Community Collaboration Proposal 2022

Prepared by Deandra Lee, MS, Tania Perez, MPH, and Nupoor Kulkarni, MPH

SAN MATEO COUNTY HEALTH
PUBLIC HEALTH, POLICY & PLANNING

Get Healthy SAN MATEO COUNTY gethealthysmc.org

California Department of PublicHealth

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

This project was made possible through the leadership and heart of Tania Perez, former Sr. Community Health Planner, as well as with the support from Public Health, Policy, and Planning (PHPP) leadership. A special thank you to all the San Mateo County community groups, the six local public health jurisdictions/ organizations, and the PHPP managers that participated in this project to share space and thought partnership. This project is an example of expert research and community guidance working together.

Participating San Mateo County Health, Behavioral Health and Recovery Services, Health Equity Initiatives

African American Community Initiative
Chinese Health Initiative
Diversity and Equity Council
Latino Collaborative
Native and Indigenous Peoples initiative
Pacific Islander Initiative
Pride Initiative
Spirituality Initiative

San Mateo County Commissions

San Mateo County LGBTQ+ Commission
San Mateo County Commission on Disabilities

San Mateo County Community Groups

Bay Area Community Health Advisory Council (BACHAC)
Casa Circulo Cultural
Childcare Coordinating Council of San Mateo County (4C's)
Coastside Hope
Daly City Youth Health Center
Faith in Action
Healthways
OneEPA
Nuestra Casa
Multicultural Institute
Redwood City Together
Self Help for the Elderly
Senior Coastsiders
Starvista
UMOJA

PHPP Managers

Matt Geltmaker, LCSW
Bonnie Holland, RN

Local Public Health Jurisdictions/ Organizations

Alameda County
Santa Clara County
San Francisco City/County
Contra Costa County
Latinx Taskforce of San Francisco
King County, Washington

EXECUTIVE SUMMARY

Health is important to all of us and a commitment to health equity includes all of us. San Mateo County Health, Public Health, Policy and Planning (PHPP) was awarded the California Equitable Recovery and Initiative (CERI) grant through the CA State Department of Public Health (CDPH). The purpose of the CERI grant is to address COVID-19 health disparities and advance health equity by building equity infrastructure within local health jurisdictions. PHPP has invested these funds into the creation of a Community Collaboration Framework Proposal that is designed to strengthen and expand external community engagement structures that will promote systemic change. To do this, we developed a community-centered collaboration process that honors the needs of our diverse residents. This proposal was created in collaboration with community-based organization (CBO) leaders and representatives, community members and equity staff. During this process we met with 28 distinct groups selected by geography and race/ethnicity. Approximately 354 people were engaged in this process through community input sessions, interviews with six jurisdictions in our region, and 10 CBO leaders through our working group. Community input is vital to a sustainable health equity and social justice effort. The community proposes five recommendations for building trust as well as five recommendations for a potential community collaboration structure:

Trust Building

1. **Increase presence in community meetings and events**
   - Participate in program presentations at workgroup meetings and in health equity workshops

Values:

1. **Anti-racist and trauma-informed practice**
   - Incorporate frameworks into decision-making processes within PHPP
2. **Transparent, honest, and consistent communication**
   - Increase accountability for transparency about limitations and capacity for shared-decision making with community

Systems Transformation:

1. **Staff and employees should reflect the community or be members of the community being served**
   - Report on PHPP demographics and invest in employment pipelines for SMC residents
2. **Consistent access to health education**
   - Invest in the creation of a community-responsive, robust health education program across all of the PH department

Structure
PHPP: 1. **Develop a PHPP strategic plan** ◦ Partner with the community to identify target populations, activities, and priority areas for PHPP 2. **Establish a consistent public health agenda item within an existing community-run group** ◦ Alleviate community burnout by attending existing meetings and groups 3. **Fund a convening organization to lead a collective impact model whose scope spans the social determinants of health** ◦ Build connections with the community and support the work that is being done ***Health Division-wide:*** 1. **Create a cohesive community collaboration process that expands Health-wide** ◦ Create inventory of health-wide community collaboration efforts and best practices 2. **Resource existing co-run community engagement structures such as the Health Equity Initiatives (HEI)** ◦ PH staff can serve as a co-chairs, members, and participate in HEI strategic planning

Next Steps	As an effort to practice transparent, honest, and consistent communication, we have promised community that we would return to present the data back and inform them of what became of their input. After PHPP leadership has thoroughly reviewed this proposal, we will be presenting the results to the community.

INTRODUCTION

CA State prioritized equity by leveraging COVID-19 recovery funds to address upstream health and equity efforts through the CERI grant. With these funds, we seek to establish equity infrastructure within PHPP's community-facing work. Therefore, we co-designed this proposal to guide what this external equity infrastructure looks like with community stakeholders. We prioritized marginalized community voices to build a community-informed structure for collaboration, ensuring that it's not only a structure that is useful to them, but that it also reinforces community belonging, and a culture of collective care.

To address the need for community collaboration within PHPP, we must highlight the data that reinforces this need. In San Mateo County, 60% of our residents identify as people of color.[1] People of color are most concentrated in the northern and southern parts of the county, including Daly City, South San Francisco, Redwood City, Menlo Park - Belle Haven, and East Palo Alto.[1] Additionally, four percent of our county residents are food insecure, and food insecurity is more

[1] https://www.gethealthysmc.org/demographic-data

than five times higher among unhoused individuals, Blacks, and younger adults.[2] Lack of healthcare access and delivery is especially high among Hispanics (18%) and those who live in South County (16%).[2] Similarly, lack of reliable transportation is high among low-income residents (16%) and Hispanics (12%).[2] Hispanics are the highest reported (35%) to be lower income.[2] Finally, homelessness is highest among younger adults (Under 40 years old) (8%) as well as those living on the Coastside (5%).[2] This data informed our populations' approach—prioritizing marginalized communities and identifying the appropriate stakeholders to include in the community collaboration process.

COVID-19 has devastated our communities and exacerbated the already existing health disparities in many of our communities as shown in the data above. We know that going back to how we worked towards addressing the social determinants of health before the pandemic was not really working in the first place. In San Mateo County, there have been a disproportionate number of COVID-19 cases and deaths among our Latinx and Pacific Islander communities (Table 1).[3] In order to acknowledge and honor the lives that have been lost, we are dedicated to creating a structure that supports the lives of our marginalized communities by investing in our external equity infrastructure and bringing PHPP closer to the community to work towards a healthier San Mateo County.

COVID-19 Cases in San Mateo County, Sept. 2022

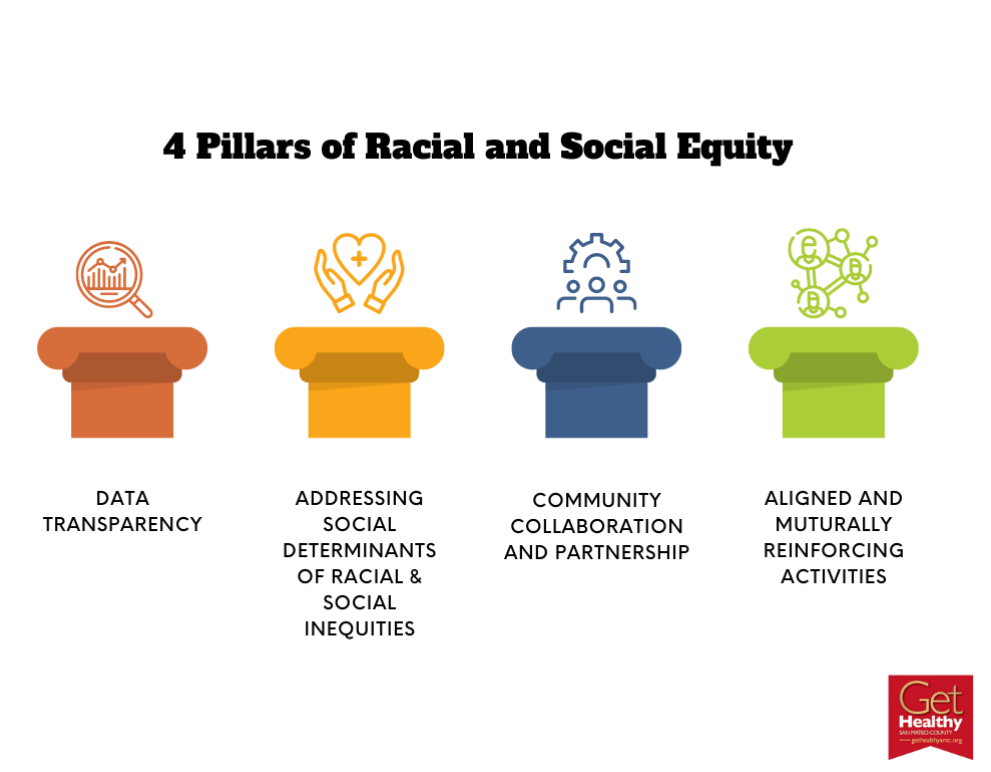
Race/Ethnicity	Case Rate	% Of Population
Hispanic/Latinx	28.1%	24%
Black/ African American	1.7%	2.8%
Native Hawaiian/ Pacific Islander	2%	1.4%
American Indian/ Alaskan Native	0.2%	0.9%
Asian	19.1%	31.8%
White	21.9%	37.4%

[2] https://www.smcalltogetherbetter.org/content/sites/sanmateo/Reports/CHNA_2019_Major_Findings_Community_FINAL.pdf

[3] https://www.smchealth.org/post/county-data-dashboard

4 PILLARS OF RACIAL AND SOCIAL EQUITY

The health equity team within PHPP was formed in early 2021 with the scope of ensuring equity in COVID-19 vaccine distribution. To guide this work, the team created the *4 Pillars of Racial and Social Equity* that values centering the community, trauma-informed approaches, and fostering a sense of belonging for historically marginalized communities.



- **Data transparency**: Using community defined disaggregated data to inform decision making.
- **Addressing structural inequities and Social Determinants of Health (SDOH):** Identifying and eliminating barriers to access, information, and care. Recognizing that barriers and SDOH create inequitable outcomes.
- **Community Collaboration and Partnership:** Centering communities and creating authentic partnerships that value thought, co-design, shared decision making and accountability.
- **Aligned and mutually reinforcing activities:** Ensuring collective impact via alignment of activities and ongoing engagement.

These four pillars helped guide the development and execution of this process. The data transparency, as shown above, helped to identify the necessary stakeholders to include in this process. We also identified and addressed any structural inequities and SDOH as we engaged

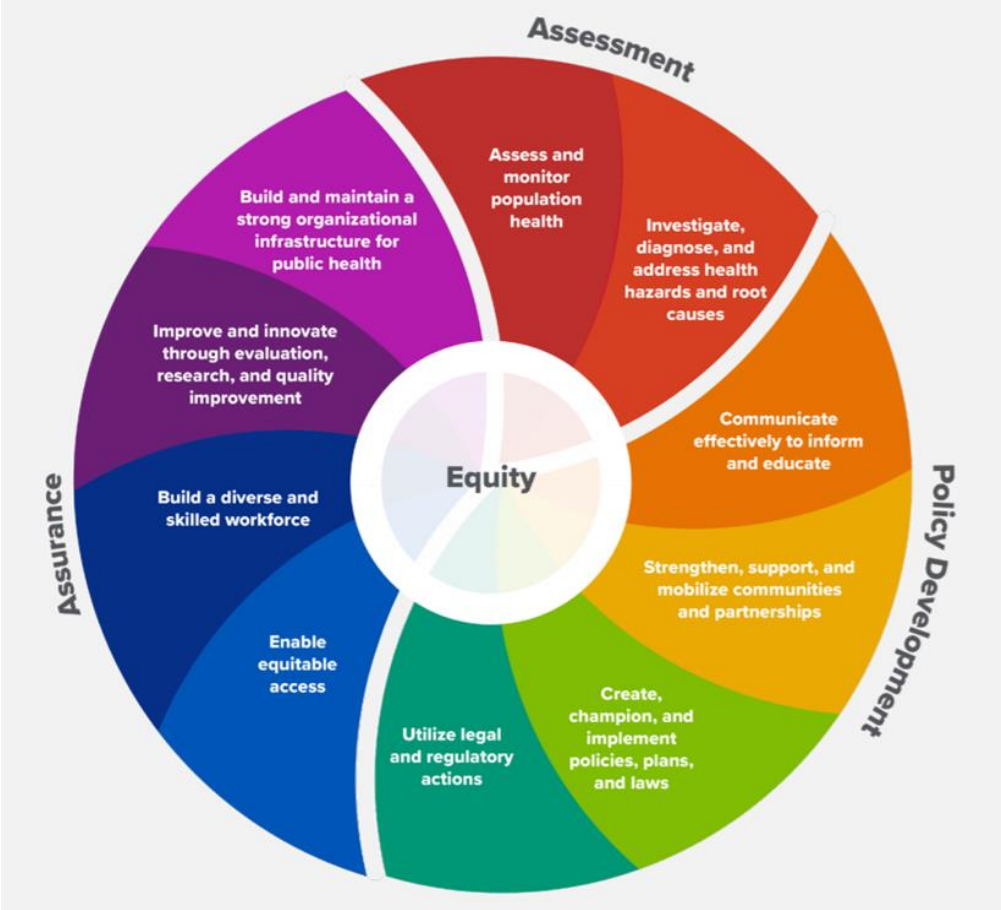
community members by meeting them where they already visit, providing information in the seven threshold languages (English, Spanish, Tagalog, Samoan, Tongan, Chinese- Traditional, and Chinese-Simplified), providing presentations in both English and Spanish, and not overburdening our community by only asking for time to present at existing meetings. Community collaboration and partnership is the most outstanding pillar as we developed a working group of community leaders and representatives and included community input as the foundation for this process. Finally, to align activities and create ongoing engagement, we are developing a free community-facing health equity resource and plan to return to community groups to share the data findings from this process.

THE TEN ESSENTIAL PUBLIC HEALTH SERVICES

The ten essential public health services[4], which serves as a framework to guide the field of public health, was recently updated to include equity at its center through a recognition that we must remove systemic and structural barriers that have resulted in health inequities. The Community Collaboration Process (CCP) is directly tied to Essential Public Health Service #4 which states that we must strengthen, support, and mobilize communities and partnerships to improve health. The ways to do this are by:

- Authentically engaging with community members
- Fostering and building, strengths-based relationships with diverse group of partners
- Convening and facilitating multi-sector partnerships and
- Learning from and supporting existing partnerships

[4] https://www.cdc.gov/publichealthgateway/publichealthservices/essentialhealthservices.html



POWER-SHARING IN GOVERNMENTAL PUBLIC HEALTH AND COMMUNITY

Throughout US history, assertions of individual and collective will by members of dominate groups have created and sustained an imbalance of power in the name of colonialism, imperialism, and white supremacy. Locally, this imbalance of power is evident in historical redlining and discriminatory housing practices in East Palo Alto and in the Belle Haven neighborhood of Menlo Park; internment camps for Japanese American communities in San Bruno; housing covenants on the Coastside, and more. These "sustained imbalances in power consistently benefit some over others and [are] reinforced in the systems and structures that affect decision making and resource allocation. The resulting dynamic…creates persistent and avoidable inequities [such as in income and health for those who lack power]".[5] Furthermore, racial and social justice advocates have long understood that achieving equity necessitates building power in communities most harmed by inequities.

[5] https://www.healthaffairs.org/do/10.1377/forefront.20180129.731387/full/

Recognizing the governmental, and Public Health, harms on marginalized communities, the CCP sought to learn directly from community on what power-sharing and co-creation between community and Public Health must look like. The community spoke of collective power throughout the input sessions. Collective power and community collaboration with Public Health must be rooted in the knowledge and experiences of those who live in the County. As one community member shared, "[we must] make sure the voices of Public Health are not overpowering the voices of community, not speaking for community even when staff reflects the community". The community also recognizes that public health means "protecting and promoting the health of society as a whole (as determined by those in *power*)". The community members spoke of power-sharing as transparency over any barriers to addressing community needs. Co-creation was expressed as a desire for inclusion throughout decision-making processes for health policy, program and/or initiative development.

The community is wholly aware of the historical and current power imbalances that reinforce inequities. This awareness requires a shift in the purpose of community engagement to support community power building.[6] To achieve the mission of public health, we must design more community-centered decision-making processes that widen the range of people and communities involved in efforts to reduce inequities.

COMMUNITY COLLABORATION PROCESS

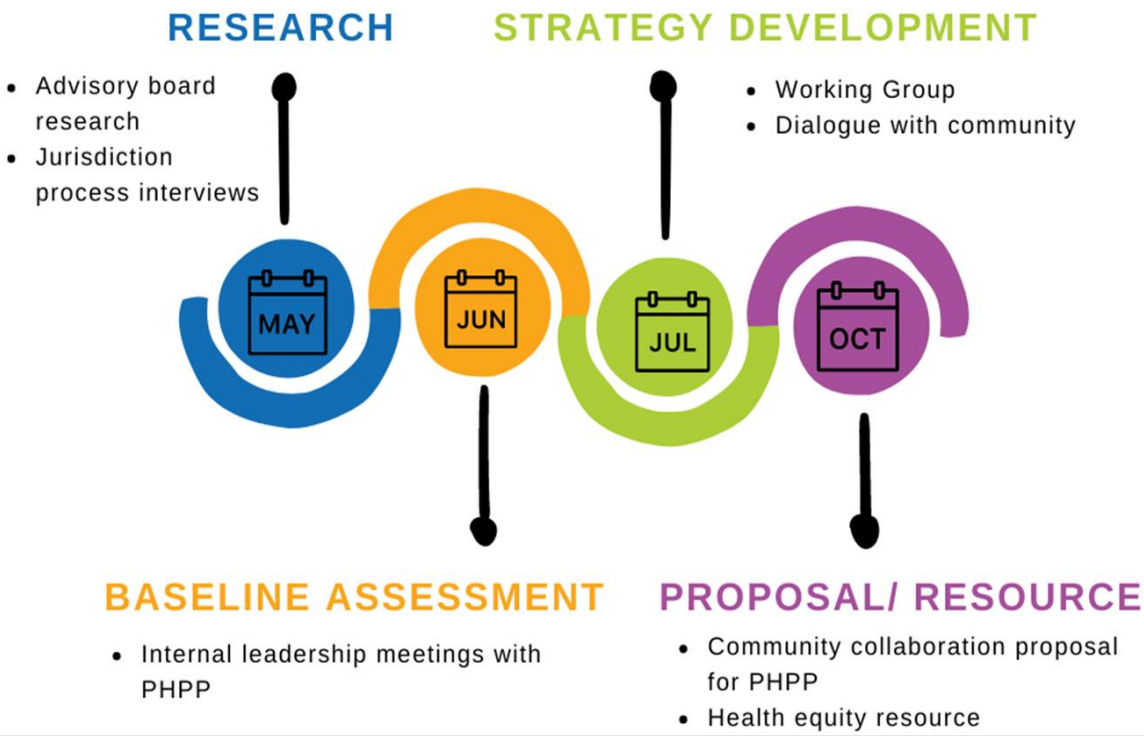
The CCP has two main goals. The first is to utilize learnings from the literature and community input to develop a community collaboration structure proposal that centers co-design between community and PHPP. The second goal is to design a community-facing and -informed resource to support community dialogue with and understanding of SMC public health services. Both goals have been achieved through co-creation with the community via a working group and various input sessions and are supported by research through an extensive process including a literature review, jurisdiction interviews, and a baseline organizational assessment. The timeline for this project is shown below.

Goals:

Community Collaboration Structure Proposal: Utilize learnings and community input to develop a community collaboration structure proposal that centers co-design with community

Health Equity Resource: Design a community-facing and -informed academy/resource(s) to support community dialogue with Public Health

[6] https://www.naccho.org/blog/articles/naccho-exchange-winter-2021-health-equity



LITERATURE REVIEW

An extensive literature review of existing advisory board research was executed to determine the appropriate fit for an advisory board as the proposed community collaboration structure. From this literature review we found that most advisory boards are mandated, and the board of supervisors generally appoints the members, and the power these advisory boards have is limited to recommendations to the board.[7] Based on this research and from feedback from multiple community groups, we also decided to investigate other methods for community collaboration.

A literature review on community engagement frameworks reinforced the "why" community engagement is important. A published paper on community engagement best practices for government agencies stated, "Simply acknowledging that community input is welcomed in the planning, provision, and governance of health services is not enough to catalyze effective engagement. Formal systems must be implemented to encourage, solicit, and respond to

[7] Research-Regional-Advisory-Boards.docx

community members concerns, suggestions, and needs."[8] The paper also lists out a set of best practices including having stakeholders define the focus of the community engagement intervention. Many of these practices have been incorporated into our own architecture of community engagement for this process.

JURISDICTION INTERVIEWS

Findings from the literature on existing community engagement structures led to the need for more information. We contacted six leaders of public health departments/organizations across jurisdictions in our area to learn more about their community engagement frameworks. We spoke to the Alameda County, Contra Costa County, Santa Clara County, San Francisco, and King County Public Health Department as well as the Latino Task Force of San Francisco.

From these interviews, we found that levels of community engagement vary across jurisdictions. Many formal bodies of engagement do not participate in shared decision-making, and do not hold real power for change as defined by our community. Similarly, formal structures such as commissions and advisory boards do not engage in shared decision-making despite being the formalized structure for engagement. Additionally, many commissions are not very diverse and do not accurately represent marginalized populations. This holds true for San Mateo County's HIV/STD community advisory board as described by the SMC AIDS Director.

As for informal structures, these organic structures tend to be where authentic relationships are built between the staff, community leaders, and advocates. Jurisdictions that had engaged community members via authentic reciprocal relationships through previous work including Census 2020, taskforces, or other previous work were able to pivot more during COVID-19 and continue those relationships during a state of emergency. Another major finding from these interviews has been that buy-in from leadership is crucial for success and this is highly variable across the region. Many health equity teams across the region are led by people of color, and in many instances, are caught in between the community and the institution with limited amounts of power or leadership roles.

Several recommendations from the leaders were made regarding our efforts to establish a community collaboration framework. One recommendation was to write a policy for how to operationalize equity that includes community collaboration, similar to how SMC Health and BHRS have similar policies for cultural humility. Another recommendation was to be transparent and define terms of engagement for community and ensure that the internal structure within SMC Health is ready to hear community needs even if all cannot be met. Finally, there was a recommendation to consider community burden by acknowledging which other parts of the

[8] https://improvingphc.org/sites/default/files/Community%20engagement%20last%20updated%2012.13.2019.pdf

health system are asking for engagement and what they can expect from us based on this engagement.

BASELINE ASSESSMENT

To understand current community engagement efforts and areas for improvement within PHPP, we conducted interviews with two (2) PHPP program managers that were identified as having some level of community engagement during the Statewide Baseline Organizational Equity Assessment survey as part of the CERI grant. We interviewed Matt Geltmaker, Clinical Services Manager, and Bonnie Holland, Clinical Services Manager. From these interviews we determined that the most significant areas of community engagement that exist within PHPP can be found among the Health Policy and Planning staff partners and the STD/HIV Community Advisory Board that sits within the STD/HIV Communicable Disease Program.

Engagement among Health Policy and Planning staff partners is limited to providing input on topic areas and does not reach the level of shared decision-making as defined by the community. Additionally, the STD/HIV Community Advisory Board is mandated under federal Ryan White funding, and the power that these community members have is limited to setting priorities for HIV medical and wrap-around support service categories. Additionally, the current community advisory board does not accurately reflect our SMC population, as the board struggles to recruit younger and Latinx participants, despite them being disproportionately affected by STD/HIV infections.

The interviews also found that most PHPP managers do not consider their programs to provide direct-service activities that would provide opportunities for community to be involved in decision-making processes. Despite this, PHPP managers do see the need for more efforts around community collaboration as found our local Baseline Organizational Equity Assessment data. PHPP managers scored our division at a “2”, for the CBO and Resident Engagement domain that evaluates how we “build trust with the community/residents through transparent and inclusive communication, respectful co-learning, and leveraging community expertise to inform equitable practices.”, indicating that CBO engagement planning is in place, but in the early stages of implementation.

STRATEGY DEVELOPMENT

Working group

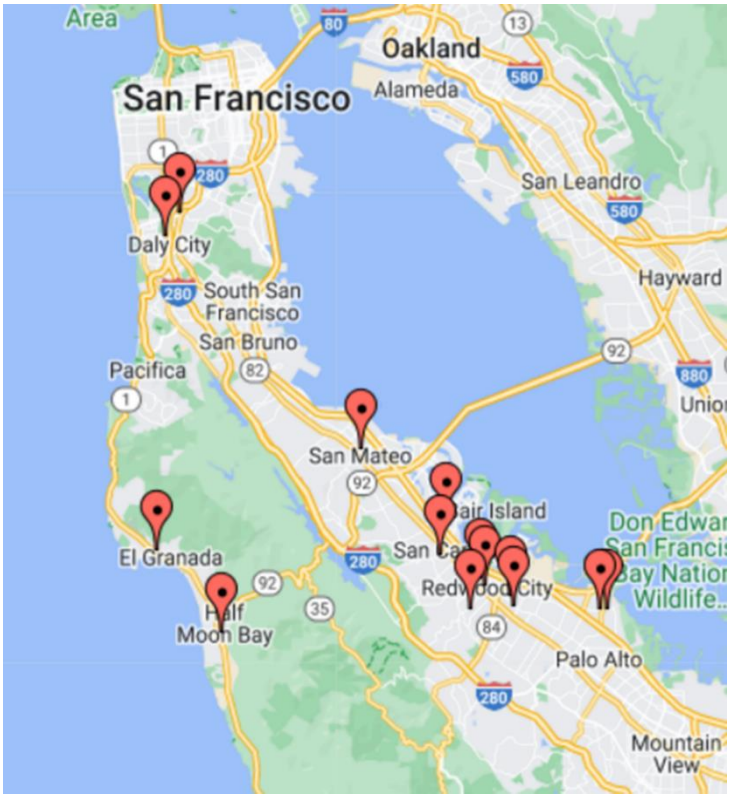
Building a structure for authentic community collaboration requires that community collaboration is embedded into the process. Therefore, we established a working group made up of ten diverse community leaders and representatives across the county. These members helped

vet our community engagement process by providing input on the relevance and understanding of the questions that we asked the community and on the presentation we gave. The members also hosted input sessions with their community groups as well as connected us with various other community groups. Finally, through bi-monthly meetings for the first three months, and monthly beginning in October, the members participated in throught partnership around the deliverables coming out of the CCP including this proposal. Members were able to provide input on the structure and information presented within this proposal and they will also provide input on the document that will presented to the community.

Workgroup Members

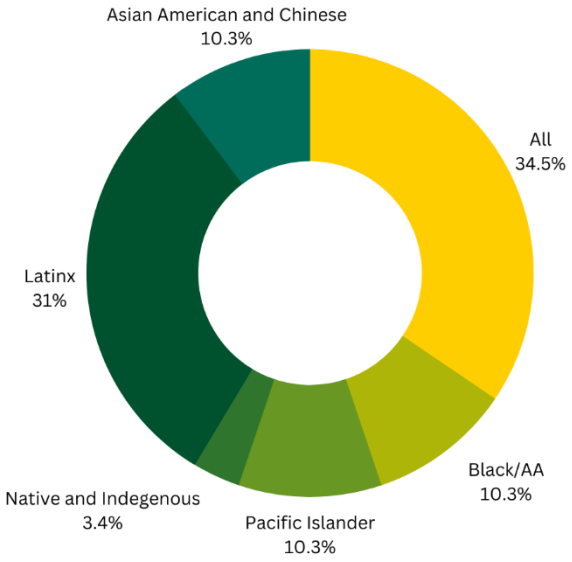
Region	Organization	Populations of Focus
South County	Nuestra Casa	Latinx, Promotoras, parents, and General community
	El Concilio of San Mateo County	LatinX, General Adults, and Families
	Belle Haven Action	Black, Latinx, Pacific Islander, and youth
	One EPA	Pacific Islander, mental health consumers, and youth
	Casa Circulo Cultural	Latinx, Adults, and youth
	Multicultural Institute	Latinx day laborers, domestic workers, and low income groups
	Faith in Action	Latinx community leaders
Coast	Coastside Hope	Latinx, adult serving, social safety net, farmworkers
Central	BACHAC	Black, AA, older adults, and adults
North	Healthways	General population, specifically Philipinx and other Asian Americans

Community input sessions



The second arm of authentic community collaboration included conducting input sessions with historically neglected community groups to gather their thoughts and ideas around the design of this proposed community collaboration framework. We were able to gather input from 27 community groups across regions within San Mateo County. There was also thoughtful consideration for diversity in terms of the demographics the groups served or represented including race/ethnicity, age, gender/sexual identity, faith-based, and physical ability). The graphic below illustrates the diverse races and ethnicities that were captured with the community input sessions. A total of 342 community members provided their thoughtful input into this process. During the input sessions, we provided an overview of what public health is and what it looks like within PHPP. After a public health overview, we discussed the scope and goals of the community collaboration process with clear transparency that any ideas that came from this process were not promised to be executed but would be included in the proposal to PHPP leadership and relevant data would be relayed to interagency departments and units. This presentation was followed by asking the community members a set of four (4) questions. Data from the responses to the questions were collected via Mentimeter, an online presentation platform that allows participants to engage in discussions and

Demographics served by Community Groups Surveyed



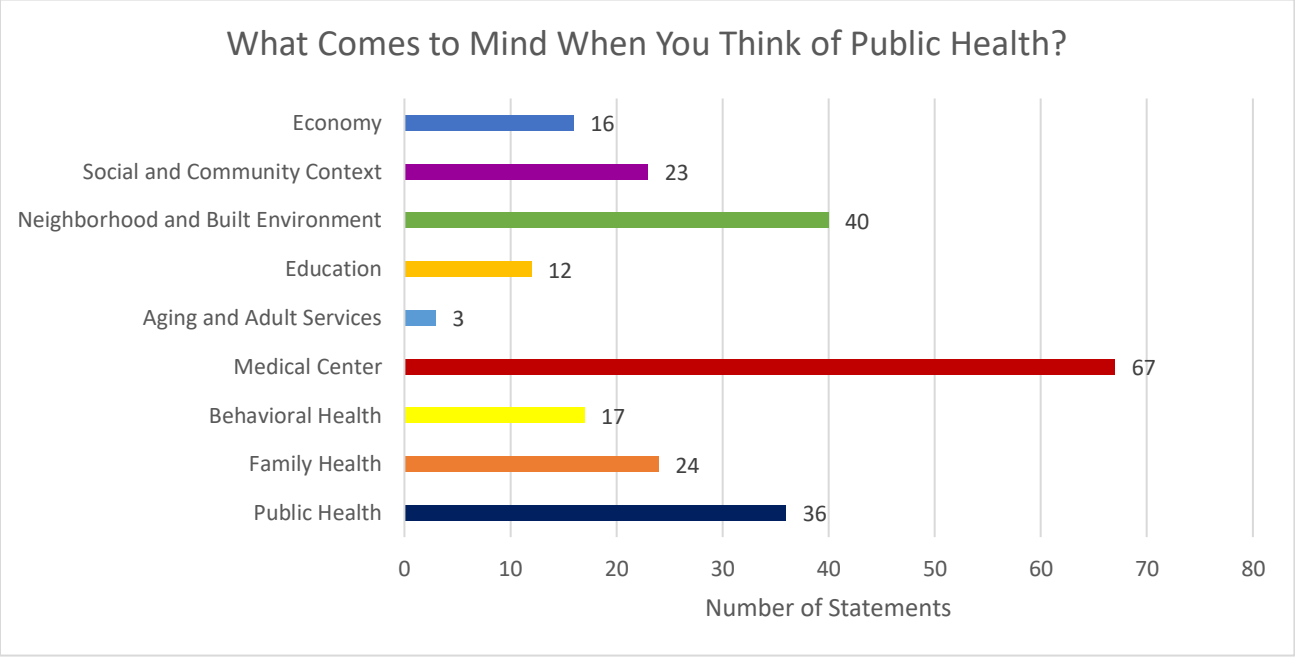
Q&A anonymously, via their smart phone or on their computer browser. Responses were also captured via live notetaking of verbal responses for the folks who were unable to participate using Mentimeter. The four questions asked were as follows:

1. What comes to mind when you think of public health?
2. What are ways in which the public health department can build trust with the community?
3. If you could design an ideal structure for co-creation and shared decision making with public health, what would it look like?
4. What are some topics you and/or your community are interested in learning about and how can public health provide you that information?

DATA FINDINGS

QUESTION 1: WHAT COMES TO MIND WHEN YOU THINK OF PUBLIC HEALTH?

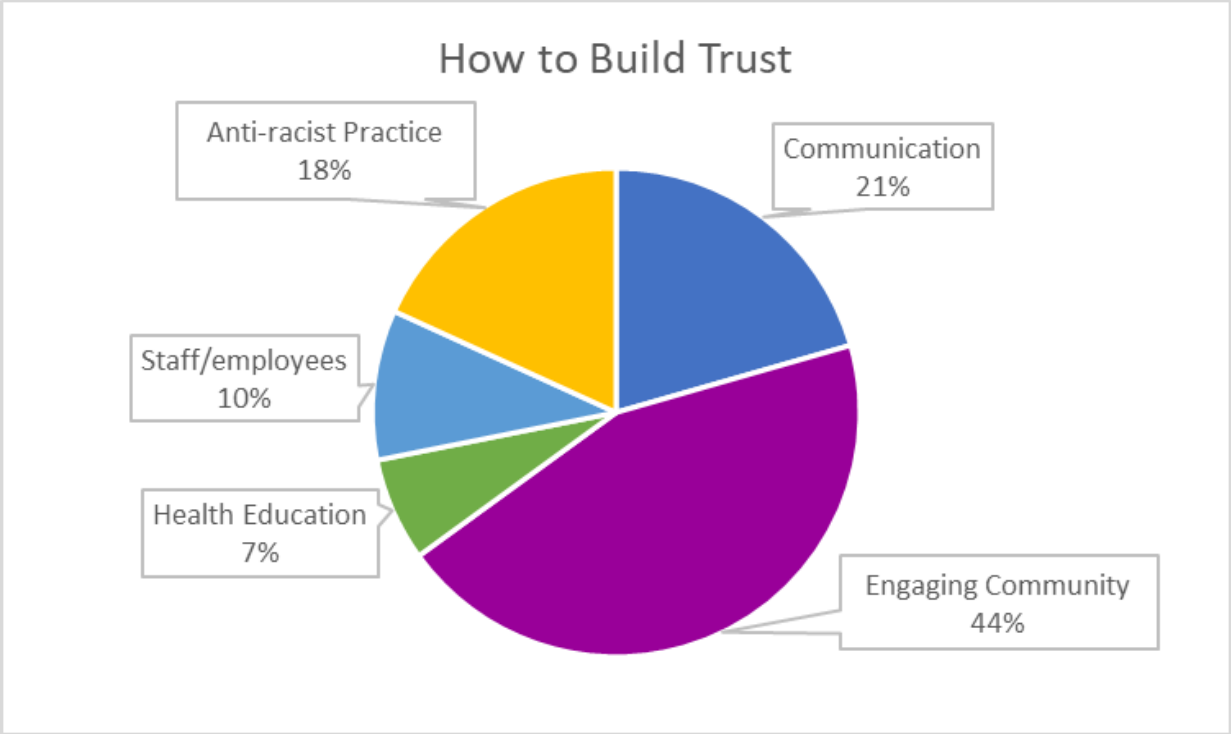
The major finding of this question was the fact that there are artificial borders when community members interact with us. They do not see different divisions within Health, rather, they see us as one unit. This question was asked to measure the baseline understanding of what public health is and what we found was that many of our community members did not distinguish general health and medical care with public health. Most of the community spoke more about medical care and treatment over any other health, social determinants of health, or general public health related topics. This data reinforces the need for a community workshop on what public health is, as described in the next steps.



QUESTION 2: WHAT ARE WAYS IN WHICH THE PUBLIC HEALTH DEPARTMENT CAN BUILD TRUST WITH THE COMMUNITY?

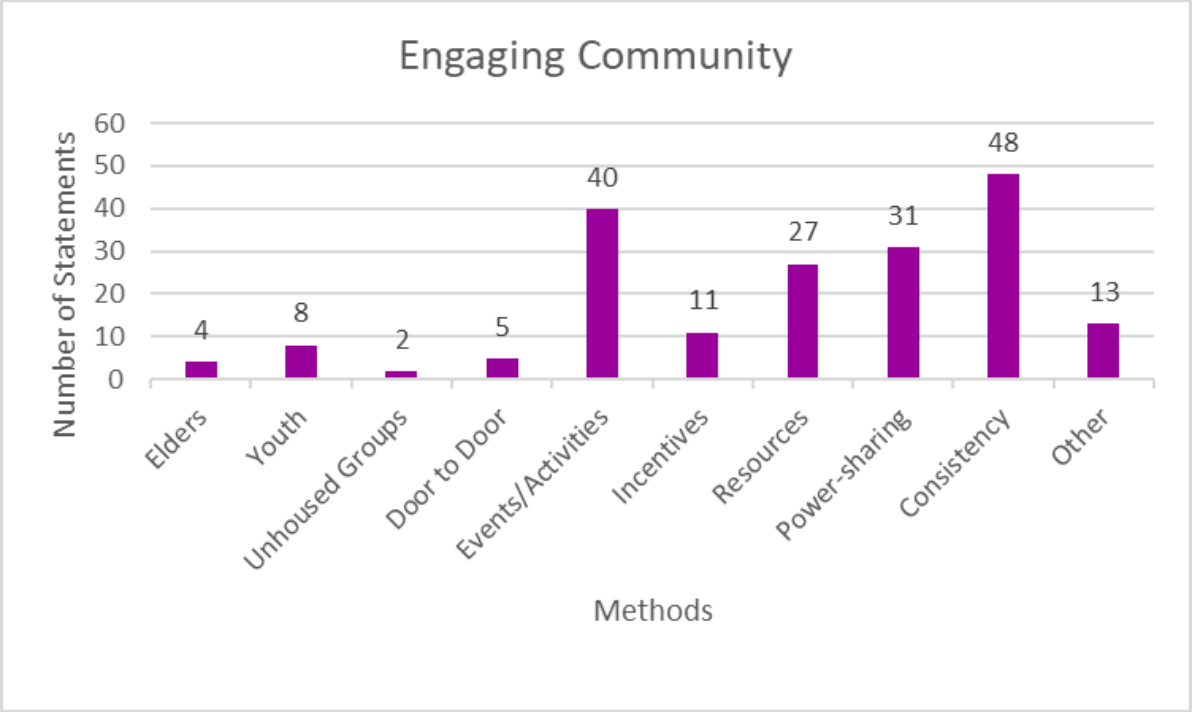
Building trust is essential to authentic community collaboration and the community has pointed out five (5) major ways for PHPP to build and maintain trust with the community. These mechanisms include:

1. *Engaging the community*
2. *Consistent, transparent, and honest communication*
3. *Anti-racist practice*
4. *Diversifying staff and employees*
5. *Access to consistent health education*



The **first** most mentioned mechanism for building trust was by **engaging the community**. The community members specifically called out the need to show up consistently with the community, attend community events and activities, provide transparency about power-sharing when applicable, share resources, and provide incentives when asking for community time.

> "Keep being involved with the community, even if public health is ready to move on, sometimes the community isn't ready."



> Make only the promises you can keep. Emphasize what's actually available, don't put the Utopian aspirations at the top of messaging.

The **second** mechanism identified by the community for building trust was **consistent, transparent, and honest communication** especially related to project outcomes and community involvement. The community stated that many times community does not trust PHPP officials due to lack of consistency in communication when the community makes requests for information especially regarding the COVID-19 pandemic. The community also stated that expectations of engagement with community should be transparent so that there would be a clear understanding of what is and is not possible for PHPP.

The **third** mechanism was to apply **anti-racist practices** to address the need for racially, culturally, and socially conscious communication and interaction with the community. According to the community, anti-racist practices include consideration for language access needs, diversity of identities, as well as an acknowledgement of privileges.

> Build partnerships not dictatorships, the controlling factor that continues to happen when collaboration should occur. The information presented to community should include language/vernacular identified by the community

> Staff that looks like you 'looks like community' there is a large amount of staff that are white but community is highly Latinx. More likely to trust government agencies when staff have similar names and lived experiences.

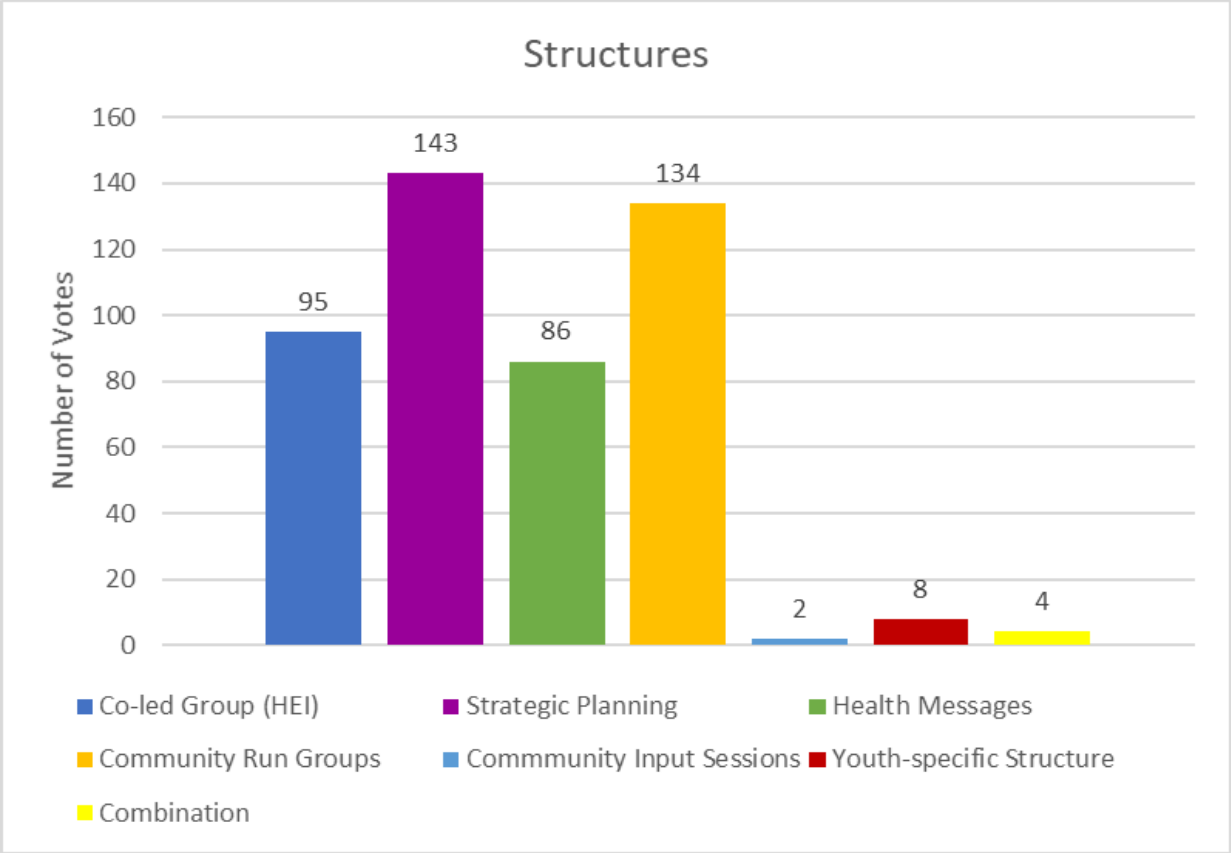
The **fourth** mechanism for building trust was to ensure that **staff and employees reflect the community and/or are members of the community**, so that the community would be able to trust PHPP staff and leadership more.

> Public Health is responsible for education, right? It's important. It's unfortunate that there isn't a division dedicated to it, there are many topics people would like to know about.

Finally, the **fifth** mechanism was to ensure a more **thoughtful and consistent health education process** to empower our community members as well as to establish credibility with the community, which would then lead them to trust PHPP more. The community called out more relevant and accessible health education specifically around COVID-19 and other emerging communicable diseases. There was also an emphasis on opening dialogue with the community to understand what the concerns and needs are around providing health education.

QUESTION 3: IF YOU COULD DESIGN AN IDEAL STRUCTURE FOR CO-CREATION AND SHARED DECISION-MAKING WITH PUBLIC HEALTH, WHAT WOULD IT LOOK LIKE?

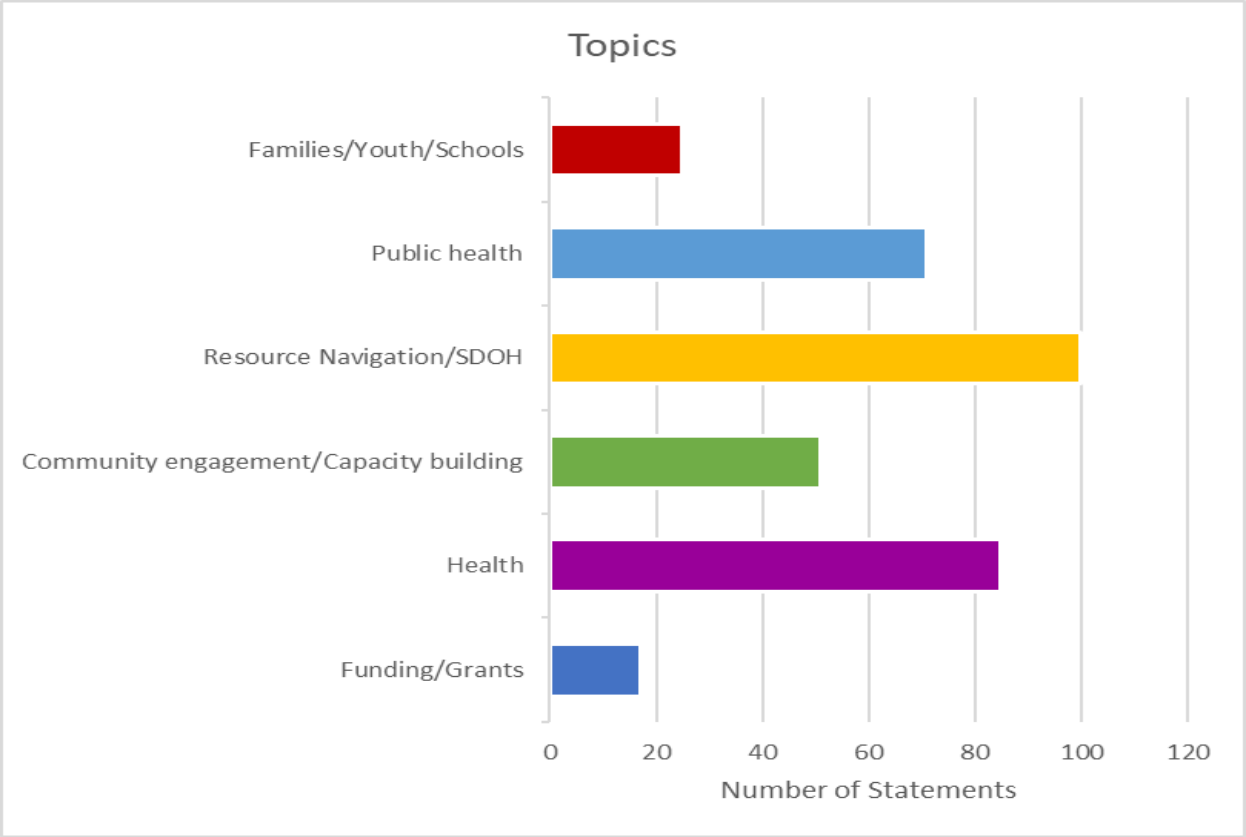
This question addresses the first goal for the creation of a community collaboration structure. The community members were provided four options and were also given the opportunity to provide different ideas. The most voted on structure for community collaboration was **strategic planning, identifying target populations and priority areas**. The second was a **community run group that PHPP staff attends**. There was also a specific call out for the consideration of expanding upon an existing structure to not overburden our communities with the creation of another meeting.



For this question we also received multiple comments on some requirements of the structure that is developed. The first and most advocated for requirement is that the structure that is created should be culturally sensitive and linguistically and physically accessible. We also had some comments about accountability, as many folks expressed that there needed to be a follow up with the community about what became of this structure and how this structure would be sustainable.

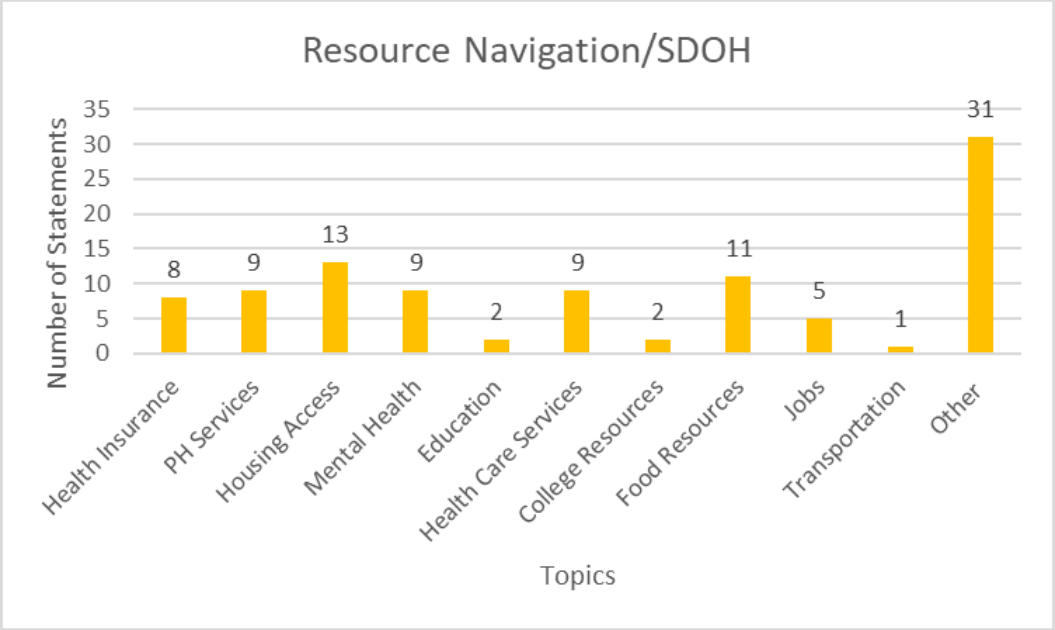
> We want to see leadership take this seriously and take action. We've seen this thing before, but it stalled out. We want to see something meaningful and powerful come out and want to support it.

QUESTION 4: WHAT ARE SOME TOPICS YOU AND/OR YOUR COMMUNITY ARE INTERESTED IN LEARNING ABOUT AND HOW CAN PUBLIC HEALTH PROVIDE YOU THAT INFORMATION?

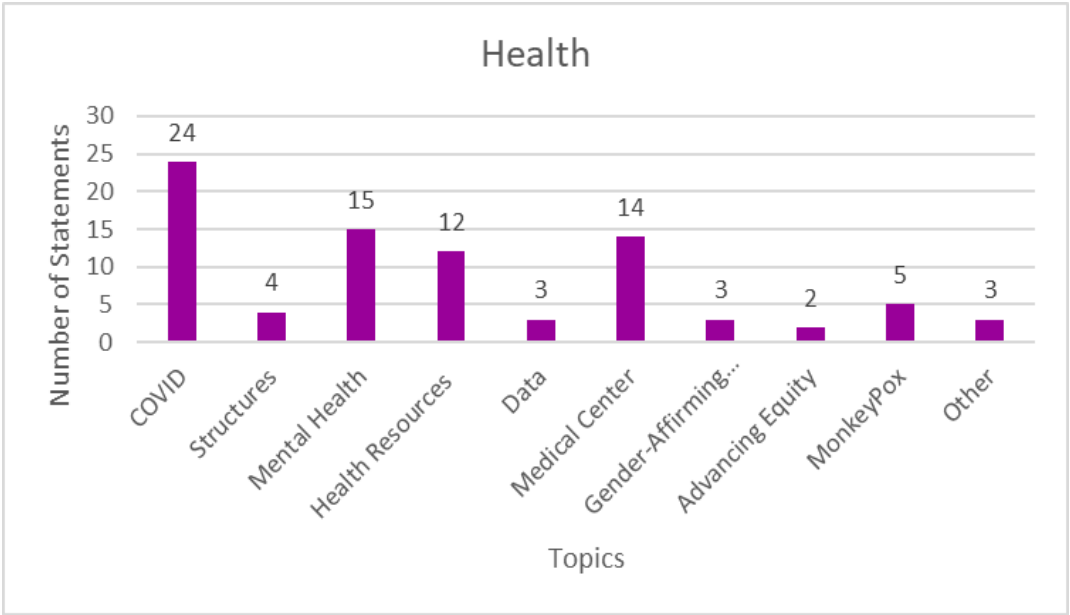


This final question addresses the second goal of designing a community-informed health equity resource. For this question, many community members advocated that any topics that are selected should center marginalized groups. The community specifically called out topics centering LGBTQ+ groups, older adults, faith-based groups, Indigenous groups, disability groups, youth, and race-based groups.

The community identified a myriad of topics that interested them with the number one topic being **resource navigation**, specifically calling out *housing access, food, public health services, healthcare services* and more.

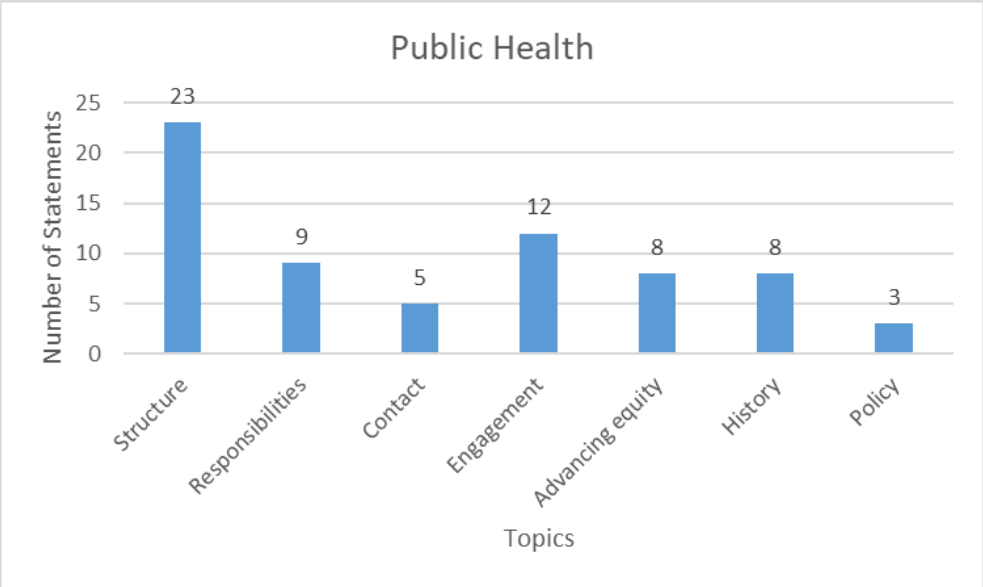


This was followed by general **Health** topics that lie outside of the PHPP scope of work such as *COVID-19, mental health, medical care, health-specific resources,* and more. While this data is not relevant to PHPP, it is important to mention as a reinforcement that community does not see public health as a separate division from all other health divisions. This data will be shared with internal partners as described in the next steps.

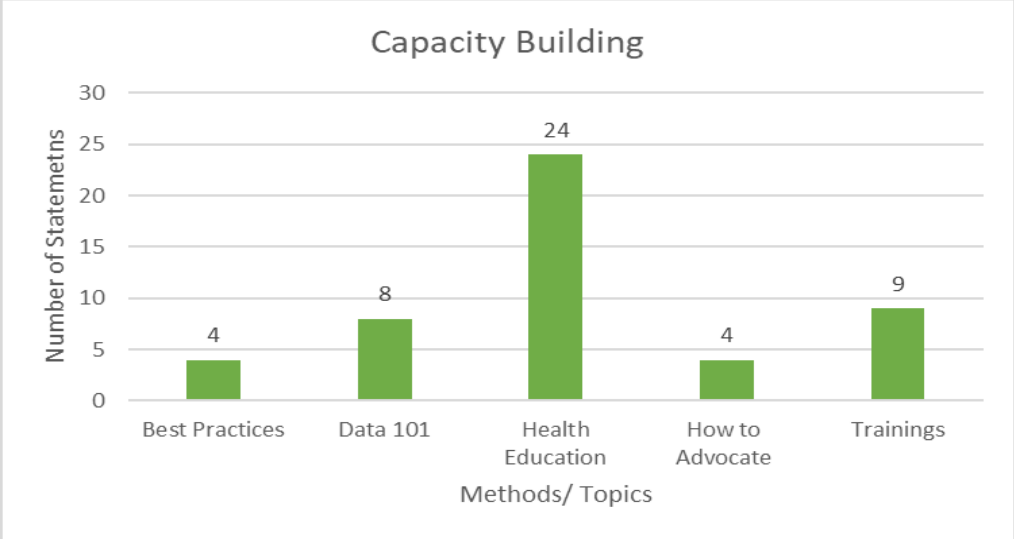


The third most requested topic was on general **Public Health 101** including the structure of PHPP, the responsibilities of each program, how each program engages different identity-based

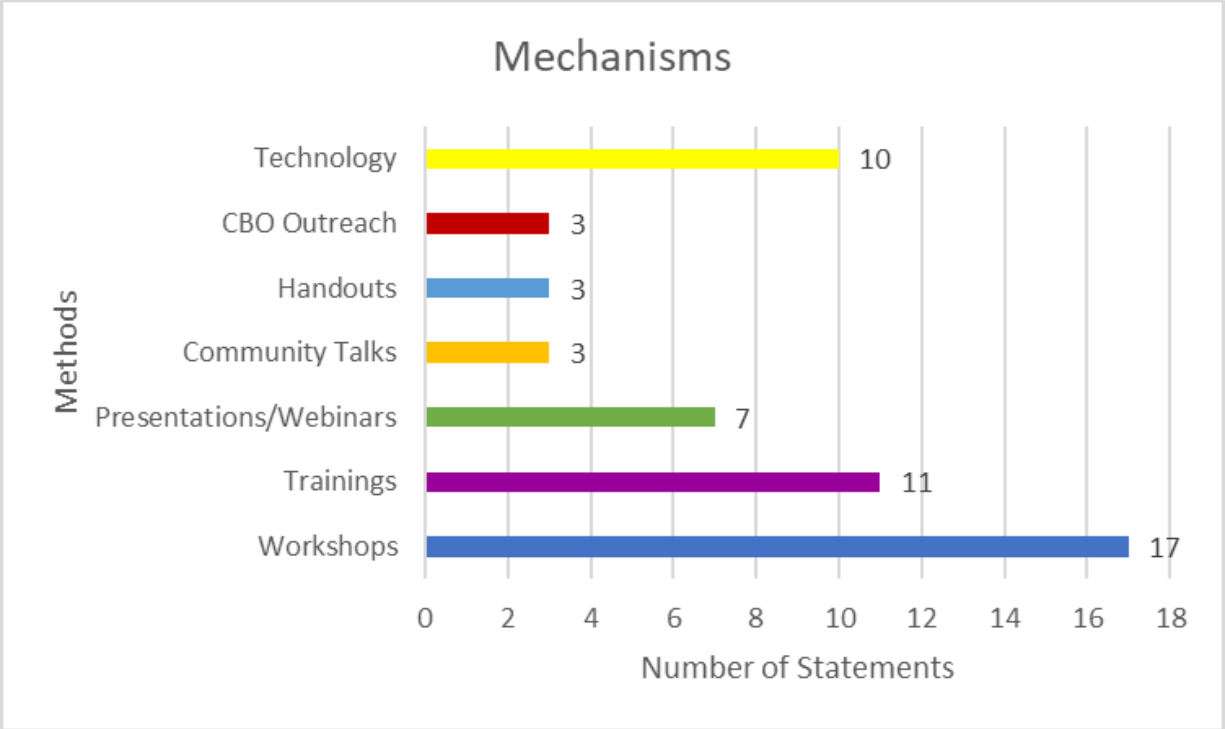
community groups, the history of racism and equity in public health, and how PHPP is advancing equity.



The fourth most requested topic was on **capacity building** by engaging communities to equip them for stronger equity practices with topics such as trainings for outreach workers/Promotoras on health education, train-the-trainer models, data 101, how to advocate within PHPP, and best practices on community engagement.



Finally, as part of the last question we also asked community members on their preferred mechanisms to receive this resource and the most voted on method was workshops/trainings that were hosted by different community groups funded by or in partnership with PHPP.



COMMUNITY STORIES

To stay true to this process, we would like to highlight some of the stories to not lose the community voice in this proposal. These stories, while they may not directly relate to the work that we do in PHPP, are very important to acknowledge as the basis for why there is a need to engage in thorough processes like these and continue to commit to collaborate with community to address these inequities/disparities. Community collaboration is an important upstream infrastructure mechanism for early intervention in addressing disparities that lead to inequities experienced in service delivery and health outcomes.


"Reaching out to different communities, more effort in going to communities. There are community challenges and barriers to participation. Asians make 31% of the county, and only single digit percent use BHRS services. When advocating for funding to have dedicated worker, the feedback (pushback) from county was 'our population doesn't use services'. What are you trying to achieve? "we will fund for 3 years"—this is a slap in the face; part time and a cap in years. When interested in youth, and when youth speak up you say 'yes that's important', also happens at BOS level, and nothing happens. Heard but dismissed?"
"For queer community in my experience, some trust with our demographics isn't there bc we're often not represented. Priority populations has people with disabilities, across race, but not queer. So how can you build trust when intersectionality is not reflected. Sexuality and gender identity is rarely represented. "
"Medical care here is very deteriorated, its hard when you don't know how to speak English. My son has appendicitis, but I don't take him to the hospital because it is too expensive, when the pain was too strong I took him to the ED and we waited 45 min and no one came. They didn't end up operating him until the next day in the afternoon. Hospitals do not listen to us. They only think about money and they profile us as Latinas who don't have money to pay for the services." (translated from Spanish)
Pacifica
Burlingame
Half Moon Bay
Alamed
I took my husband to the hospital, but it was taking so long to get attended to we ended up just leaving after a period where he felt a little bit better. Now he is still sick and refuses to go back since they never get attended. (translated from Spanish
Public Health has done tremendous work over the years as related to HIV and included every community in the planning around HIV. How can we do something similar with all social determinants of health?
Santa Clara
"Unfortunately, on the occasions that I have had to apply for a service, I have been contacted by people who make me feel very bad because they ask me a lot of unnecessary questions. Sometimes the questions make me feel uncomfortable. It is something that we can feel, the way that they make you feel less and experience racism as if you are asking for money out of their own back, even though we are going to ask for help to see if we qualify and we are not asking for something from them." (translated from Spanish)
Pescader
"Trust is earned with better attention. When I went to fair oaks, I was waiting for a call for an operation, and I still have not heard from them. They said I did not belong to that clinic because I used to live in EPA, but I live here now and they still refused to serve me. Even though I was in pain, no one wanted to give me service because I did not belong to the clinics. Now I have an appointment all the way in mountain view." (translated from Spanish)
Santa Cruz

OPPORTUNITIES FOR IMPROVEMENT

Due to the time limitations of our CERI grant and lack of capacity with only two staff members dedicating their full time to this project, there are a few aspects of this process that have some room for improvement. First, we found it hard to engage more of our Chinese community. Given the time limitations, we were not able to follow up as thoroughly as we would have liked to. We also found it hard to engage partners and communities in Central County. Knowing these limitations, future processes should ensure that these groups are accurately represented in the data by considering more time allotted for engaging these communities to show up to community events and making introductions in person rather than making "cold calls/emails".

EVIDENCE-BASED RECOMMENDATIONS

TRUST BUILDING RECOMMENDATIONS

For sustainable, inclusive, and responsive community collaboration within the chosen structure, we recommend the following practices for trust building, that were also supported by the extensive literature review.

Recommendation #1: More presence in community meetings and events.

The top mechanism for building trust was to engage the community by being more present in community meetings and events. See Appendix or a list of community meetings and events to consider attending as a guest. Another immediate, more intentional way to engage our community is by participating in program presentations at our monthly work group meetings. These presentations would be a great start to have community leaders get to know the leaders within PHPP as well as find out more information about the services and work that PHPP provides to the communities that they serve. Finally, another active way to engage would be to require that staff participate in the Health Equity resource workshops that we will be rolling out as a result of this community collaboration process. For these workshops, the request is that PHPP leadership and staff attend one of the four workshops that will be offered so that they can introduce themselves to the community and talk about the resources provided by PHPP.

Values:

Recommendation #2: Anti-racist and trauma-informed practice

Anti-racist, trauma-informed, culturally relevant, and inclusionary practices are important values to consider in the work that we do. The community members have specifically requested that PHPP be responsive and inclusive of marginalized populations in any decisions being made that

would impact the community. A best practice, as supported by the literature review, is to consider and incorporate anti-racist and trauma-informed frameworks into the architecture of the decisions that are being made within each program. For example, the Health Equity Team uses the Four Pillars of Racial and Social Equity to inform and guide all projects they engage in. Similarly, the SMC Health GARE team considers the GARE Racial Equity Toolkit in their processes. Reinforcing the use of these frameworks among the PHPP programs would help to address the need for more intentional equity practices.

Recommendation #3: Transparent, honest, and consistent communication

A best practice, as supported by the literature review, for authentic community collaboration is to ensure transparency, honesty, and consistency when engaging community. This is an arm of practicing trauma-informed engagement. The community identified that, historically, the County has had a bad reputation for coming into the community with empty promises or lack of transparency about the scope of engagement and outcomes. PHPP managers also recognize the opportunity to be more intentional and sustain community engagement. We see this in the results from the Statewide Baseline Organizational Equity Assessment as mentioned previously.

To address this, there is a need for more accountability that starts with following through on projects where community is involved, and information-sharing. Additionally, when engaging community there needs to be clear definitions of roles and responsibilities, capacity for shared-decision-making, and transparency about limitations. Collaboration should also be consistent and maintained always, not only in times of crisis.

System Transformation:

Recommendation #4: *Staff and employees should reflect the community or be members of the community being served*.

This recommendation aligns with what has already been considered as part of the SMC Health Racial Equity Action Plan under area of work 3C that states "Recruitment, promotion and hiring process, professional/skill development opportunities, and pathways for career advancement in the department further racial/ethnic diversity, inclusion of people with lived experience". The community has specifically called out two examples that work towards this recommendation and that are also in line with the County's Anchor Institution strategy "to better align County workforce demographics across classifications, especially in higher level positions, with County eligible workforce demographics". The first example is to provide public data reports on PHPP staff demographics that include race/ethnicity and gender/sexual identity, including Limited Term/Extra Help positions. Another example is to continue to invest in pipeline programs for county residents similar the County's EMS Corps partnership and programs like the California Pathways into Public Health Initiative (Cal-PPH) that San Mateo County PHPP is a part of.

Recommendation #5: Consistent access to health education

The third mechanism for achieving equity in alignment with the Ten Essential Public Health Services is to "communicate effectively to inform and educate people about health, factors that influence it, and how to improve it". Historically, there has been a disinvestment in community health education as PHPP currently does not have a dedicated health education program or staff person. Additionally, each division across health is responsible for their own health education as it relates to their programs. As a result, community feels that this has led to siloed messaging and lack of uniformity in health messages. The repercussions of this are especially apparent with the COVID-19 pandemic and emerging M-Pox outbreak as community members are often confused about the messaging that is available to them and the lack of timely, community tailored information from the County. Instead, the County has been working with the State and private partners that have these resources to meet community needs. The community has specifically called out the need for more regular and consistent messaging that is culturally tailored and timely by investing in health education capacity and formalizing a health education process.

An example of a successful program is within San Bernardino County in Southern California, where they have a health education program embedded into their public health department that has seven areas of work: 1. Implement Health Education Strategies, Interventions and Programs 2. Administer Health Education Strategies, Interventions and Programs 3. Serve as a Health Education Resource Person 4. Assess Individual and Community Needs for Health Education 5. Plan Health Education Strategies, Interventions, and Programs 6. Communicate and Advocate for Health and Health Education 7. Conduct Evaluation and Research Related to Health Education.[9] Another recommendation would be to fund and support, perhaps using Get Healthy San Mateo County funds, a community organization that leads a collective impact to develop health education materials based on the needs of their communities.

STRUCTURE RECOMMENDATIONS

Using Arnstein's ladder of Citizen Participation[10] or the Spectrum of Public Participation[11] we have found that we are frequently working in the *consultation* and *informing level of community engagement*. Through this process, we were able to stretch beyond these levels with the creation of a working group that vetted our process and their review of our proposal. Ultimately, engagement in this process leans toward *collaboration*. Through our research process and

[9] https://wp.sbcounty.gov/dph/programs/health-edu/

[10] https://www.citizenshandbook.org/arnsteinsladder.html

[11] https://organizingengagement.org/models/spectrum-of-public-participation/

engaging with regional jurisdictions, we found that the structure of engagement that community members recommend is inclusion in strategic planning, and through community-run groups where community members have control over the agenda and the institution attends as a guest. Multiple recommendations have been made, however not all are intended to function together in order to allow for the flexibility of adopting one or multiple recommendations. The following are the top recommendations made explicitly by the community via the input sessions. These top recommendations are in line with best practice research including the results of the jurisdiction interviews.

PHPP recommendations:

Recommendation #1: Develop a PHPP Strategic Plan

The top recommendation from community was to be included in strategic planning for identifying target populations, activities, and priority areas for PHPP. This inclusion would hold the values stated above, observed throughout the community collaboration process. This process could potentially follow a similar engagement process as we have done for this proposal by going to our community partners for input instead of them coming to us. To expand beyond the usual stakeholders that we engage, see Appendix for a list of stakeholders that have been identified by our working group as essential to this plan. Beyond this list, collaboration with marginalized communities and non-traditional groups, such as unhoused shelters and faith-based organizations, should be considered. It is imperative that during this process, PHPP is clear on what decisions and which parts of the strategic plan the community can influence. This strategic plan would encompass work among all programs in PHPP.

Recommendation #2: Establish a consistent public health agenda item within an existing community run group.

The community members have expressed the need to acknowledge community burnout and not add to the burden of having community members join an additional meeting or create something new. The idea is to build upon an existing structure. Ideally, this existing (and potentially expanded upon) meeting would involve multiple stakeholders from across the County that serve diverse populations. A PHPP leader would attend the regular meeting and have a standing agenda item to provide PHPP updates as well as obtain any necessary feedback on community-impacting decisions. A strong example of this is the South and North-County UMOJA meetings in which HPP and Family Health representatives attend regularly and have standing agenda items as they relate to the current COVID-19 epidemic and Monkey Pox outbreak. In this example, to meet the community's needs, a representative from all programs within PHPP, not just HPP, would attend to provide a public health update and gather any information from the community as needed or requested by the community. See Appendix for a list of existing community meetings to consider.

Recommendation #3: Fund a convening organization to lead a collective impact model whose scope spans the social determinants of health.

The data from our process shows that community members and leaders must be considered in strategic planning to identify target populations and priority areas, and that they prefer to be engaged through community run groups with whom they have built relationships and trust. This convening organization would create the agenda of meetings and PHPP would join to listen to needs, build relationships, and support the work happening in the community. One of our regional jurisdiction partners stated, "power lies in outside community organization coupled with data on the necessity of advocating for SDOH (social determinants of health)." This statement is also in line with the results that were found in relation to how public health can build trust with the community. However, this group also needs to have a clear purpose, an outline of commitments for ways in which we will engage in shared decision making, and clear communication of the power that the group holds. For example, one of the jurisdictions we talked to engages in participatory budgeting with their community partners, and this enables community leaders and stakeholders to have a say on how funds are spent. Redwood City in San Mateo County has also participated in participatory budgeting for their People's Budget.[12] A convening organization would enable us to directly impact our internal as well as our external practices.

Health-wide recommendations:

Recommendation #4: Create a cohesive community collaboration process that expands throughout Health.

One of our major findings throughout this process was that community engagement can become burdensome when there is an expectation that community members must join our existing structures such as boards and commissions. As other divisions within health are also considering community engagement as central to equity work, we recommend that we create a cohesive structure so that we are not overburdening community, especially those most impacted by the system.

A great first step would be to create an inventory of Health-wide community collaboration efforts and best practices. This idea was also a recommendation provided through the jurisdiction interviews. Additionally, through this process we are developing a community collaboration process toolkit that can be shared across divisions and used as a best practice when engaging community members. Another step to create a cohesive community collaboration process would

[12] https://www.redwoodcity.org/departments/city-manager/city-manager-s-initiatives/the-people-s-budget#:~:text=The%20People's%20Budget%20(PB)%20is,is%20a%20participatory%20budgeting%20process.

be to consider accreditation of SMC Health as Santa Clara County has done. When health systems are accredited, community collaboration is systematized with resources and support from the accrediting body to "strengthen, support, and mobilize communities and partnerships to improve health."[13]

Recommendation #5: Resource existing co-run community engagement structures such as the Health Equity Initiatives

The Behavior Health and Recovery Initiative's (BHRI) Health Equity Initiatives (HEI) are funded under the Mental Health Services Act to create linkages to access to care, as well as to work towards stigma reduction for mental health services. The HEI's are open to all members of the community, Community Based Organizations, and internal County staff. While their focus is mental health, the HEI's have advanced work in many other cross-sectoral public health concerns such as COVID-19, housing, food security, and more. Public health staff can be involved in the following ways: 1. Serve as a co-chair for one of the HEI's in order to foster relationships with the community and bring a public health lens to the work (2 year commitment), 2. Join as a member of the HEI's to share information, obtain feedback, listen, and collaborate with community on public health topics, 3. Participate in the strategic planning of the HEI's priorities which are established by all of the members and can encompass issues beyond and intersecting with mental health. This new relationship with PHPP and BHRS could also serve as a model for other divisions to be involved in the HEI structure to expand it even further to bring SMC Health closer to the community and support interdepartmental collaboration.

NEXT STEPS

The second goal of the community collaboration process is to develop a free community-facing health equity resource informed by the needs of the community. The community requested a baseline understanding of public health, and an orientation to the PHPP structure and services it provides via workshop sessions. To meet this request, the Health Equity Team is soliciting consultants to develop a "Public Health 101/What is Public Health" workshop in partnership with the Health Equity Team to incorporate PHPP-specific service navigation. This hybrid workshop (virtual and in-person) will be offered 4 times in English and Spanish, simultaneously, one in each region of SMC (North, Central, South, and Coast). We will also work with the consultant to create a Spanish and English 5-minute Public Health 101 video with subtitles in threshold languages, and a PHPP resource one-pager in the threshold languages, for CBOs and partners to share with community members beyond the workshop offerings.

[13] https://phaboard.org/wp-content/uploads/Standards-Measures-Initial-Accreditation-Version-2022.pdf

To address the fact that community often does not see different divisions and programs within Health, we made it clear to the community during the input sessions that any information provided, regardless of if relevant to PHPP, would be gathered and shared to the relevant divisions within Health. Additionally, our internal Health partners are very interested in this process therefore we will be creating and sharing data one-pagers with divisions within Health that community called out during our input sessions. As we worked on rolling out this proposal, we also engaged in and offered presentations of our findings to various divisions and programs across SMC Health. These presentations will continue as requested.

Additionally, in an effort to practice transparent, honest, and consistent communication, we promised community that we would return to present the data back and inform them of what came of their input. After PHPP leadership has thoroughly reviewed this proposal, we will be presenting the results either at a community town hall or if time and capacity allows, by returning to each of the groups we collaborated with to present the results.

As we engaged with the multiple jurisdictions, each of them stated their interest in our findings from the jurisdiction interviews, as well as the need for a space to continue the discussion around community collaboration. In response to this, we will also be creating a jurisdiction findings one-pager that we will disseminate to all of the jurisdictions that we met with. We are also partnering with BARHI to develop a community engagement roundtable to convene jurisdictions in the Bay Area, to troubleshoot, and share best practices on community engagement efforts.

Finally, as mentioned above, we will also be creating a community collaboration process toolkit that will detail the research aspect of this entire process and the details for how to engage community authentically. This toolkit will be developed in alignment with the County Community Engagement Toolkit. It will be shared with any interested partners internally as well as across the jurisdiction to take and adapt as relevant to their own efforts.

APPENDIX

List of existing community meetings—*Limited to the knowledge of the workgroup*

UMOJA Health (North and South County)- BACHAC and UCSF
Community Service Area (CSA)- OneEPA
Belle Haven Climate Change Community Team (CCT)- Climate Resilient Communities
East Palo Alto Substance Abuse Prevention Coalition- OneEPA
East Palo Alto Mental Health Advisory Group- OneEPA
UndocuSupport Initiative- Redwood City Together
Welcoming Redwood City Workgroup- Redwood City Together
Climate Ready North Fair Oaks- Climate Resilient Communities

List of community events—*Limited to the knowledge of the workgroup*

Thanksgiving and Christmas parties at the Menlo Park Senior Center
Weekly food distribution with Nuestra Casa
Monthly food distribution with Coastside Hope

List of community stakeholders—*Limited to the knowledge of the workgroup*

ALAS
Anamatangi
Bay Area Community Health Advisory Council (BACHAC)
Belle Haven Action
Calvary Church in Redwood City
Casa Circulo Cultural
Catholic Charities San Francisco
Coastside Hope
Daly City Youth Health Center
El Concilio of San Mateo County
EPA Seventh Day Adventist Church
Faith in Action
Healthways
Knights of Columbus
Multicultural Institute
Nuestra Casa
OCA Peninsula Chapter of San Mateo County
One East Palo Alto
Peninsula Family Service

Puente
Redwood City Together
Redwood City Mandarin Immersion Scholars
San Bruno Chinese Church
San Mateo Union School district
Samoan Solutions
Second Harvest Food Bank
Self Help for the Elderly
Senior Coastsiders
St. Mt. Carmel Church
Starvista
Tauluma for Tongans
YMCA South San Francisco
Youth Community Service
Youth Leadership Institute