HHS coordinating one event in one neighborhood for two years.

The following year, the BHWI planning group combined efforts with a local non-profit that was hosting a large community event and, as a result, they were far more successful in community engagement efforts. Subsequently, the planning group also recognized the need to reach Latinos who are spread out geographically and so they partnered with community leaders and CBOs in five areas of the County. The first step of the planning group was to go to these communities and ask residents what



they needed and what they thought HHS could do to address those needs. One LHD participant stated, *“Instead of it being the County who’s controlling this and decides what’s going on, over time... and it has taken time to say, okay, you know, this is your community, your needs, and slowly kind of stepping back, and I’ve seen it work really well in that venue.”*

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Community Capacity-Building

The LHD supports the community’s ability to advocate for their own needs as well by building capacity of community agency staff to create more effective program plans and apply for more funding to sustain or start community health efforts. In these capacity-building efforts, not only are LHD staff members building community skills, but they are also building relationships and trust with the community. One CBO participant stated that the *“Community’s relationship with HHS is that they rely on HHS for support in terms of training, direct services, funding, logic models, and these are particularly helpful to the degree they help CBOs get funding. There could be stronger trust overall. Specific HHS staff members*

are the go-to people for community members.” As the quote demonstrates, there are some existing, quality relationships of trust and information-sharing between Marin’s LHD and community agency staff which help to build skills of community members, and yet there is still room for improvement and expansion of these efforts to develop additional relationships with LHD staff.

Services Located in Community

The outcomes of building stronger relationships with the community helps the LHD in developing opportunities to decrease isolation and increase understanding of geographic and culturally-specific needs by bringing services to where people already are. County-sponsored local resources like the West Marin Service Center and the Marin Health and Wellness Campus, as well as local community centers like the San Geronimo Valley Community Center, Canal Alliance, Canal Welcome Center, Novato Youth Center, Marin City Community Services District, and other agencies like local school districts, are seen as pivotal to community engagement and reducing inequities while providing direct services and opportunities for skill-building. In addition to their dissemination of culturally-appropriate and needed services, these community-based organizations were also recognized for providing a place for social or community connection, which is a critical component of community wellness. Some LHD representatives added that County-sponsored programs make it easier to engage the community regarding public health issues when there is an identified community-based and community-oriented place to gather.

Professional Development in Health Equity

The integration of health equity tools into HHS professional development opportunities and

community conversations were seen as an important step to engaging LHD staff and CBOs in addressing inequities. To begin on the same page with a basic understanding of primary, secondary and tertiary prevention in public health as well as a to present a broader view of the Spectrum of Prevention⁴ (see graphic on page 6), HHS purchased copies of *Prevention is Primary*⁵ which were shared with key community stakeholders. This capacity-building helped explain the different perspectives and approaches in public health – from focusing on medical services and individual behavior change to addressing the root causes and social determinants of disparate health outcomes. Key steps for success in these interactions were to both define the social determinants of health (SDOH) and to allow community members to share local stories in order to illustrate the concrete meaning of SDOH in people’s lives. In addition, screenings and discussions of California Newsreel’s *Unnatural Causes* were offered to HHS decision-makers and staff of all levels, Kaiser Permanente Pediatrics and other health institutions, external partner agencies, community resident groups, and other County programs, including the jails.

Upstream Practices and Policy Change

Legislation and appropriate action at the state and federal levels to create healthier communities for everyone was seen as the most effective, preventative and upstream practice. A key role for HHS in this advocacy work is to serve as information translators between the community voice and the institutional voice. Although there are numerous other examples

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4 Larry Cohen, Prevention Institute: www.preventioninstitute.org

5 Larry Cohen, Prevention Institute; Sana Chehimi, Prevention Institute; Vivian Chavez, San Francisco State University (September 2010)

of local public health policy advocacy, the specific examples raised by participants of policy change that came from efforts shared with community providers, included the content areas of breast cancer and mammography, nutrition and wellness with Champions for Change, and health and safety policies at the Marin County Fair.

Other examples of upstream health equity work, that were shared by HHS leadership, highlighted the importance of “*livable communities for seniors*,” where high-density, affordable housing is community-centered near transportation, which decreases isolation and addresses potential challenges of poverty or being “*house poor*.” The Marin Employment Connection was also mentioned as another health equity effort which helps people move to self-sufficiency and independence through improving work-related skills and increasing earning potential through better employment. As research suggests, an increase in income is associated with an increase in life expectancy.

Administrative Support for Health Equity Efforts

At the time the HHS focus group occurred, the CHANGE Unit (Community Health Action Now for Growth and Equity) worked as a team to build community capacity and engagement and looked at internal and external benefits and consequences to HHS efforts. One of the contributions of the CHANGE Unit was to recommend improvements to existing human resources (HR) practices by including community members on interview panels and by including questions that reflect the “*heart and soul of the candidate around community issues*,” according to LHD staff. This was an effort to move beyond basic cultural competency expectations into a workforce that values the voices of various communities on an ongoing basis in HHS related work.

Best Practices in Health Equity and Community Engagement of Local Community Agencies

Focus groups and site visits with LHD staff and CBOs described the following successful community engagement and health equity CBO strategies:

Community Engagement

Bringing community members such as local residents and stakeholders together, both socially as well as formally, was mentioned by several CBO representatives as a strategy that works to improve community cohesion, to understand the fluctuating goings-on of the community and to surface the challenges that are being faced by individuals and community groups. One community representative explained the importance of community cohesion: “*One thing about this community is we’re really trying to work hard to partner with people who really live here, because folks that came here to live on top of the hill... they would come in Marin City and fly through the main street down here and zip up the hill in order not to have to interact with us... We’re really trying to change that, and I think people on top of the hill are seeing the need to change it, because our goal is to really be community... people do care about one another... and that’s really special. If your neighbor is sick, hey, folks will watch your kids... if you have to go to the hospital, if a funeral happens, people will make sure you have some food or help you do whatever you need to do... the things that make you feel like you belong, we have the basis of that.*”

Another community resident identified the importance of community engagement when there was an increase in breast cancer in their community. Their residents and stakeholders united and created a breast cancer screening program. Another community member talked about the importance of School Linked services for connecting youth to necessary, local services and providers.

Community Capacity Building

Linking community members to current information, access to local resources, and options for follow up were described by community agency representatives as critical to the health and wellbeing of the community. Community agencies highlighted a strength of their staff as their ability to communicate effectively with community stakeholders and residents in a culturally appropriate way about the important and empowering information that health departments are trying to share. One community staff member described this as “It is the empowerment of people...all the people that come here, we give them the inspiration to get the services they need, and we give them the information that we are having a health fair, (and) that they have choices (in the types of services they receive). So they get the information and then they’re empowered to do something with it. That’s something that I appreciate down here.”

Addressing Inequities as a Community

Community representatives reported that addressing inequities together as a community was more successful than identifying the issues and approaching the work in isolation. One community talked about the work that they had done to decrease isolation in the senior communities while also taking steps to make the community center more welcoming to Latino residents living in the area. Another group talked about the efforts that had gone into mobilizing the community and its supporters when ICE immigration sweeps had occurred, reportedly terrorizing the neighborhood and increasing stress and

fear in its residents. One executive director mentioned the strength of the documented advocates who stepped up to walk children to bus stops and home from school, offered crisis counseling to families who were affected, and advocated for policies that would positively change the local response to future events.

One-Stop Service Delivery

Perhaps the practice that multiple community agency representatives were most proud of was their ability to help people with whatever their needs were from wherever they found themselves in the County. Local accessibility to services and information was shared by all site visit representatives as an effort that worked best for their residents. Places that offer access to basic needs like food, direct services, transportation, referrals to providers, and other resources are particularly successful in that residents trust them to help them meet

their needs. One community representative discussed the importance of engaging schools as a one-stop shop in an effort to inform parents who speak all different languages and to engage educators in a dialogue about their roles in addressing inequities. The ability to offer educational resources at multi-service agencies, for children as well as adults, was seen as a best practice to build the capacity of individual residents to communicate their own needs and create solutions for sustainable outcomes.

Community Space

Offering local space for community residents to convene for professional services and socially was seen by all groups as vital to building the capacity

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of the community and engaging stakeholders in community cohesion strategies. Access to local services was described as critical to local health in that people would go without medical care or other benefits if they had to go to another community to access resources. Programs like Tina Action Project, which brings women's health screenings, breast exams and educational information to different communities in West Marin, were touted as addressing local needs through a lens of cultural humility. The issue of food access was presented both as an inequity as well as something that was working well to reach community residents. Food pantry representatives mentioned the recent increase in visits from people outside of their communities. They also shared that, by providing this space for a direct access to food, it also helped the organization provide a platform for linking County residents to other necessary services.

Challenges in Health Equity and Community Engagement Practice

Focus groups and site visits with LHD staff and CBOs described the following challenges to successful community engagement and health equity work that have been or still are common despite the successes described above.

Lack of Meaningful Community Engagement

Overall, there were different perspectives between the community and LHD perceptions of their relationship to one another. In the community site visits, people asked for more collaboration and partnerships between HHS and communities which include individual community members and not just CBOs. Whereas, in the HHS focus group, there were a mixture of comments about how HHS does support community work – emphasizing the building of the Health and Wellness Campus in the Canal neighborhood where

a high number of service users live – but some HHS focus group members felt that community work was not seen as a priority to the department to carry out the majority of their business. HHS staff additionally reported a challenge in the lack of funding available that is allocated for community engagement efforts, both in the creation of the Health and Wellness Campus as well as other programs. Using the Ladder of Community Engagement⁶ as a guide, according to community representatives, Marin County is at the “Limited Community Input and Consultation” level of engagement; however, according to HHS representatives, Marin County is at the “Bridging” level, by narrowing the gap between communities and themselves. There is most likely truth to both of these assessments, depending on the specific HHS program. However, an important take-away here is the differences in perspectives between community and HHS and how, by engaging community more in dialogue and HHS decision-making, this gap in perceptions can narrow.

Although there are ongoing efforts to engage community from HHS, one story that stood out was when HHS came to the community for input on the Marin Health and Wellness Campus – which was a priority initiative to bring existing services together in central Marin, as a ‘one stop shop’ location in the community. Initial community meetings were met with frustration by residents wanting meaningful input into the process. One community member described the progression: *“So we kind of sat down with the county officials and we said, ‘Look, . . . if you really want input from the community we need to know what is untouchable, what is negotiable and what can we actually make decisions about, because if people don’t know that, they’re not going to care, they’re not going to*

⁶ The Ladder of Community Engagement was developed by staff at Contra Costa Public Health Department and includes the following steps: Health Department Initiates and Directs Action; Health Department Informs and Educates Community; Limited Community Input/Consultation; Comprehensive Community Consultation; Bridging; Power-Sharing; and Community Initiates and Directs Action. For more read this article: http://www.barhii.org/resources/downloads/community_engagement.pdf

be there, plus they're not going to be engaged with whatever you're doing.' Well, they really heard us. They stopped their series of meetings, they went back and retooled their old approach to the community taking those ideas into consideration, and then were successful and actually have integrated quite a bit of what the community has asked them for in areas where there was actually some... ability to do that. So those are the kind of ways I think that we can support each other." HHS stopped their meetings and instead held 30 focus groups across the county asking about the quality of existing services, what prevention efforts should look like, and how to bring services to communities and residents to existing County services. Many of the suggestions from the focus groups were used in the final development of the Campus, such as the development of a community advisory board. One important step in this process was hearing feedback from the community and taking action on their concerns. While not all suggestions were able to be incorporated into the Campus, responding and partnering with community members was a step forward, and a lesson learned for the future. Other important lessons from this community engagement example are clarity in decision-making and mutual accountability. LHD staff noted the importance of being clear with the community and LHD staff regarding roles and responsibilities, project boundaries and decision-making early on in the process. Being clear, working together, and agreeing upon outcomes from the start can help manage expectations and build mutual partnership and understanding.

Other examples of lessons learned in the LHD's community engagement efforts relate to the challenges in appropriately serving geographically and ethnically diverse communities. Community participants

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shared that health education materials cannot be "one size fits all" and that consideration to the cultural needs of the community may change the wording, literacy level, and culturally relevant messaging. Additionally, food was seen as an important part of the process of community engagement, when done correctly. It was recommended that LHD staff find healthy food options to offer, coupled with a cultural, historical and economic understanding about the community's current eating habits and access to healthy food, as well as finding ways to engage the community to modify their own cooking and food choices to be healthier. It was important to community for LHD staff to understand how certain cultural eating behaviors are formed – including a lack of access to fresh fruits and vegetables, affordability, history and culture – and that, by taking the time to learn these cultural elements, trust is built between communities and LHD staff.

Limitations in Institutional Structures

In addition to the above-mentioned need for an increase in meaningful, working relationships between community representatives and LHD decision-makers and some of these communication barriers that exist in the current County structure and functions, the internal HHS "silos," or categorical program divisions, were seen as main barriers to collectively addressing the broader social determinants of health inequities. One LHD staff member stated that: *"the (funding) boxes are sort of mandated... but there's plenty of white space between all those, and that's where we can come together, sort of the mortar... the area that's between, that is where the opportunity lies, and if we can create a culture of 'can do', of being part of an organization that's bigger than our individual efforts, then we want*

to... *it's that process of being a part of a changing, learning organization.*" This idea of working outside the box with intentional, cross-divisional work is one strategy that emerged that could help increase internal and external communication and illuminate patterns that contribute to health inequities, while reducing duplication of efforts with the same families in multiple HHS systems.

LHD participants shared that, due to the economic downturn, a different set of clients started using HHS services, which can strain the system's capacity, but also offers opportunities for organizational change as the LHD moves to assess and understand the changing demographics and community needs.

One community participant explained how existing HHS-based funding priorities often differ from the community's priorities, stating: *"it's hard to care about getting a mammogram when you don't have food to put on the table."*

In addition, although previously mentioned efforts exist in professional development in health equity (i.e. screenings of Unnatural Causes), HHS staff development training in cultural humility and diversity was expressed as inconsistent across programs and is not implemented as a prerequisite for HHS staff service delivery. Participants expressed that some programs within HHS did not seem to foster the knowledge or capacity to work appropriately with diverse communities or to understand relevant socio-economic and cultural issues that would help meet clients' needs. An LHD staff member explained: *"I think cultural understanding and speaking the same*

language is very, very important when you go into a community and you want to talk to them and give them your ideas or your advice and listen to what their needs are, that has to be there, the language and the cultural... or it's not going to be something that is going to be worth taking the time to do."

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Some suggestions were raised by participants for work in this area, such as: allowing LHD staff time to develop community-driven programs vs. only offering institutionally-developed programs, releasing staff to practice in the field more to better understand their clients' environments, and being cognizant and proactive as an organization about assumptions and potential biases people may have about certain communities and how that may affect their public health work.

In addition, one CBO leader also shared that people in the community do not always understand what HHS does and that *"community members don't know that you can go to the health department for air pollution."* By building more direct relationships with community and engaging residents in more of what public health does, the LHD can both increase the public's knowledge-base about existing programs and services as well as develop community-driven programs that more effectively impact the neighborhoods where residents live and work.

Recommendations

In summary, the main themes that emerged as recommendations for the Marin County Department

of Health and Human Services to increase health equity and community engagement include:

1. Continue building meaningful, on-going relationships with community members and community based organizations by having a consistent presence, building trust and being accountable to the community's self-identified best interests;
2. Provide opportunities for community members to participate in meaningful dialogue with LHD staff on issue development, strategic planning and decision-making regarding health equity work;
3. Advocate for non-categorical funding, cross-sector collaborations and flexible staff schedules that allow for focused work in community engagement and the social determinants of health areas such as transportation, housing, immigration, etc.;
4. Institutionalize HHS professional development programs focused on social determinants of health and upstream strategies for public health work in health equity;
5. Provide culturally appropriate public health services where clients live and work throughout the County.

The results summarized in this BARHII report are based only on the qualitative data from seven focus groups in April 2009. In order to more completely assess the strengths and areas for improvement in the efforts of the LHD to increase health equity and community engagement, BARHII recommends the implementation of the Organizational Self-Assessment for Addressing Health Inequities Toolkit. This toolkit, available as a free PDF download (<http://www.barhii.org/resources/toolkit.html>), includes information on how to assess and work to improve both the organizational and staff capacity to better address health inequities. In addition, the community survey templates provided in this toolkit are a great resource for incorporating more health equity and social determinant measures into mandated hospital

community assessments and public health department accreditation processes.

One final recommendation BARHII has for the usage of these data is to share this report with the community agencies who participated and additional, key community partners. By coming together and sharing this information, health department and community agency staff can discuss how far along they have come since these data were collected a few years ago and where there are still crucial gaps in local community engagement and social determinants of health efforts. Together, the LHD and partnering community agencies can develop a plan for improving on these strategies to meet their common goals to improve health equity and improve the quality of life of all their residents.

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