

COMMUNITY HEALTH IMPROVEMENT PLAN

2026 – 2028

A HEALTHIER, MORE
EQUITABLE MARIN
FOR ALL



HEALTHY MARIN
PARTNERSHIP



COUNTY OF MARIN
HEALTH & HUMAN SERVICES
MARIN COUNTY PUBLIC HEALTH

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1. Executive Summary

Marin County is often recognized as the healthiest county in California. That distinction is well-earned, but it does not tell the full story. In 2025, Marin ranked 15th among California counties for racial disparity.¹ Black residents have an average life expectancy that is 12 years shorter than that of Asian residents.² Latino children are eight times more likely to live in poverty than white children.³ Residents of Marin City, the Canal neighborhood in San Rafael, and agricultural communities in West Marin face disproportionate burdens across nearly every health indicator. Marin’s overall rankings do not reflect everyone who lives here, and this plan is a commitment to change that.

The 2025 Community Health Assessment (CHA), conducted by Healthy Marin Partnership (HMP) through analysis of over 85 health indicators, interviews with 21 community leaders, and focus groups with 33 residents, identified six priority health needs.⁴ The 2026–2028 Community Health Improvement Plan (CHIP) focuses coordinated action on *four selected focus areas* drawn from the six CHA-identified priorities:

Focus Area		Core Work
	1. Access to Coverage & Care	Strengthen coordinated access to care through coverage protection, CHW expansion, care coordination, and healthcare workforce development.
	2. Chronic Disease & Disability	Improve chronic disease and disability outcomes through equitable access to nutrition, preventive care, healthy aging supports, oral health services, tobacco prevention, and culturally responsive community-based programs.
	3. Behavioral Health	Advance behavioral health and well-being through prevention, early intervention, treatment, recovery supports, stigma reduction, and coordinated community-based care.
	4. Climate Action	Improve community preparedness, climate resilience, and environmental health equity through coordinated emergency response, trusted community partnerships, and resident-led initiatives.

Housing instability and economic insecurity are recognized as foundational upstream drivers and are woven in as cross-cutting commitments throughout all four focus areas.

This plan is developed and implemented through Healthy Marin Partnership (HMP). Marin County Public Health (MCPH) serves as the backbone organization. A CHIP Steering Committee provides strategic oversight, and annual progress reports will be made publicly available.

Successful implementation of the CHIP will require coordinated investment alongside coordinated action. HMP and its partners will pursue a sustainable financing approach that aligns public health funding, hospital community benefit investments, managed care plan resources, philanthropy, and state and federal funding opportunities to advance shared priorities. Where appropriate, partners will leverage braided and blended financing strategies and maximize existing reimbursement opportunities, including Medi-Cal and CalAIM, to strengthen community-based services, support trusted community partners, and build the long-term infrastructure needed to improve health and advance equity in Marin County.

Equity is not a separate chapter in this plan — it is the organizing principle running through every goal, strategy, and measure.

About Healthy Marin Partnership

Healthy Marin Partnership (HMP) is Marin County's collective impact collaborative, bringing together healthcare providers, community organizations, public agencies, schools, businesses, and residents to improve health and advance equity. Since 1995, HMP has coordinated community health assessment and improvement planning and serves as the governance structure for implementation of this CHIP.

2. Purpose & Context

Purpose of the Community Health Improvement Plan

The purpose of the Community Health Improvement Plan (CHIP) is to provide a shared, community-driven roadmap for improving health and advancing equity in Marin County. Grounded in findings from the 2025 Community Health Assessment (CHA), the 2026-2028 CHIP translates data and community input into coordinated strategies, measurable goals, and collective action across sectors.

The CHIP aligns the efforts of Marin's public agencies, healthcare providers, community-based organizations, schools, businesses, and residents around common priorities. By establishing shared accountability, tracking progress, and fostering cross-sector collaboration, the CHIP ensures that resources are used effectively and that strategies address the root causes of the health challenges our community faces.

Ultimately, the CHIP serves as a living framework that guides sustained action, promotes transparency, and drives measurable improvements in health and well-being for all Marin County residents.

How the Community Health Improvement Plan Will Be Used

This plan focuses on four priority areas identified through the Community Health Assessment (CHA): Access to Coverage & Care, Chronic Disease and Disability, Behavioral Health, and Climate Action. These focus areas were selected based on their impact on health equity, community input, and alignment with local data, systems capacity, and readiness for action.

The CHIP serves as a roadmap for coordinated, cross-sector implementation and directly supports the Marin Health and Human Services (HHS) Strategic Plan: advancing racial equity, improving community conditions, strengthening partnerships, and using data to drive decisions. Together, these efforts will drive measurable progress toward a healthier, more equitable Marin for all residents.

Alignment with County, State, and Community Priorities

The 2026-2028 CHIP reflects and reinforces a broader set of county, state, and community commitments to equity-driven, accountable public health practice. It is closely aligned with the HHS Strategic Plan and supports priorities identified by the Marin County Board of Supervisors, including housing, racial equity, climate resilience, emergency preparedness, and community and economic vitality.

The CHIP is also central to Marin County Public Health's national Public Health Accreditation (PHAB), demonstrating adherence to standards for community health assessment, planning, and continuous quality improvement.

Rather than creating new workstreams, the CHIP is designed to align and strengthen existing planning efforts across sectors. It complements state initiatives, hospital community benefit strategies, managed care planning, and community-led plans, creating opportunities to leverage shared investments, coordinate implementation, and maximize collective impact.

Key aligned frameworks and initiatives include:

- **Marin County Race Equity Action Plan (REAP)** serves as the equity framework governing all CHIP strategies. First adopted by the Board of Supervisors in 2017, renewed in 2022, and led by the Marin County Office of Equity, REAP addresses Marin's racial inequities through a systems-change approach centered on economic opportunity, housing, and mental health.
- **California's Behavioral Health Services Act (BHSA)** requires Marin County Behavioral Health and Recovery Services to align its planning with Marin County Public Health's CHA/CHIP process, connecting mental health, substance use, and social determinants strategies across county departments.
- **DHCS CalAIM** requires Kaiser Permanente and Partnership HealthPlan of California, Marin's Medi-Cal managed care plans, to participate in and contribute resources to the CHA/CHIP process. CHIP priorities and community health data also inform managed care population health strategies and investments in Enhanced Care Management, Community Supports, and community-based care.
- **California's Master Plan for Aging** establishes statewide goals related to health, housing, caregiving, social connection, and economic security. In Marin, the Area Agency on Aging leads this work. The CHIP intentionally aligns with and supports implementation of the Local Master Plan for Aging through shared strategies, performance measures, and community partnerships.
- **Community partner strategic plans and collaborative initiatives**, including First 5 Marin's strategic priorities, Canal Promise Neighborhood, Marin Promise Partnership, the Marin County Nutrition Security Plan, Community Resiliency Team initiatives, hospital Community Health Needs Assessment (CHNA) implementation strategies, and other partner-led efforts. The CHIP strengthens coordination across these initiatives while respecting each organization's unique mission, governance, and funding responsibilities.

Together, these alignments position the CHIP as a shared framework for collective action, connecting partners around common priorities, shared accountability, and coordinated action to improve health and advance equity throughout Marin County.

Plan Timeframe and Intended Impact

The 2026–2028 CHIP outlines a three-year roadmap for coordinated action. By the end of 2028, the CHIP aims to demonstrate measurable improvements in key health indicators, strengthened cross-sector collaboration, increased alignment of resources and strategies, and meaningful progress in addressing the root causes of health inequities. This timeframe allows for sustained implementation, continuous learning, and mid-course adjustments through a planned 2027 mid-cycle review.

3. Guiding Principles and Framework

VISION

All Marin County residents live long, healthy lives, and disparities in life expectancy based on race, ethnicity, income, and geography are eliminated.

Core Values

These values guide the purpose of this plan and the outcomes it is intended to achieve.

EQUITY AND JUSTICE: Health is a human right. In Marin County, outcomes vary significantly by race, ethnicity, income, and geography. Every person deserves the opportunity to achieve their highest level of health. We are committed to eliminating avoidable and unjust health disparities.

COMMUNITY LEADERSHIP: Lasting solutions are built with communities, not for communities. Residents and community-based organizations are essential partners in shaping priorities and decisions.

COLLECTIVE IMPACT: Complex health challenges require shared responsibility, coordinated action, and sustained collaboration across public agencies, healthcare systems, schools, community-based organizations, businesses, and residents.

PREVENTION: Investing upstream to address the conditions that shape health helps build healthier communities and reduces inequities over time.

Guiding Principles for Implementation

These principles describe how partners will work together to implement this plan and achieve lasting systems change.

EQUITY-CENTERED: Use equity data, community voice, and culturally responsive practices to prioritize communities experiencing the greatest inequities.

COMMUNITY-LED: Engage residents and community-based organizations as partners in planning, implementation, evaluation, and decision-making.

SYSTEMS-FOCUSED: Advance policy, systems, and environmental changes that address root causes, strengthen cross-sector collaboration, and improve population health rather than relying primarily on individual-level interventions.

UPSTREAM PREVENTION: Address the social, economic, and environmental conditions that shape health by strengthening protective factors, reducing risk factors, and investing in prevention and early intervention.

COLLABORATIVE: Align strategies, resources, financing, and accountability across public agencies, healthcare organizations, community partners, and residents.

TRANSPARENT AND ACCOUNTABLE: Use shared measures, publicly report progress, and continuously improve based on data and community feedback.

TRAUMA-INFORMED: Promote trust, safety, dignity, and healing by recognizing the impacts of historical and ongoing trauma.

Life Course Approach

Where appropriate, the strategies, objectives, and activities within the 2026-2028 CHIP are informed by the Life Course Health Development Framework, a widely recognized public health model developed through decades of research by organizations including the U.S. Centers for Disease Control and Prevention (CDC), the Maternal and Child Health Bureau (MCHB), and leading public health researchers.

The Life Course Model recognizes that health is shaped by the cumulative influence of biological, social, economic, environmental, and structural factors throughout life, beginning before birth and continuing into older adulthood. Experiences and exposures during critical periods of development can influence health and well-being for years to come, while protective factors and timely interventions can improve outcomes across the lifespan. Guided by this framework, the CHIP prioritizes coordinated investments in prevention, early intervention, equitable access to care, healthy aging, and community conditions that support health across the lifespan.

Systems Transformation for Collective Impact

The Community Health Improvement Plan is more than a collection of strategies and activities, it is a commitment to transforming how organizations work together to improve community health. Achieving the goals outlined in this plan will require more than new programs or additional funding. It will require partners across sectors to strengthen collaboration, align resources, and adopt approaches that prioritize prevention, equity, and long-term sustainability.

Several shifts in how we work together are essential to achieving meaningful and lasting change:

From reacting to preventing. Partners commit to investing in upstream prevention and early intervention whenever possible, recognizing that addressing the root causes of poor health, including housing instability, food insecurity, economic hardship, social isolation, and structural inequities, reduces the need for more costly downstream services and improves health across the lifespan.

From siloed systems and organizational priorities to shared accountability. Improving community health requires organizations to move beyond traditional boundaries and individual organizational priorities. Partners will align around shared goals, measures, and investments while coordinating policies, practices, and decision-making processes wherever possible to reduce barriers, strengthen service delivery, and improve shared outcomes.

From fragmented funding to coordinated investment. Sustainable implementation depends on aligning public, private, healthcare, and philanthropic resources to support shared priorities. Partners will pursue opportunities to braid and align funding streams, maximize existing reimbursement mechanisms where appropriate, and invest in community infrastructure that benefits multiple sectors.

From disconnected systems to coordinated care. Residents experience health and social services as one system, regardless of organizational boundaries. Partners will continue strengthening care coordination, data sharing, referral pathways, and trusted community-based navigation to improve access and reduce barriers to care.

From institutional decision-making to community partnership. Community members and community-based organizations bring essential expertise about the conditions affecting health. Their leadership, lived experience, and ongoing participation are critical to designing, implementing, and evaluating effective solutions.

From short-term initiatives to sustained systems change. While individual projects may begin with time-limited funding, the long-term objective is to strengthen policies, partnerships, financing strategies, workforce capacity, and community infrastructure that endure beyond any single grant or planning cycle.

These shifts reflect the collective commitment of Healthy Marin Partnership members to advance health equity through coordinated action, continuous learning, and shared responsibility for improving the health and well-being of all Marin County residents.

Equity Framework

Marin County's health equity approach recognizes that current disparities are rooted in structural inequities shaped by institutional racism, exclusionary policy, and delayed government action.⁵ These inequities have deep historical roots. The health impacts of colonization on Coastal Miwok and other Indigenous peoples began with dispossession, forced labor, and cultural disruption during the Spanish mission period in the late 18th and early 19th centuries.⁶

For more than eight decades, community members, including Black residents in Marin City, farmworkers in West Marin, and immigrant communities in the Canal, have led equity efforts, often without adequate government support. Beginning with efforts to challenge segregation and discriminatory labor practices, including the landmark 1944 case *James v. Marinship*,⁷ this work expanded over the decades to include civil rights era activism, fair housing advocacy, redevelopment initiatives in Marin City,⁸ support for Vietnamese refugees following the fall of Saigon,⁹ and participation in the Sanctuary Movement.¹⁰ During this period, immigrant-led organizing and mutual aid networks became foundational to the Canal neighborhood.⁹ This legacy of community-led resilience continues today. Newer arrivals, including growing Asian immigrant communities and refugees from Ukraine and other displacement contexts, are establishing roots in Marin, bringing distinct needs, strengths, and organizing traditions that will shape the county's equity work in the years ahead.⁵

These community-driven efforts persisted despite structural barriers embedded in housing, education, and economic systems. Notably, explicitly racist policies such as racially restrictive covenants remained legal until 1968, and their impacts continue to shape inequities today.¹¹ Indigenous communities have sustained ongoing efforts to preserve land, culture, and sovereignty, while farmworkers and immigrant communities have organized for labor rights, housing, and access to services.¹²

In 2018, Marin County HHS released its *Strategic Plan to Achieve Health and Wellness Equity*, establishing a countywide roadmap centered on racial equity. The plan marked a significant shift in aligning programs, policies, and resources toward more equitable outcomes. Building on the County's 2017 Racial Equity Action Plan, this work also marked a turning point for the CHIP, shifting it to explicitly center racial equity as a guiding framework for priorities, strategies, and implementation.

This history underscores a central principle of Marin County's equity framework: *those most impacted by inequities have long been leading the work to address them*. The County's recent plans represent an institutional commitment to align with and support these community-led efforts. Advancing health equity requires not only addressing present-day disparities but also acknowledging and dismantling the structural conditions that produced them, in partnership with the communities most affected. This framework guides the CHIP's focus areas and strategies, ensuring they are rooted in equity, informed by community voice, and designed to achieve measurable reductions in disparities across Marin County.

4. Community Engagement & Planning Process

The 2026–2028 CHIP was developed through a structured, equity-centered planning process convened by Healthy Marin Partnership and Marin County Public Health. The process drew directly from the 2025 Community Health Assessment, which included:

- Analysis of over 85 health indicators
- Key informant interviews with 21 community leaders
- Focus groups reaching 33 residents representing Spanish-speaking, LGBTQ+, and Black/African American communities

Partners from healthcare, education, public health, community-based organizations, and county agencies participated in priority-setting, strategy development, and review. Community Resiliency Teams (CRT) and community members contributed local knowledge and lived experience to ensure strategies, goals, and activities reflect the needs of communities most impacted by health inequities.⁴

Community voice is not a one-time input — it is an ongoing governance commitment. Community Resiliency Team (CRT) lead agencies are co-implementers of this plan, and a CRT Executive Director serves as co-chair of Healthy Marin Partnership.

Community Profile

Marin County is a medium-sized, geographically diverse county of approximately 260,000 residents, located north of San Francisco on the ancestral lands of the Coast Miwok people, who have inhabited this region for thousands of years. Most residents live in affluent suburban cities and towns along the Highway 101 corridor, while the county's western edge stretches to a rugged Pacific coastline and rural agricultural lands. This geography shapes not only the landscape but the distribution of resources, opportunity, and health. The county's population is also notably older, with a median age of 46.5 and nearly one in four residents 65 or older.³

Marin is one of the wealthiest counties in the United States, yet it is the fourteenth most racially unequal in California. Residents of the Canal neighborhood in San Rafael, Marin City, and the farmworker and rural communities of West Marin experience health outcomes far worse than the county average. The life expectancy gap between Marin City and the most affluent areas of the county is as large as 17 years. A disparity rooted in race, disinvestment, and decades of exclusionary policy. Distance from services, limited transit, and housing instability compound these inequities in coastal and agricultural areas. These same communities are home to many of Marin's immigrant residents, whose labor, mutual aid, and civic organizing have long shaped the county's economic and cultural life.

Community Snapshot

Marin County sits at the intersection of remarkable assets and persistent inequities. Understanding both is essential context for this plan.

Who Lives Here³

- Approximately 260,000 residents across urban, suburban, coastal, and agricultural geographies
- 22% of residents are over age 65 (median age 46.8 vs. 36.5 statewide), one of the oldest county populations in California
- 20.2% of residents over age five speak a language other than English at home; 18.6% were born outside the United States
- Largest racial/ethnic groups: White non-Hispanic (72%), Hispanic/Latino (16%), Asian (5%), Black/African American (3%)
- Canal neighborhood (San Rafael), Marin City, and agricultural West Marin are home to the largest concentrations of Latino, Black, and immigrant residents

Strengths and Assets

- Marin County is home to hundreds of community-based organizations with a longstanding commitment to improving health, advancing equity, and supporting community well-being
- Marin residents demonstrate high levels of civic engagement and advocacy, with a long history of community organizing, volunteerism and participation in local decision-making
- The County of Marin, guided by Board of Supervisors priorities that align with this CHIP, including housing, racial equity, climate resilience, emergency preparedness, and economic vitality, works in partnership with community-based organizations to maintain a strong and responsive safety net.
- HMP has operated since 1995 as one of California's most sustained collective impact collaboratives in public health
- Five CRTs provide trusted, place-based outreach and coordination across Marin County. Each team serves a specific geographic area, working closely with government, healthcare, and community partners to improve access to services and advance CHIP priorities.
- Strong philanthropic infrastructure led by the Marin Community Foundation (e.g., Marin Funders' Network) that provides flexible funding that public systems cannot
- High educational attainment and income levels countywide support health literacy and access to care for many residents
- Extensive open space, trail networks, and coastal access support physical activity for residents with geographic and economic access

Persistent Disparities

- Latino children are 8x more likely to live in poverty than white children (19.2% vs. 2.6%); 34.6% of Black children live in poverty¹³
- Marin ranked 15th most racially disparate county in California in 2025, despite its top 3 overall health ranking¹
- Marin City and the Canal neighborhood face compounded disadvantages: higher housing cost burden, environmental health risk, and barriers to care access

The *2025 Community Health Assessment* (available at HealthyMarin.org) provides the full data foundation for this plan. This snapshot provides the essential context needed to understand why the four selected focus areas were prioritized and for whom. Because community conditions and health indicators continue to evolve, newer data have been included where available to supplement the assessment and provide a more up-to-date picture of key health issues.

About Healthy Marin Partnership

Healthy Marin Partnership (HMP) was established in 1995 to create a unified, countywide approach to the state-mandated Community Health Needs Assessment (CHNA). Kaiser Permanente, MarinHealth Medical Center, and Novato Community Hospital (Sutter Health) were founding members, and their long-standing co-investment in Marin's collective health planning infrastructure is the foundation on which this CHIP is built. This collaborative model was strengthened by the regulatory requirements in Affordable Care Act, and deepened through the COVID-19 pandemic response, which demonstrated the power of cross-sector collaboration. By 2024, HMP had evolved to meet new federal and state challenges, including threats to Medicaid and core health equity infrastructure.

HMP is advancing its role as a collective action platform by expanding cross-sector membership, deepening authentic community engagement, and bringing diverse partners together to align around shared priorities and improve health and well-being in Marin County. Membership includes organizations representing healthcare, community-based organizations, public agencies, education, business, and philanthropy.

5. Community Health Assessment Summary

The 2025 Marin County CHA confirms that Marin’s strong overall health rankings mask deep and persistent inequities. Key findings include:

- Black residents have a life expectancy of 78.6 years — 12 years shorter than Asian residents at 90.7 years²
- Latino residents have the highest uninsured rates in the county at 5.7%, compared to 2.0% for white residents¹⁴
- 60% of Black Medicare beneficiaries have hypertension, signaling gaps in early detection and management¹⁵
- Marin’s suicide death rate (14.4 per 100,000) exceeds the California average (10.5)¹⁶
- While overdose deaths are declining, overdose is still one the leading causes of death for Marin County residents aged 55 and under, with fentanyl driving nearly half of all overdose deaths¹⁷
- 22% of Marin adults report binge or excessive drinking, compared to 18% statewide¹⁸

The CHA identified six priority health needs, listed in priority order:⁴

CHA Priority	Description
1. Housing & Homelessness	Promote housing stability, prevent homelessness, strengthen tenant protections
2. Access to Care	Ensure timely, affordable, culturally responsive access for all residents
3. Mental & Behavioral Health	Expand trauma-informed, culturally appropriate services for all age groups
4. Climate & Environmental Health	Protect public health from climate risks; invest in resilient infrastructure
5. Chronic Disease & Disability	Reduce chronic disease burden; reduce racial disparities
6. Income & Employment	Advance economic equity; increase access to living wages and job benefits

Community Health Improvement Plan Focus Areas

Four of the six CHA-identified priority areas were selected for action in the CHIP based on the severity and breadth of community need, the strength of existing partnerships, and the potential for measurable progress over the next three years. The CHIP focus areas are Access to Coverage & Care, Chronic Disease and Disability, Behavioral Health, and Climate Action

Housing instability and economic insecurity, CHA priorities one and six, are addressed as cross-cutting drivers of health equity and are integrated across all focus areas.

6. Governance Structure

The 2026–2028 CHIP transitions from MCPH-led workgroups to a fully integrated HMP governance model, representing a significant maturation of Marin’s collective impact approach.

Governance Hierarchy

Layer	Body	Function
Governance	HMP General Membership HMP CHIP Steering Committee HHS CalAIM Steering Committee	Strategic oversight, priority-setting, progress review
Coordination	HMP Workgroups and Implementation Teams	Annual work planning, cross-sector coordination, reporting
Implementation	HHS, CRTs, Community Based Organizations, healthcare providers	Direct community-level implementation and outreach
Backbone	Marin County Public Health	Coordination, data infrastructure, accountability, admin support

HMP CHIP Steering Committee

To strengthen strategic oversight and coordination, a CHIP Steering Committee has been established as part of the HMP infrastructure. The Steering Committee will:

- Guide countywide priority-setting and strategy alignment
- Ensure alignment with the Health and Human Services Strategic Plan
- Uphold the principles of the Performance Management framework
- Monitor shared performance measures and systems-level outcomes
- Review annual CHIP progress reports and approve mid-cycle adjustments

Meeting cadence: Quarterly. Composition includes HMP co-chairs, implementation leads, MCPH leadership, managed care plans, and hospital partners. Kaiser Permanente, MarinHealth Medical Center, and Novato Community Hospital (Sutter Health), as founding members of HMP, serve on the Steering Committee, ensuring their community benefit planning cycles are aligned with and informed by this CHIP.

Workgroups and Implementation Teams

Each focus area is supported by designated workgroup(s) and/or implementation team(s) responsible for developing annual work plans, coordinating activities across partners, and reporting progress to the Steering Committee.

Focus Area	Implementation Team Leads
 1. Access to Coverage & Care	Aliados Health (ACC Workgroup backbone agency) / BluePath Health (HMP Healthcare Workforce Development Initiative)
 2. Chronic Disease & Disability	Marin Area Agency on Aging / Public Health / Emergency Medical Services
 3. Behavioral Health	Marin County Behavioral Health and Recovery Services / Public Health
 4. Climate Action	CRTs Lead Agencies / Marin City Climate Resilience / Nuestro Canal, Nuestro Futuro (Canal Alliance)

Meeting cadence: Implementation teams and aligned workgroups meet monthly or bi-monthly, depending on scope and stage of work. These groups may lead new strategies or advance existing efforts and report progress through the plan's governance structure. Annual work plans are developed each fall with mid-year progress reviews each spring.

Community Resiliency Teams

CRTs are trusted, community-rooted organizations anchoring implementation in five zones across Marin County (Southern Marin, San Rafael, West Marin, Novato, and Central Marin). CRTs are not merely participants; they serve as co-designers and co-implementers of this work.

Backbone Organization: Marin County Public Health (MCPH)

Marin County Public Health serves as the backbone organization for the CHIP, providing coordination, data infrastructure, performance measurement, and administrative support. MCPH stewards the overall CHIP process, ensures alignment with CHA findings, supports cross-sector engagement, and maintains a structured, data-driven approach to planning and implementation. MCPH also maintains the Clear Impact Scorecard and Healthy Marin data dashboard used to track CHIP progress. Hospital Implementation Strategies are adopted by each hospital's governing board, posted publicly on their respective websites, and filed publicly with the IRS (Form 990, Schedule H), creating a parallel accountability structure that complements CHIP annual progress reporting and strengthens collective transparency to the community.

7. Cross-Cutting Strategies

Several strategic priorities cut across all four focus areas. These are not add-ons — they are the connective tissue of the CHIP. Without them, focus-area strategies lose effectiveness, and equity commitments remain aspirational.

1. Data Sharing, Equity Dashboards, and Shared Measurement

Shared measurement is a core principle of collective impact. This CHIP commits to tracking and using indicators disaggregated by race, ethnicity, language, geography, and other equity dimensions whenever possible and to making that data visible and actionable.

- Maintain and update the Healthy Marin data dashboard and Performance Management Scorecards on a quarterly basis
- Advance a unified care coordination framework that positions HHS and affiliated human services agencies as an integrated, client-centered system that supports Medi-Cal billable services and enables seamless coordination through a Community Information Exchange (CIE)
- Strengthen data exchange infrastructure (i.e., Data Exchange Framework [DxF]) and shared information flows across healthcare and social service partners to support coordinated, data-driven population health management
- Use disaggregated data to inform resource allocation and drive equitable decision-making

2. Community Engagement Infrastructure

Authentic community engagement is an ongoing governance commitment, not a planning-phase activity. This CHIP embeds community voice through CRT governance, resident-led processes in the Canal and Marin City, and HMP annual meetings and community forums.

- Maintain CRT lead agency representation within HMP governance
- Support resident-led planning and engagement processes: Nuestro Canal, Nuestro Futuro, and Marin City Climate Resilience
- Gather and incorporate ongoing community feedback through CRT outreach, HMP stakeholder convenings, and the annual HMP meeting
- Sustain investment in community-based organizations, Community Health Workers (CHWs) and Promotores as trusted bridges between systems and communities

3. Policy Advocacy

Many of the health disparities documented in the CHA are the direct result of policy decisions. This CHIP supports evidence-informed policy advocacy as a legitimate and necessary strategy at the local, state, and federal levels.

- Monitor and respond to federal Medicaid, public benefits, and public health funding changes
- Monitor, align with, and facilitate implementation of local policy actions that address key drivers of health, including tobacco and other substance use, housing stability, and climate-related health risk

- Align with state policy frameworks: CalAIM, BHSA, Master Plan for Aging
- Advocate for CHW and safety-net provider workforce funding sustainability
- Advocate for the funding and policy conditions that make safety-net infrastructure viable across Community Health Improvement Plan (CHIP) cycles

4. Sustainable Financing: Braiding, Blending, and Resource Alignment

Why this Matters

Sustainable financing is not solely about securing additional funding; it is about aligning existing investments across partners to advance shared priorities and maximize collective impact. Achieving the goals of the CHIP requires coordinated investment that leverages public, private, philanthropic, and healthcare resources. Rather than relying on isolated grants, partners will braid and blend funding where appropriate to reduce duplication, strengthen long-term sustainability, and support coordinated implementation.

Braided and Blended Financing

- Align County funding, hospital community benefit investments, managed care plan community reinvestment, philanthropy, and state/federal grants.
- Coordinate investments around shared CHIP priorities.
- Pursue joint funding opportunities.

Maximizing Medi-Cal Financing

- Expand use of Medi-Cal reimbursement opportunities.
- Support CalAIM ECM and Community Supports.
- Explore reimbursement for CHWs, Family Advocates, peer support specialists, and other community-based workforce.
- Encourage integration of CHW functions into existing roles where appropriate to improve sustainability.

Shared Backbone Infrastructure

- Sustain backbone coordination.
- Support shared data infrastructure.
- Maintain implementation support across workgroups.

Continuous Funding Alignment

- Annual review of funding landscape.
- Identify funding gaps.
- Coordinate advocacy around financing priorities.

5. Housing and Economic Security as Cross-Cutting Commitments

Housing instability and economic insecurity, CHA priorities one and six, are upstream drivers of every health priority in this plan. While the CHIP does not have stand-alone focus areas for housing and income, these factors are integrated into strategies across all four areas:

- Access strategies address housing-related barriers to care (transportation, fear, instability)
- Chronic disease strategies explicitly frame nutrition security in terms of economic justice

- Behavioral health strategies recognize housing instability and poverty as root drivers of mental health burden
- Climate strategies prioritize communities facing concentrated poverty and displacement risk

Hospital community benefit investment is one concrete expression of this cross-cutting commitment: Novato Community Hospital invests in short-term residential care to help patients experiencing housing insecurity heal and transition to stable housing, and MarinHealth Medical Center supports housing navigation for patients experiencing homelessness through its emergency department and care coordination programs. These hospital-based strategies complement CHIP cross-sector housing efforts and will be coordinated through the HMP Steering Committee.



FOCUS AREA 1

Access to Coverage & Care

Access is more than coverage.

It means being able to find, reach, afford, and navigate trusted care when it is needed.

Community Goal

Ensure equitable, timely, affordable, and culturally responsive access to health coverage and care for all Marin County residents, while protecting essential services and strengthening coordinated systems of care.



Coverage

Insurance and benefit continuity



Navigation

Trusted, culturally responsive support



Coordinated Care

Connected health + social systems



Workforce

Pathways into the future care workforce



Data & Information Sharing

Cross-sector infrastructure for coordinated referrals + care

8. Focus Area 1: Access to Coverage & Care



Why This Matters

Equitable access to health coverage and care is the foundation of community health. Without coverage, people delay care, skip medications, and arrive in emergency rooms with conditions that could have been prevented or managed. Without care that is culturally responsive, affordable, and easy to navigate, coverage alone is not enough. Timely access to preventive care, primary care, and trusted community-based services can prevent disease progression, reduce avoidable hospitalizations, and improve health outcomes across the lifespan.

In the 2025 CHA, access to coverage and care ranked as the second highest priority health need countywide, and among communities most impacted by barriers, it ranked first. Marin's access landscape faces new and accelerating threats: federal and state policy changes enacted in 2025 are reducing Medi-Cal coverage for thousands of California residents, and safety-net providers face workforce shortages, cost pressures, and funding uncertainty.

What We Know: Key Data

- Marin's uninsured rate is 3.5%, but Latino residents experience uninsured rates of 5.7% vs. 2.0% for white and 1.4% for Asian residents¹⁴
- Approximately 1 in 4 Marin residents are enrolled in Medi-Cal¹⁹
- Covered California no longer covers undocumented immigrants. Medi-Cal has also frozen new full-scope enrollments for undocumented adults (19+); those already enrolled can stay covered if they renew on time.^{20, 21, 22}
- Black residents average 78.6 years vs. 90.7 for Asian residents — a 12-year structural inequity in life expectancy²
- 20.2% of residents speak a language other than English at home; bilingual/bicultural providers are in critically short supply²³

Access to Coverage & Care Strategies & Objectives

Strategy 1.1: Establish countywide leadership and governance for Access to Coverage & Care

- **Objective 1.1.1:** By April 30, 2026: Adopted a shared, equity-centered definition of Access to Coverage & Care, approved by HMP CEOs, to guide CHIP strategy development and implementation.
- **Objective 1.1.2:** By April 30, 2026: Secured Board of Supervisors approval for Managed Care Plan (MCP) funding to support backbone coordination for this focus area.
- **Objective 1.1.3:** By March 31, 2026: Establish a dual governance structure for Access to Coverage & Care:
 - The HHS HR1 Work Group serves as the lead government body for policy alignment, CalAIM implementation, and departmental coordination across County priorities

- The HMP Access to Coverage & Care (ACC) Workgroup serves as the cross-sector partner body, incorporating the Marin CalAIM Collaborative and engaging health systems, community-based organizations, and managed care plans.
- Across both bodies, Marin HHS and Public Health serve as strategic and policy co-backbone, retaining authority for policy direction, funding stewardship, and regulatory compliance; Aliados Health serves as backbone agency for ACC Workgroup operations, responsible for convening, facilitation, partner coordination, and community implementation.
- **Objective 1.1.4:** By December 31, 2026: Establish an integrated reporting and accountability framework linking the HR1 Work Group and ACC Workgroup to shared performance indicators, targets, and partner accountability structures, reviewed quarterly by both bodies and reported annually to the HMP Steering Committee.
- **Objective 1.1.5:** By June 30, 2027: Implement a cross-sector data-sharing approach to monitor coverage, access, and equity indicators in near real-time, connecting government and community partners across the unified care coordination architecture.

Strategy 1.2: Protect Medi-Cal coverage and close coverage gaps for the most vulnerable populations

- **Objective 1.2.1:** By May 31, 2026: Finalize and adopt Medi-Cal performance indicators in partnership with Marin HHS, establishing the baseline measurement framework for coverage continuity and equity tracking across the HR1 Work Group and ACC Workgroup.
- **Objective 1.2.2:** By June 2026: Develop and implement a targeted communications plan to reach affected residents through trusted community channels.
- **Objective 1.2.3:** By December 31, 2026: Launch a targeted retention campaign reaching at least 500 uninsured or underinsured residents; integrate CHW/Promotores outreach through the First 5 Marin-led network to support application assistance, renewals, and coverage navigation.

Strategy 1.3: Strengthen safety-net infrastructure, expand Community Health Worker (CHW) capacity, and increase CalAIM Benefit utilization among populations of focus

Joint Managed Care Plan (MCP) Population Needs Assessment (PNA) & Local Health Jurisdiction Priority

CHWs and Promotores serve as trusted bridges between health systems and underserved communities by helping navigate language and cultural barriers, coordinating care, and extending the reach of services across all focus areas. Strengthening CHW infrastructure has been identified as a county priority through local CalAIM planning and community needs assessment efforts. In alignment with the DHCS Bold Goals, Partnership HealthPlan of California, Kaiser Managed Care Plan, First 5 Marin, and Marin County Public Health developed a joint strategy with First 5 Marin designated as the lead coordinating entity. This strategy focuses on sustaining countywide CHW infrastructure, expanding training and coordination capacity, embedding CHWs across focus areas, and supporting long-term financing and integration into care systems.

- **Objective 1.3.1:** By December 31, 2026: First 5 Marin will establish a CHW Hub serving 0–5-year-olds and their families and will lead CHW recruitment, training, convening, coordination, professional development and communications.

- **Objective 1.3.2:** By December 31, 2026: Marin County Public Health, in partnership with First 5 Marin, will provide CHWs with education on childhood vaccines and changes in Medi-Cal eligibility requirements.
- **Objective 1.3.3:** By December 31, 2027: Partner with Kaiser and Partnership to assess the impact of CHW services on early childhood preventive care.

STRATEGY 1.4: Improve youth and Transitional Age Youth (TAY) awareness of and navigation into healthcare career pathways to strengthen the future healthcare workforce and support access to care.

- **Objective 1.4.1:** By April 30, 2026, complete a youth- and equity-centered assessment of healthcare career pathways, programs, and barriers.
- **Objective 1.4.2:** By May 31, 2026, engage employers and develop youth-informed healthcare career pathway maps for priority entry-level roles.
- **Objective 1.4.3:** By May 31, 2026, develop youth-centered tools and resources to support awareness of and navigation into healthcare career pathways.
- **Objective 1.4.4:** By May 31, 2026, develop a youth-informed healthcare workforce roadmap that includes coordinated partner roles, funding strategies, a coalition model, and a shared evaluation framework.
- **Objective 1.4.5:** By October 31, 2026, convene youth, transition-age youth (TAY), healthcare providers, educators, workforce organizations, and community partners to review roadmap recommendations, identify Year 1 implementation priorities, and explore funding and backbone coordination needs to support ongoing healthcare workforce pathway efforts in Marin County.
- **Objective 1.4.6:** By December 31, 2027: Expand career pathways, especially in the healthcare sector, for Canal-based high school and college students. (Canal Promise Neighborhood).

STRATEGY 1.5: Strengthen cross-sector data infrastructure and information sharing to improve coordinated access to care

- **Objective 1.5.1:** By September 30, 2026, complete a comprehensive assessment of Marin County's current technology, data, and referral infrastructure across health care, behavioral health, social services, community-based organizations, and homelessness-serving systems, including stakeholder engagement, workflow mapping, and identification of opportunities and barriers to interoperability.
- **Objective 1.5.2:** By March 31, 2027, develop and obtain endorsement from the HMP Access to Coverage & Care Workgroup of a countywide Community Information Exchange roadmap that identifies governance recommendations, priority use cases, implementation options, and phased next steps for improving coordinated referrals and whole-person care.
- **Objective 1.5.3:** By December 31, 2028, launch one or more pilot use cases for cross-sector electronic referrals and closed-loop care coordination among participating health care, community-based, and County partners, with evaluation measures to inform future expansion.

Performance Indicators: Access to Coverage & Care

Indicators are reviewed according to the reporting frequency outlined in the table by the Objective Lead and relevant stakeholders, with an annual review conducted by the HMP Steering Committee. Whenever possible, data are disaggregated by the demographic and geographic characteristics identified in the table to identify disparities.

Indicator development is ongoing. For select indicators, baseline data are still being obtained or validated, and 2028 targets are being developed in collaboration with Objective Leads and relevant partners. These fields are identified as “Baseline pending” and/or “Target under development” and will be updated as data become available and targets are established. A CHIP performance dashboard is also under development to support ongoing monitoring of these indicators and progress toward CHIP objectives. The dashboard will be shared with CHIP partners and stakeholders to promote transparency, shared accountability, and data-informed decision-making throughout the implementation period.

INDICATOR	BASELINE	2028 TARGET	DATA SOURCE	REPORTING FREQUENCY	PLANNED DATA DISAGGREGATION
COVERAGE					
% OF UNINSURED MARIN RESIDENTS, OVERALL	3.8% (2020-2024)	Target under development	ACS 5-YR Estimates ¹⁴²³	Annual	Race/ethnicity, immigration status, geography
% OF UNINSURED LATINO MARIN RESIDENTS	11.1% (2020-2024)	Target under development	ACS 5-YR Estimates ¹⁴	Annual	Geography
# OF MARIN RESIDENTS ENROLLED IN MEDI-CAL	Baseline pending	Increase enrollment & retention; specific target under development	MMEF (Marin's Monthly Medi-Cal enrollment file)	Monthly	Race/ethnicity, geography, age, sex
ACCESS TO CARE					
PRIMARY CARE PROVIDER OFFICE VISIT UTILIZATION PER MEMBER PER YEAR FOR MEDI-CAL ENROLLEES	2.5 (2023)	Target under development	Partnership Health Plan	Annual	Race/ethnicity, geography
CHILD AND ADOLESCENT WELL-CARE VISITS	55.51% (2023)	Target under development	Partnership Health Plan – HEDIS-QIP	Annual	To be confirmed with data source
WELL-CHILD VISITS IN THE FIRST 15 MONTHS	48.69% (2023)	Target under development	Partnership Health Plan – HEDIS-QIP	Annual	To be confirmed with data source
WELL-CHILD VISITS FOR AGE 15 MONTHS–30 MONTHS	76.28% (2023)	Target under development	Partnership Health Plan – HEDIS-QIP	Annual	To be confirmed with data source
BREAST CANCER SCREENING (BCS-E)	58.02% (2023)	Target under development	Partnership Health Plan – HEDIS-QIP	Annual	To be confirmed with data source
CERVICAL CANCER SCREENING (CCS)	73.68% (2023)	Target under development	Partnership Health Plan – HEDIS-QIP	Annual	To be confirmed with data source
COMMUNITY ACCESS & NAVIGATION					
# OF TRAINED AND ACTIVE COMMUNITY HEALTH WORKERS CONNECTED TO THE FIRST 5 CHW HUB	Baseline pending	Target under development	First 5 Program Data	Quarterly	
# OF MEMBERS SERVED FOR COMMUNITY SUPPORTS SERVICES	Baseline pending	Target under development	Partnership Health Plan – HEDIS-QIP	Quarterly	Race/ethnicity, language, insurance group, age group, gender
# OF MEMBERS SERVED FOR ECM SERVICES	Baseline pending	Target under development	Partnership Health Plan – HEDIS-QIP	Quarterly	Race/ethnicity, language, insurance group, age group, gender

Key Partners

County Agencies

- Marin County Health and Human Services
 - Public Health
 - Behavioral Health and Recovery Services (BHRS)
 - Social Services
 - Homelessness and Coordinated Care

Healthcare Systems/Plans

- Kaiser Managed Care Plan
- Kaiser Permanente
- MarinHealth Medical Center
- Novato Community Hospital (Sutter Health)
- Partnership HealthPlan of California
- RotaCare

Community-Based Organizations/Networks

- Community Action Marin (CAM)
- Community Resiliency Team (CRT) Lead Agencies
 - BluePath Health
 - Canal Alliance
 - Marin County Cooperation Team
 - North Marin Community Services
 - San Geronimo Valley Community Center
 - West Marin Community Services
 - Marin Center for Independent Living (MCIL)

Education/Community Partners

- First 5 Marin: lead partner for the Community Health Worker (CHW) / Marin Promotores for Well Being

Technical/Support Partners

- Aliados Health: backbone agency for the Access to Coverage and Care (ACC) Workgroup and FQHC operational support
- BluePath Health
- Intrepid Ascent



FOCUS AREA 2

Chronic Disease & Disability Prevention

**Health is built
across the lifespan.**

Healthy environments, & community supports help people stay healthy, independent, & connected at every age.

Community Goal

Reduce the burden of chronic disease and disability by addressing racial disparities, expanding equitable care for older adults and addressing upstream drivers through coordinated, equity-driven prevention and management.



Nutrition Security

Healthy food access + addressing root causes of food insecurity



Healthy Aging

Independence, fall prevention + community supports



Oral Health

Early screening + connections to dental care



Tobacco Prevention & Policy

Prevention, policy change + reduced youth access



Community Based Linkages

Healthier community conditions at local levels

9. Focus Area 2: Chronic Disease & Disability



Why This Matters

Chronic disease and disability are the leading causes of death and diminished quality of life in Marin County — and their burden is not equally shared. Poor nutrition drives obesity, diabetes, and heart disease. Commercial tobacco is a leading cause of preventable illness. Poor oral health leads to lifelong complications. For older adults, falls are a major and preventable cause of injury and disability.

Marin has one of the oldest populations in California — 22% of residents are over age 65, with a median age of 46.8 — and that demographic reality is driving increasing chronic disease burden. Communities in the Canal, Marin City, low-income families, immigrants, and older adults face greater exposure to risk and fewer resources to prevent and manage disease.

The strategies in this focus area reflect a life course approach, recognizing that investments in nutrition, prevention, oral health, healthy aging, and community supports at every stage of life contribute to healthier outcomes across the lifespan.

What We Know: Key Data

- 22% of residents are over age 65; by 2030, one-third will be age 60 or older³
- Marin's Alzheimer's death rate (56 per 100,000) exceeds the state rate²⁴
- 60% of Black Medicare beneficiaries have hypertension — signaling gaps in early detection²⁵
- Poverty rates: Black children 34.6%, Latino children 19.2%, vs. white children 2.6%³
- Untreated dental caries is the most common chronic condition among children in Marin's low-income and immigrant communities²⁶
- Vaping and tobacco use among Marin adolescents now outpace state trends²⁷

Chronic Disease & Disability Strategies & Objectives

Strategy 2.1: Build a countywide nutrition security system grounded in racial and economic justice

- **Objective 2.1.1:** By June 30, 2027: Complete a countywide planning process and adopt a Nutrition Security Plan that reflects community input and supports a stronger local food system, reduces reliance on emergency food programs, and prepares for climate impacts.
- **Objective 2.1.2:** By June 30, 2028: Advance key initiatives from the Marin County Nutrition Security Plan, including securing funding (this objective will be revised once the Marin County Nutrition Security Plan is finalized).

Strategy 2.2: Develop a Marin Master Plan for Aging

- **Objective 2.2.1:** By December 31, 2026: Convene a cross-sector leadership group to inform Master Plan for Aging (MPA) development, aligned with California’s Master Plan for Aging.
- **Objective 2.2.2:** By June 30, 2027: Complete a community-informed MPA with equity-centered framework integrating health care, social services, housing, and community supports.
- **Objective 2.2.3:** By December 31, 2027: Adopt and begin implementation across County and partners.
- **Objective 2.2.4:** By June 30, 2028: Advance key initiatives from the Master Plan on Aging (MPA), including securing funding (this objective will be revised once the MAP is finalized).

Strategy 2.3: Establish Cross-System coordination between EMS and Aging & Adult Services for Fall Prevention and Recovery

- **Objective 2.3.1:** By June 30, 2026: Establish an EMS–Aging and Adult Services fall prevention and referral protocol.
- **Objective 2.3.2:** By December 31, 2026: Pilot a referral pathway from emergency medical responders to Aging and Adult Services to connect older adults with community-based services that support independent living and reduce unmet non-emergency needs.
- **Objective 2.3.3:** By June 30, 2027: Expand outreach for fall prevention in priority communities (Marin City, West Marin, low-income senior housing).

Strategy 2.4: Improve oral health through school-based screening and referral

- **Objective 2.4.1:** Through 2026–2028: Sustain school-based oral health screening program in partnership with Marin school districts, Marin Community Clinics, Marin Medical Reserve Corps, and local dentists, prioritizing schools serving the highest proportions of low-income, Medi-Cal, and immigrant children.
- **Objective 2.4.2:** By June 30, 2026: Assess impact of anticipated Prop 56 Denti-Cal funding reductions and develop contingency referral plan.
- **Objective 2.4.3:** By December 31, 2026: Establish a prioritized referral pathway from school screenings to dental care, reducing time from identification to treatment.

Strategy 2.5: Reduce the availability and use of tobacco products, particularly among youth and priority populations, through policy changes, prevention efforts, and community partnerships

- **Objective 2.5.1:** By September 20, 2026: Support all local jurisdictions to adopt the Minimum Floor Price ordinance, or a more restrictive tobacco prevention policy.
- **Objective 2.5.2:** By December 31, 2026: Conduct enforcement visits and provide community education to support Tobacco Retailer Licensing Ordinances that aim to reduce youth access to tobacco and nicotine products, including e-cigarettes and oral nicotine pouches.

- **Objective 2.5.3:** By December 31, 2027: Provide tobacco and nicotine prevention programming in family and youth-serving settings, prioritizing communities where youth tobacco use rates are highest and targeted industry marketing is most concentrated.
- **Objective 2.5.4:** By June 30, 2028: Engage the Marin County Board of Supervisors and all local jurisdictions in a community-informed policy conversation about Tobacco Endgame strategies.

Strategy 2.6: Improve chronic disease outcomes through community-based prevention and care linkages

- **Objective 2.6.1:** By December 31, 2026: Implement routine chronic disease screening (blood pressure, diabetes risk, and referrals) across community-based settings, including health fairs—in priority communities (Canal, Marin City, and West Marin) and ensure referral pathways to care.
- **Objective 2.6.2:** By June 30, 2027: Partner with community initiatives (e.g., Nuestro Canal, Nuestro Futuro; Marin City Climate Resilience) to use local data to inform neighborhood-level chronic disease prevention and health improvement strategies.
- **Objective 2.6.3:** By December 31, 2027: Expand access to culturally and linguistically appropriate chronic disease self-management education (e.g., diabetes prevention, hypertension management), delivered through community-based organizations, and clinical partners.
- **Objective 2.6.4:** By December 31, 2027: Strengthen the infant-toddler system of care by conducting bilingual, culturally informed focus groups to identify gaps in early childhood care and co-design solutions with sensitivity to mixed-status families, and by improving connections to early learning programs such as developmental playgroups, postpartum home visits, and childcare programs. (Canal Promise Neighborhood)
- **Objective 2.6.5:** By December 31, 2028: Increase the availability of center-based care for infants and toddlers in the Canal neighborhood as part of a mixed delivery system. (Canal Promise Neighborhood)

Performance Indicators: Chronic Disease & Disability

Indicators are reviewed according to the reporting frequency outlined in the table by the Objective Lead and relevant stakeholders, with an annual review conducted by the HMP Steering Committee. Whenever possible, data are disaggregated by the demographic and geographic characteristics identified in the table to identify disparities.

Indicator development is ongoing. For select indicators, baseline data are still being obtained or validated, and 2028 targets are being developed in collaboration with Objective Leads and relevant partners. These fields are identified as “Baseline pending” and/or “Target under development” and will be updated as data become available and targets are established. A CHIP performance dashboard is also under development to support ongoing monitoring of these indicators and progress toward CHIP objectives. The dashboard will be shared with CHIP partners and stakeholders to promote transparency, shared accountability, and data-informed decision-making throughout the implementation period.

Indicator	Baseline	2028 Target	Data Source	Reporting Frequency	Planned Data Disaggregation
NUTRITION SECURITY					
% Medi-Cal Births that Received Prenatal WIC	88% (July 2025-September 2025)	Target under development	WIC	Quarterly	Race/ethnicity
# of eligible residents enrolled in CalFresh	15,502 (2025)	Target under development	CalSAWS	Annual	Race/ethnicity
HEALTHY AGING					
Years of Potential Life Lost (Cardiovascular)	Baseline pending	Target under development	Vital Records	Annual	Geography, race/ethnicity
911 responses for falls (age 60+)	Baseline pending	Target under development	EMS	Quarterly	Geography, age
ORAL HEALTH					
% of Medi-Cal members receiving ≥1 preventive dental service annually	Baseline pending	Target under development	PHC QIP / DHCS Dental	Annual	Age, race/ethnicity, geography
% of Medi-Cal enrolled children ages 1 through 20 who received at least two topical fluoride applications	0.6% (2024)	Target under development	Partnership Health Plan	Annual	Age, race/ethnicity, geography
# of Children screened during MCPH oral health screening events in priority schools	1510 (2025)	Target under development	School-based program data	Annual	School, race/ethnicity, insurance
Untreated caries rate among children screened during MCPH oral health screening events in priority schools	342 (2025)	Target under development	School-based program data	Annual	School, race/ethnicity, insurance
TOBACCO AND NICOTINE					
Youth tobacco/nicotine use among 11th grade respondents, past 30 days	14% (2023-2025)	Target under development	CA Healthy Kids Survey	Biennial	Age, race/ethnicity, school
# of Marin County jurisdictions that have adopted one or more evidence-based tobacco retail ordinances (e.g., minimum price laws, sales restrictions, or product bans)	3 (2025)	Target under development	MCPH Tobacco Program	Annual	Geography
CHRONIC DISEASE PREVENTION AND SELF-MANAGEMENT EDUCATION					
HbA1c Poor Control (>9%)	Baseline pending	Target under development	Partnership Health Plan – HEDIS-QIP	Annual	Race/ethnicity, payer, geography
Blood Pressure Control (CBP)	62.07% (2023)	Target under development	Partnership Health Plan – HEDIS-QIP	Annual	Race/ethnicity, payer, geography
Colorectal Cancer Screening	Baseline pending	Target under development	Partnership Health Plan – HEDIS-QIP	Annual	Race/ethnicity, payer, geography
Breast Cancer Screening	58.02% (2023)	Target under development	Partnership Health Plan – HEDIS-QIP	Annual	Race/ethnicity, payer, geography

Key Partners

County Agencies

- Marin County Aging and Adult Services (AAS) / Area Agency on Aging (AAA)
 - Marin County Public Health (MCPH)
 - Community Health and Prevention (CHP): Nutrition Wellness, Oral Health, and Tobacco Prevention Programs
 - Emergency Medical Services (EMS)
 - Marin Medical Reserve Corps (MMRC)
- Marin Parks and Open Space District — FARE funding

Healthcare Systems/Plans

- Marin Community Clinics (MCC)
- MarinHealth Medical Center: Braden Diabetes Center, Integrative Wellness Center, and community grant programs
- Partnership HealthPlan of California

Community-Based Organizations/Networks

- Agricultural Institute of Marin
- Bay Area Community Resources (BACR)
- Canal Alliance - Nuestro Canal, Nuestro Futuro
- Community Resiliency Teams (CRT)
- ExtraFood
- Marin City Climate Resilience
- Marin Food Policy Council
- SF-Marin Food Bank
- Smoke-Free Marin

Education/Community Partners

- Marin County school districts and education partners

Technical/Support Partners

- None currently identified

Philanthropic Partners

- Marin Community Foundation



FOCUS AREA 3

Behavioral Health

Behavioral health is more than treatment.

Well-being is shaped by connection, prevention, timely support, treatment, and recovery across the lifespan.

Community Goal

Ensure equitable access to behavioral health care and coverage, across the lifespan, through prevention, early intervention, treatment and recovery.



Suicide Prevention

Protective factors, training + crisis response



Substance Use Prevention

Prevention, overdose reduction + harm reduction



Mental Health Wellness

Well-being and support across the lifespan



10. Focus Area 3: Behavioral Health

Why This Matters

Behavioral health encompasses both mental health and substance use and is shaped by far more than access to treatment alone. Housing stability, economic opportunity, social connection, trauma, and the availability of supportive systems all influence behavioral health and well-being throughout life. These conditions are not simply background context—they are fundamental drivers of health and equity.

Marin County's suicide death rate (14.4 per 100,000) exceeds the California average (10.5).²⁸ While drug overdose deaths are declining and fentanyl involvement in overdose deaths is decreasing, overdose remains one of the leading causes of death among Marin County residents age 55 and under.²⁹

Additionally, 22% of Marin adults report binge or excessive drinking, compared with 18% statewide.¹⁸ Marin youth report persistent sadness and hopelessness at levels that call for sustained action, while youth substance use rates consistently exceed state averages.²⁷

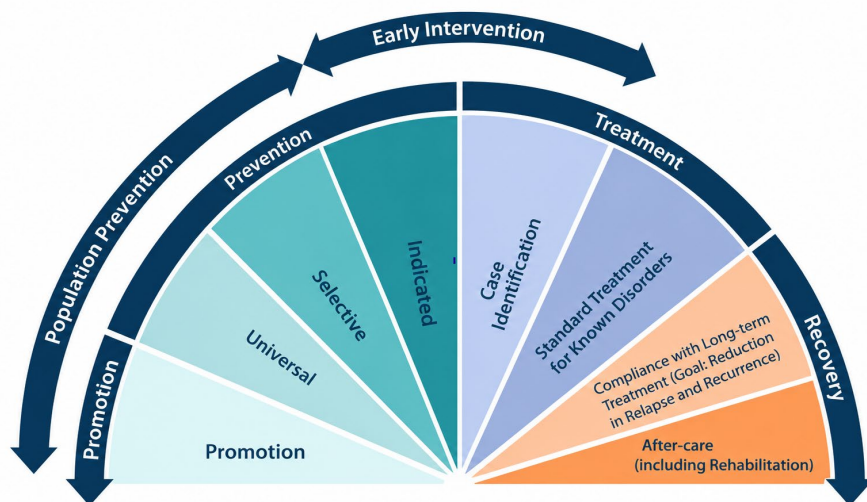


Figure 1: Infographic depicting the Continuum of Care Model, adapted from Institute of Medicine Continuum of Care Model³⁰

Guided by the Life Course Health Development Framework, this focus area recognizes that experiences across every stage of life—from childhood through older adulthood—influence lifelong behavioral health. The strategies and objectives are organized along the Continuum of Care, encompassing promotion, prevention, early intervention, treatment, and recovery. Together, these approaches emphasize strengthening protective factors, reducing risk factors,

preventing behavioral health challenges whenever possible, and ensuring timely access to appropriate care and recovery supports when needed.

The CHIP also strengthens coordination across the behavioral health system by aligning Community Health Assessment (CHA) and Behavioral Health Services Act (BHSA) priorities into a shared framework for action. Recognizing an evolving federal and state funding environment—including reductions in school-based mental health and other prevention-focused investments—partners will work collaboratively to preserve prevention and early intervention services, align resources, identify sustainable financing opportunities, and improve coordination across systems to better support children, youth, families, and adults across the lifespan.

What We Know: Key Data

Suicide

- Marin suicide death rate: 14.4 per 100,000 vs California average 10.5
- Firearms are used in 26% of all suicide deaths, and are the second leading means of suicides among males
- Males make up 3/4 (74%) of Marin County suicide deaths
- Females are about two times more likely than males to have an emergency department visit for self-harm injuries
- Black/African American residents and residents between the ages of 15-24 are over-represented among those having an Emergency Department visit for injuries from self-harm³¹

Overdose

- Overdose is one the leading causes of death for Marin County residents aged 55 and under, with fentanyl driving nearly half of all overdose deaths
- 22% of Marin adults report binge or excessive drinking vs 18% statewide
- White men ages 50 and older are disproportionately at risk of fatal overdose
- White men ages 19 to 49 are those most frequently experiencing non-fatal overdose
- In 40% of overdose deaths another person is present²⁹

Mental Wellness Across the Lifespan

- Black/African American residents and residents between the ages of 15-24 are over-represented among those having an Emergency Department visit for injuries from self-harm.
- Key informants shared that accessibility and cost of mental and behavioral health services are prohibitive particularly for those individuals who don't qualify for Medi-Cal or other low-income support and those who can't afford the high out-of-pocket cost of private care. Participants in the CHA reported seeing heightened levels of depression and anxiety in young people influenced by use of social media which disconnects them from reality and contributes to feelings of isolation.⁴

- During Marin’s initial 2004 Mental Health Services Act planning process, the adult Latino population was identified as the most underserved racial/ethnic population by the existing County Mental Health Services. Despite ongoing and substantial efforts over the years to address this, the disparity remains.³²
- Marin County has the oldest population of any county in the state, and it’s estimated that one-third of the local population will be 60 or older by 2030. There is a need for providers who specialize in providing mental health services for seniors over age 65 in Marin County.³³

Behavioral Health Strategies & Objectives

Strategy 3.1: Strengthen suicide prevention and intervention efforts with special focus on increasing protective factors, amplifying statewide campaigns, training and education, and crisis response.

- **Objective 3.1.1:** By December 31, 2028, increase participation in the Suicide Prevention Collaborative by 5–10% annually to strengthen community connections, reduce stigma surrounding mental health and suicide, and promote help-seeking behaviors during times of distress.
- **Objective 3.1.2:** By December 31, 2028, conduct 15 evidence-based suicide prevention and early intervention trainings (e.g., SP 101, Signs and Symptoms, Safety Planning, Psychological First Aid) for providers, educators, and advocates.
- **Objective 3.1.3:** By December 31, 2028, collect, coordinate, analyze and report annually on data related to suicide deaths, ED visits, self-injury/attempts, and mobile crisis response visits to inform surveillance and future programming.
- **Objective 3.1.4:** By December 31, 2028, increase impressions by 5% for two seasonal campaigns to raise awareness about warning signs, promote available resources, and increase help-seeking (e.g. 988 Learn our Stories, Hope and Help and Ask, Listen, Connect).

Strategy 3.2: Strengthen substance use supports and overdose prevention efforts while reducing related harms through a full continuum of care of evidence-based approaches, focused on youth, families, and the broader community.

- **Objective 3.2.1:** By June 30, 2027, develop an integrated HHS Substance Use Prevention Strategy that brings together OD Free Marin, the Marin Prevention Network, and school-based prevention efforts to better align current work, identify priority population gaps, and guide evidence-based substance use, overdose prevention, and harm reduction strategies in Marin.
- **Objective 3.2.2:** By June 30, 2027, establish a shared, county-wide protocol for identifying substance-affected infants and delivering Plans of Safe Care that includes clear roles and responsibilities and a reliable process for reporting aggregate data to Child Welfare in compliance with state statute.
- **Objective 3.2.2:** By June 30, 2027, identify and pilot implementation of new substance use intervention and treatment services in at least two public high schools.

- **Objective 3.2.3:** By June 30, 2028, evaluate the impact of county-wide communications and outreach efforts designed to reduce stigma associated with substance use disorder (including opioid use disorder) that increases understanding of the health conditions, promotes the continuum of care, and links residents to an array of local treatment, recovery, and support resources.

Strategy 3.3: Strengthen Mental Health Wellness Across the Lifespan

- **Objective 3.3.1:** By June 30, 2027, expand access to mental health services in communities of color by increasing the number of peer support groups in communities of color (in alignment with the Racial Equity Plan).
- **Objective 3.3.2:** By June 30, 2027, complete a plan to address older adults' health and wellness that focuses on strategies to decrease social isolation among caregivers, older adults of color, low-income older adults, and older women (in alignment with the Marin County Master Plan on Aging).
- **Objective 3.3.3:** By December 31, 2027, develop a new communication strategy that will successfully promote and amplify 1 statewide campaign (e.g. *Take Space to Pause* campaign, a public education and change campaign co-designed with youth to reduce stigma around behavioral health and increase help-seeking behavior and wellness support).
- **Objective 3.3.4:** By June 30, 2028, Marin youth within at least three public school districts are able to access an array of wellness services on campus through cross-agency partnerships.
- **Objective 3.3.5:** By December 31, 2027: Foster alignment between youth serving organizations and public agencies to enable all young people to access culturally responsive mental health care and services. (Canal Promise Neighborhood)
- **Objective 3.3.6:** By December 31, 2027: Provide comprehensive advising / case management to current high school students and graduates, ensuring they have a consistent connection to a trusted mentor who can provide holistic supports. (Canal Promise Neighborhood)
- **Objective 3.3.7:** By December 31, 2027: Create connective feedback loops between partner organizations to reliably direct parents, young adults, and community residents to relevant mental health resources and care providers. (Canal Alliance/Canal Promise Neighborhood: Nuestro Canal, Nuestro Futuro)

Performance Indicators: Behavioral Health

Indicators are reviewed according to the reporting frequency outlined in the table by the Objective Lead and relevant stakeholders, with an annual review conducted by the HMP Steering Committee. Whenever possible, data are disaggregated by the demographic and geographic characteristics identified in the table to identify disparities.

Indicator development is ongoing. For select indicators, baseline data are still being obtained or validated, and 2028 targets are being developed in collaboration with Objective Leads and relevant partners. These fields are identified as "Baseline pending" and/or "Target under

development” and will be updated as data become available and targets are established. A CHIP performance dashboard is also under development to support ongoing monitoring of these indicators and progress toward CHIP objectives. The dashboard will be shared with CHIP partners and stakeholders to promote transparency, shared accountability, and data-informed decision-making throughout the implementation period.

Indicator	Baseline	2028 Target	Data Source	Reporting Frequency	Planned Data Disaggregation
MENTAL HEALTH AND WELL-BEING					
Suicide death rate per 100,000	14.4 (2022)	Target under development	CDPH Vital Statistics	Annual	Age, sex, race/ethnicity
% of youth persistent sadness / hopelessness (11th grade)	32% (2023-2025)	Target under development	CA Healthy Kids Survey	Biennial	Race/ethnicity, LGBTQ+
% Likely has had serious psychological distress in past year	8.4% (2022-2024)	Target under development	CHIS	Biennial	Race/ethnicity, income, geography
# of Self-harm ED visits	185 (2024)	Target under development	HCAI	Annual	Age, race/ethnicity
SUBSTANCE USE AND OVERDOSE					
Drug overdose death rate per 100K	24 (2021-2023)	Target under development	CDPH Vital Statistics	Annual	Age, race/ethnicity
# of Drug-related ED visits	239 (2024)	Target under development	CDPH / OSHPD	Annual	Age, race/ethnicity
OD ED-visit rate	104 visits per 100,000 residents	Target under development		Annual	
# Marin County EMS responses to non-fatal overdoses	Baseline pending	Target under development	CDPH / EMS / OD Free Marin	Annual	Age, race/ethnicity
% of Medi-Cal beneficiaries with SUD receiving treatment	Baseline pending	Target under development	DHCS / MCP QIP	Annual	Race/ethnicity, payer
% of youth past-30-day alcohol / marijuana use (11th grade)	22% (2023-2025)	Target under development	CA Healthy Kids Survey	Biennial	Race/ethnicity
ACCESS TO CARE					
% of people with unmet behavioral health need	Baseline pending	Target under development	CHIS	Biennial	Race/ethnicity, income
% of Medi-Cal beneficiaries receiving behavioral health services	Baseline pending	Target under development	DHCS	Annual	Race/ethnicity, age
QUALITY AND FOLLOW-UP CARE					
% Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence	Baseline pending	Target under development	Partnership HEDIS - QIP	Annual	Race/ethnicity, payer
% Follow-Up After High-Intensity Care for Substance Use Disorder	Baseline pending	Target under development	Partnership HEDIS - QIP	Annual	Race/ethnicity, payer

Key Partners

County Agencies

- Marin County Behavioral Health and Recovery Services (BHRS)
- Marin County Public Health
 - Family Health Programs: Maternal Child and Adolescent Health (MCAH) and Healthy Families Marin
 - Marin County Suicide Prevention Collaborative
 - Marin Prevention Network
 - OD Free Marin: overdose prevention and naloxone training

Healthcare Systems/Plans

- Kaiser Permanente
- MarinHealth Medical Center: Behavioral Health Substance Use Navigator Program and ASPIRE Intensive Outpatient Program
- Novato Community Hospital (Sutter Health): trauma-informed prevention, crisis care, and post-stabilization services
- Partnership HealthPlan of California

Community-Based Organizations/Networks

- Community-based organizations serving residents across languages, cultures, and communities, including CRT Lead Agencies and partner organizations
- Marin Family Care Collective
- First 5 Marin
- Marin Promise Partnership

Education/Community Partners

- Marin County Office of Education (MCOE): Health, Safety, and Support Department
- People with lived experience of mental health and substance use challenges

Technical/Support Partners

- None currently identified



FOCUS AREA 4

Climate Action

Climate resilience is health resilience.

Prepared communities, trusted communication, and resident-led action protect health before, during, and after climate events.

Community Goal

Marin County residents — especially communities disproportionately impacted by climate change — are protected from climate-related health risks, prepared to respond to emergencies, and supported by resilient, equitable systems that keep them safe before, during, and after climate events.



Community-Centered Response

Trusted communication, preparedness + emergency response



Climate Resilience & Environmental Health Equity

Resident-led solutions that build healthier, more resilient communities



11. Focus Area 4: Climate Action

Why This Matters

Climate change is not a distant threat — it is already shaping health in Marin County. Extreme heat, wildfire smoke, flooding, power outages, and displacement worsen chronic health conditions, increase mental health burden, and disrupt access to care. And as with every health risk in Marin, the burden falls hardest on communities that have the fewest resources to prepare and recover: the Canal neighborhood, Marin City, older adults, agricultural workers, and residents without cars or savings.³⁴

This plan anchors climate health action in Marin’s five Community Resiliency Teams — trusted, community-rooted organizations already doing this work in every zone of the county. The trust they have built, the languages they speak, the doors they can knock on: that is the infrastructure this plan runs on.

What We Know: Key Data

- Marin City and the Canal neighborhood face disproportionate heat and air quality burdens³⁵
- Respiratory ED visits increase significantly during smoke events — with disparate impacts in low-income communities³⁶
- Older adults, residents with chronic conditions, agricultural workers, and linguistically isolated residents are at highest climate health risk³⁴
- Power outage vulnerability is concentrated in rural and low-income geographies^{37 38}

Climate Action Strategies & Objectives

Strategy 4.1: Strengthen community-centered communication, preparedness, and response for climate and all-hazards emergencies

- **Objective 4.1.1:** Through 2026–2028: Support CRTs to serve as trusted hyper-local communication and coordination partners before, during, and after climate and all-hazards emergencies by sharing timely preparedness, response, and recovery information between the County and communities and elevating community needs, concerns, and emerging conditions to County partners.
- **Objective 4.1.2:** By June 30, 2027: Deliver at least two all-hazards emergency preparedness trainings per year in each CRT zone.
- **Objective 4.1.3:** By December 31, 2027: Increase AlertMarin enrollment in each CRT zone through community-based outreach, preparedness education, and trusted messenger networks.
- **Objective 4.1.4:** During all wildfire smoke events through 2028: Deploy culturally and linguistically appropriate health messaging within 48 hours, in coordination with OEM and CRT partners.

Strategy 4.2: Advance place-based, community-led climate resilience and environmental health equity

- **Objective 4.2.1:** By June 30, 2026: In partnership with Marin City Climate Resilience, create a community-partnered process to gather, review, and respond to environmental risk and health outcome data for Marin City.
- **Objective 4.2.2:** By December 31, 2026: Support at least one resident-informed climate or environmental health action in Marin City that addresses a locally identified priority
- **Objective 4.2.3:** By June 30, 2027: Support at least one resident-informed climate or environmental health action through Nuestro Canal, Nuestro Futuro (Canal Alliance).
- **Objective 4.2.4:** December 31, 2028: Advance at least two climate related initiatives, one in Marin City and one in the Canal, as identified by the community-based process (this objective will be revised once the plans are created).

Performance Indicators: Climate Action

Indicators are reviewed according to the reporting frequency outlined in the table by the Objective Lead and relevant stakeholders, with an annual review conducted by the HMP Steering Committee. Whenever possible, data are disaggregated by the demographic and geographic characteristics identified in the table to identify disparities.

Indicator development is ongoing. For select indicators, baseline data are still being obtained or validated, and 2028 targets are being developed in collaboration with Objective Leads and relevant partners. These fields are identified as “Baseline pending” and/or “Target under development” and will be updated as data become available and targets are established. A CHIP performance dashboard is also under development to support ongoing monitoring of these indicators and progress toward CHIP objectives. The dashboard will be shared with CHIP partners and stakeholders to promote transparency, shared accountability, and data-informed decision-making throughout the implementation period.

Indicator	Baseline	2028 Target	Data Source	Reporting Frequency	Planned Data Disaggregation
CLIMATE EXPOSURE AND HEALTH					
Heat-related illness ED visit rate	Baseline pending	Target under development		Annual	Age, race/ethnicity, geography
Wildfire smoke exposure days (AQI >100)	Baseline pending	Target under development	EPA AirNow / Air District	Annual	Geography
Asthma ED visit rate	Baseline pending	Target under development		Annual	Race/ethnicity, age, geography
CLIMATE RESILIENCY AND PREPAREDNESS					
% residents prepared for extreme heat/wildfire	Baseline pending	Target under development	CHIS / Local survey	Biennial	Race/ethnicity, income
% of AlertMarin household subscribers in Marin County and within each CRT zone	Baseline pending	Target under development	AlertMarin Data - Marin County OEM	Quarterly	Geography
BUILT ENVIRONMENT					
% residents with access to parks/green space	Baseline pending	Target under development	CalEnviroScreen / GIS	Annual	Geography, income
% of commuters who ride a bicycle or walk to work	Baseline pending	Target under development	ACS / Transportation data	Annual	Geography, income
HOUSING AND ENVIRONMENTAL HEALTH					
% households with healthy housing conditions	Baseline pending	Target under development	ACS / Local surveys	Annual	Income, race/ethnicity
% low-income households with high energy burden	Baseline pending	Target under development	CPUC / Energy data	Annual	Income, geography
EQUITY					

Key Partners

County Agencies

- Community Development Agency (CDA)
- Marin County Office of Emergency Management (OEM)
- Marin County Public Health
 - Epidemiology Team
 - Public Health Preparedness (PHP)
- Marin County Social Services: Aging and Adult Services (AAS)
- Homelessness and Coordinated Care (HCC)
- Office of the County Executive: Climate Division

Healthcare Systems/Plans

- None currently identified

Community-Based Organizations/Networks

- Canal Alliance: Nuestro Canal, Nuestro Futuro
- Community Resiliency Team (CRT) Lead Agencies
- Fire Safe Marin
- Marin City Climate Resilience: Marin City Health Initiative
- Marin Volunteer Organizations Active in Disasters (VOAD)
- ReadyMarin

Education/Community Partners

- None currently identified

Technical/Support Partners

- None currently identified

12. Implementation Plan

The 2026–2028 CHIP is designed to contribute to durable systems change, not just program delivery. Strategies emphasize sustainability by building community-owned infrastructure, strengthening workforce pipelines, leveraging multi-year funding, and advancing policy and regulatory changes that extend beyond individual grant cycles.

Implementation is coordinated through HMP’s governance structure and carried out by cross-sector partners, workgroups, and initiatives. Leadership varies by strategy and objective based on partner expertise, capacity, and alignment. Each objective identifies a lead partner responsible for action planning, implementation coordination, and progress reporting to the HMP CHIP Steering Committee and broader partnership.

Implementation Timeline: 2026–2028

Phase	Key Activities
Phase 1: Launch (Jan–Jun 2026)	Convene all Implementation Teams Adopt governance structures and annual work plans Establish data baselines Launch Year 1 strategies Secure initial funding streams
Phase 2: Implement (Jul 2026–Jun 2027)	Full strategy implementation underway Quarterly indicator reviews Implementation Team bi-monthly meetings Mid-year Steering Committee check-in Community forums and CRT engagement
Phase 3: Mid-Cycle Review (Jul–Dec 2027)	Full mid-cycle review of all focus areas Assess progress against measurable objectives Identify emerging needs Adjust strategies as warranted Publish Year 1 progress report
Phase 4: Deepen & Document (2028)	Continued implementation with refined strategies Intensified focus on lagging indicators Document systems changes and sustainability plans Prepare 2026–2028 final assessment to inform next CHIP cycle, along with the 2028 CHA findings

Governance Meeting Cadence

- **HMP Community Health Improvement Plan (CHIP) Steering Committee:** Bi-Monthly (strategic oversight, progress review, resource alignment)
- **Implementation Teams:** Monthly or bi-monthly (action plan development, implementation coordination)
- **Annual Work Planning:** Fall (Objective Teams develop following-year work plans)
- **Mid-Cycle Review:** 2027 (strategic assessment of all focus areas)

Sustainable Financing and Resource Alignment

Achieving CHIP goals requires coordinated action and investment. HMP will work with partners to align public, private, philanthropic, and healthcare resources; leverage existing funding; pursue new opportunities; and reduce duplication.

HMP will encourage **braided and blended financing approaches** where appropriate, aligning complementary funding streams while respecting organizational funding requirements and accountability structures. This approach can strengthen coordination, flexibility, and long-term investment in community health.

Key financing strategies include:

- **Aligning funding with shared priorities** by coordinating hospital community benefit, managed care plan community reinvestment, County, state and federal, and philanthropic resources around CHIP strategies when feasible.
- **Leveraging Medi-Cal transformation opportunities**, including CalAIM, Enhanced Care Management (ECM), Community Supports, Community Health Worker (CHW) and Promotor(a) services, peer support, and other reimbursement pathways.
- **Supporting sustainable community-based workforce models** by integrating reimbursable functions into trusted community roles and organizations where feasible, reducing reliance on short-term grants and expanding cultural and linguistically responsive services.
- **Maintaining shared backbone infrastructure** to support cross-sector coordination, data and performance measurement, community engagement, and implementation.
- **Pursuing collaborative funding opportunities** that can be jointly developed and supported across partners to maximize resources and community impact.
- **Planning for long-term sustainability** by regularly assessing implementation needs, identifying future funding gaps, and developing strategies to sustain successful approaches beyond individual funding cycles.

Recognizing the evolving policy and fiscal landscape, HMP will continue to monitor federal and state funding and policy changes, including those affecting Medi-Cal, the Behavioral Health Services Act (BHSA), and other public health financing, and work with partners to adapt and sustain CHIP priorities over time.

13. Performance Measurement & Evaluation

Progress toward CHIP goals will be tracked using a shared set of population-level indicators, strategy-specific performance measures, and implementation milestones, reviewed regularly by implementation leads and reported annually to HMP and the public.

Equity Lens on Data

Where possible, indicators will be disaggregated by race, ethnicity, language, geography, and other equity dimensions to ensure disparities are visible and drive resource allocation. Data that cannot be disaggregated will be flagged as a data gap and addressed in the Limitations section and through future data infrastructure investment.

Review Cycle

Review Level	Who / When / Purpose
Quarterly Indicator Review	Implementation Teams review progress indicators against targets; flag concerns; adjust short-term activities
Annual Strategic Review	HMP Steering Committee reviews annual progress report; makes strategic adjustments; approves revised work plans
2027 Mid-Cycle Review	Full assessment of all focus areas against 2026–2028 objectives; may result in strategy changes or resource reallocation
Public Annual Report	Published annually on HMP website; distributed to community partners, residents, funders, and Board of Supervisors

Course Correction Protocol

Indicators and performance measures will be reviewed quarterly by Implementation Teams and annually by the Steering Committee to guide strategy adjustments. If an indicator or performance measure shows inadequate progress, the Objective Team responsible will:

1. Document the gap and contributing factors at the next quarterly meeting
2. Propose a course correction within 60 days
3. Present the adjusted strategy to the Steering Committee for approval
4. Track the corrected strategy at the next quarterly cycle

The measure of this work is not a document. It is whether Marin City residents breathe cleaner air, whether Canal families have a plan when the next emergency comes, whether fewer people are left behind — and we will keep working until that is what the data shows.

14. Accountability & Community Communication

Transparency and accountability to the community are core commitments of this CHIP. Marin County Public Health and HMP will publish annual progress reports summarizing key indicators, strategy updates, and equity outcomes.

Public Reporting

- Annual CHIP progress reports — published on HMP website and shared with community partners, residents, and the public
- Equity scorecards for each focus area — published annually
- Performance Management Scorecards by Focus Area — continuously updated and accessible to partners
- HMP website and data dashboard — In development, to be launched in Fall 2026

Community Feedback Channels

- Community Resiliency Team outreach — ongoing, in all five zones
- Stakeholder convenings — convened by Implementation Teams
- Resident voice processes — Nuestro Canal, Marin City Climate Resilience

HMP is committed to communicating not just what is working, but where progress is falling short and what the partnership is doing about it. Resident voice, particularly from communities most impacted by health disparities, will inform mid-course adjustments and future planning cycles.

15. Limitations & Known Gaps

HMP is committed to transparency about the limitations of this plan and the gaps that remain. Acknowledging these is not a sign of failure — it is a precondition for genuine accountability.

Data Gaps

- Community Profile subsections (Demographic Trends, Environmental Context, Community Assets) require updating with 2025 CHA data before final publication
- Several indicators cannot currently be disaggregated by all equity dimensions due to data collection limitations
- Baseline data for some new strategies (e.g., CHW workforce map, behavioral health referral wait times) will need to be established in Year 1

Community Engagement Gaps

- While CRTs and community voice are central to this plan, representation from all communities most impacted by health disparities, including agricultural workers, monolingual Spanish and indigenous language speakers, and older adults, remains incomplete and will be strengthened during implementation
- Future planning cycles should deepen engagement with LGBTQ+ communities, people with disabilities, and monolingual non-Spanish speakers

Policy & Fiscal Uncertainty

- Federal Medicaid funding changes, SNAP reductions, and public health infrastructure cuts create significant uncertainty for strategy sustainability
- California's Proposition 56 Denti-Cal funding reductions may affect oral health strategy viability
- CalAIM implementation timelines and funding availability may affect Chronic Disease and Behavioral Health strategies

Resource Constraints

- Implementation depends on funding streams that are not all currently secured — including CHW workforce expansion, behavioral health peer support, and nutrition security planning
- The high cost of living in Marin creates structural workforce barriers that no health system investment alone can overcome
- Backbone organizational capacity at MCPH is a real constraint that may limit the pace of implementation

16. Conclusion & Call to Action

This plan is a commitment — to the residents of Marin County, to the partners who have worked to build it, and to the communities who have trusted us with their voices and their needs.

The work ahead is real and urgent. Families are making impossible choices between rent and health care. Youth are navigating mental health crises without enough support. Older adults are aging in a county that does not yet have the systems they need. And the communities that have always carried the most are still bearing the heaviest burden of risk.

Marin County has the partnerships, the data, the infrastructure, and the community to do better. This **CHIP** is the roadmap. What it requires now is consistent follow-through: showing up for the communities most impacted, tracking what matters, adjusting when the data demands it, and being transparent about both progress and shortfalls.

We invite every resident, organization, and community leader in Marin to join this work. HMP is the table where that collaboration happens. It is open, it is accountable, and it is working — because a healthier, more equitable Marin depends on all of us.

Connect & Get Involved

Residents, organizations, schools, healthcare providers, and businesses all play a role in improving health and advancing equity in Marin County. Here are some ways to learn more and find opportunities to get involved:

- Participate in Community Resiliency Team (CRT) activities, emergency preparedness trainings, and neighborhood outreach efforts in your local geographic zone.
- Join resident engagement opportunities through Canal Alliance's Nuestro Canal, Nuestro Futuro and Canal Promise Neighborhood initiatives.
- Volunteer with local organizations supporting food security and healthy living, including SF-Marín Food Bank and ExtraFood.
- Participate in overdose prevention, naloxone training, and substance use prevention efforts through OD Free Marin.
- Support youth mental health and wellness initiatives through Marin County school districts, Marin County Office of Education, and community-based youth organizations
- Participate in suicide prevention awareness and training opportunities, including our Men and Boys Group that aims to redefine strength, through the Marin County Suicide Prevention Collaborative.
- Engage with local climate resilience and preparedness efforts through Fire Safe Marin, ReadyMarin, Marin Volunteer Organizations Active in Disasters (VOAD), and Marin City Climate Resilience initiatives.
- Sign up for AlertMarin to receive emergency notifications, evacuation information, and public safety alerts related to wildfires, flooding, extreme weather, and other emergencies in Marin County.

- Partner with trusted community organizations to support culturally responsive outreach and resource navigation (e.g with Community Health Workers/Promotores).
- Support older adults and people with disabilities through volunteer and community engagement opportunities with Vivalon, Marin Center for Independent Living, and Aging and Adult Services.
- Collaborate with Marin Promise Partnership, First 5 Marin, schools, and youth-serving organizations to support educational success, early childhood well-being, and family resilience.
- Advocate for policies and investments that improve housing stability, healthcare access, transportation, behavioral health services, environmental health, and economic opportunity across Marin County.

To learn more about current initiatives, volunteer opportunities, and community partnerships, visit Healthy Marin Partnership’s website, HealthyMarin.org, and other partner organization websites.

Appendices

Appendix A: Formal Adoption Page

This Community Health Improvement Plan for Marin County (2026–2028) was developed collaboratively through Healthy Marin Partnership, with community and stakeholder engagement grounded in the 2025 Community Health Assessment. It was formally adopted by Healthy Marin Partnership on [DATE OF ADOPTION].

Authorized Signatures

[Name, Title — Marin County Health Officer] Date: _____

[Name, Title — HMP Co-Chair] Date: _____

Note: PHAB Measure 5.2.2A requires formal adoption of the CHIP by the health department's governing entity. This page must be completed with actual signatures and date before submission for accreditation documentation.

Appendix B: Glossary of Terms and Acronyms

The following terms and acronyms appear throughout this plan. For additional definitions, see the [2025 Marin County Community Health Assessment](https://www.healthymarinpartnership.org/) ([HealthyMarinPartnership.org](https://www.healthymarinpartnership.org/)).

Term / Acronym	Definition
AAA	Area Agency on Aging — federally designated entity responsible for planning, coordinating, and administering services for older adults and adults with disabilities under the Older Americans Act; in Marin County, this designation is held by Aging and Adult Services (AAS)
AAS	Marin County Aging and Adult Services — county division responsible for services to older adults and adults with disabilities; Implementation Lead for Chronic Disease & Disability focus area
Aliados Health	Regional association of Marin’s community health centers; backbone agency for the HMP Access to Coverage and Care (ACC) Workgroup; embedded operational support across coverage continuity, workforce, and technology implementation
BAAQMD	Bay Area Air Quality Management District — regional agency regulating air quality; provides AQI data and wildfire smoke alerts
BHRS	Marin County Behavioral Health and Recovery Services — county division under Health and Human Services (HHS) providing mental health and substance use services; Implementation Lead for Behavioral Health
BHSA	Behavioral Health Services Act — California state legislation (2024) restructuring behavioral health funding and delivery
CalAIM	California Advancing and Innovating Medi-Cal — statewide Medi-Cal transformation initiative including enhanced care management and community supports
CAHPS	Consumer Assessment of Healthcare Providers and Systems — standardized survey for patient experience measurement
CalEnviroScreen	OEHHA/CalEPA environmental justice screening tool that scores California census tracts by pollution burden and population vulnerability
CBO	Community-Based Organization — a nonprofit organization rooted in and serving a specific community
CHA	Community Health Assessment — a systematic process for identifying health needs, assets, and disparities in a defined population; conducted every 5 years per PHAB standards
CHNA	Community Health Needs Assessment — a systematic, data-driven process used by nonprofit hospitals to identify and prioritize community health needs, incorporating community input and public health data. Conducted at least every three years in accordance with IRS requirements (Affordable Care Act)
CHIP	Community Health Improvement Plan — a multi-year, collaborative plan that translates CHA findings into coordinated strategies and measurable goals
CHIS	California Health Interview Survey — the largest state health survey in the U.S.; provides county-level health data
CIE	Community Information Exchange — a system for sharing social determinants data across health and social services providers
CRT	Community Resiliency Team — place-based community networks that support health equity, community resilience, and coordinated implementation of public health initiatives, including the Community Health Improvement Plan (CHIP), across five geographic zones in Marin County.
DHCS	California Department of Health Care Services — state agency administering Medi-Cal and behavioral health programs
EMS	Emergency Medical Services — Agency of Marin County Public Health; Marin County’s prehospital emergency care system
FQHC	Federally Qualified Health Center — a federally designated safety-net clinic receiving enhanced Medi-Cal reimbursement

HCC	Homelessness and Coordinated Care – division of Marin Health and Human Services that supports individuals experiencing homelessness through coordinated services, housing resources, and cross-system care.
HCAI	California Health Care Access and Information — state agency managing hospital discharge and outcomes data (formerly OSHPD)
HHS	Health and Human Services - The County of Marin's largest department, organized as an integrated agency encompassing Administration and Planning, Behavioral Health and Recovery Services (BHRS), Homelessness and Coordinated Care, Public Health, and Social Services.
HIE	Health Information Exchange — secure electronic sharing of patient health information across providers
HMP	Healthy Marin Partnership — the countywide collective impact collaborative that governs the CHIP
KP	Kaiser Permanente — integrated health care system serving a large share of Marin residents
MCP	Managed Care Plan — a health plan contracted with DHCS to administer Medi-Cal benefits
MCOE	Marin County Office of Education
MCPH	Marin County Public Health — division of Marin HHS; backbone organization for the CHIP
MOU	Memorandum of Understanding — a formal written agreement between partner organizations
NAICS	North American Industry Classification System — used in some tobacco retailer density analyses
OEM	Marin County Office of Emergency Management
PHAB	Public Health Accreditation Board — the national accrediting body for state, local, and tribal public health departments
PHC	Partnership HealthPlan of California — Medi-Cal managed care plan serving Marin County
REAP	Marin Race Equity Action Plan — county framework for advancing racial equity across all departments
RBA	Results-Based Accountability — performance management framework used by Marin HHS to track population-level outcomes
SDOH	Social Determinants of Health — the non-medical factors (housing, income, education, environment) that influence health outcomes
SNAP	Supplemental Nutrition Assistance Program — federal food assistance program
VOAD	Voluntary Organizations Active in Disaster — network of nonprofits coordinating disaster response

Appendix C: Framework Alignment Crosswalk

This crosswalk shows how each CHIP focus area and cross-cutting strategy aligns with major county, state, and national frameworks. ✓ = direct alignment; — = not directly applicable.

CHIP Focus Area / Strategy	Marin HHS Strategic Plan	CA Master Plan for Aging	CalAIM	BHSA	REAP
Access to Coverage & Care	Advance Racial Equity; Cross-Sector Collaboration	—	Enhanced Care Mgmt; CS Funding	—	Health Equity; Access
Chronic Disease & Disability	Improve Community Conditions	Aging in Place; Alzheimer's	Enhanced Care Mgmt	—	Economic Equity
Behavioral Health	Advance Racial Equity; Community Conditions	—	Behavioral Health Carve-in	SUD/MH Transformation	Mental Health Equity
Climate Action	Cross-Sector Collaboration	Climate & Aging	—	—	Environmental Justice
CHW & Promotores Infrastructure	Workforce Development	Workforce Pipeline	ECM Community Health Workers	Peer Support	Community Leadership
Policy Advocacy	All Goals	All Goals	All	All	All REAP Pillars
Housing & Economic Security (cross-cutting)	Advance Racial Equity	Affordable Housing; Economic Security	Community Supports	—	Housing; Economic Equity

Appendix D: Hospital Partner Implementation Strategies

Background: Hospitals as Founding Partners

Kaiser Permanente San Rafael Medical Center, MarinHealth Medical Center, and Novato Community Hospital (Sutter Health) are **founding members of Healthy Marin Partnership**, established in 1995. For three decades, these hospitals have participated in Marin’s shared community health assessment infrastructure — the same data platform, the same community engagement process, and the same commitment to addressing the health needs of all Marin County residents.

As members of the HMP Community Health Improvement Plan (CHIP) Steering Committee, all three hospitals have a formal governance role in this plan. They participate in quarterly strategic oversight, contribute to shared performance measurement, and ensure their community benefit investments are coordinated with — not parallel to — **Community Health Improvement Plan (CHIP)** implementation. Their Implementation Strategies (IS) are adopted by their governing boards and filed publicly with the IRS (Form 990, Schedule H), providing a parallel accountability structure that reinforces CHIP public reporting.

All three hospitals used the same 2025 Community Health Needs Assessment data platform and process that produced this CHIP. Kaiser Permanente’s IS covers 2026–2028; MarinHealth’s IS covers 2026–2028; Novato Community Hospital’s IS covers 2025–2027. These overlapping cycles enable shared data baselines, aligned strategy development, and coordinated community benefit investment.

All three hospital Implementation Strategies independently identified Access to Care and Behavioral Health as top priorities — the same two CHIP focus areas where community need is most acute and the equity gap is widest. This convergence, grounded in shared data and community engagement, reflects strong alignment between hospital community benefit priorities and the four CHIP focus areas.

CHNA–CHIP Alignment Crosswalk

The table below maps each hospital’s Implementation Strategy priorities and programs to the four **Community Health Improvement Plan (CHIP)** focus areas and cross-cutting commitments. Where a hospital does not plan to address a focus area, this reflects deliberate prioritization based on organizational expertise and available resources — not a gap in the collective effort.

Kaiser Permanente San Rafael Medical Center IS Period: 2026–2028				
CHNA Priorities	CHIP Focus Areas	Key Programs & Strategies	Cross-Cutting Role	Not Addressed
1. Access to care 2. Mental & Behavioral Health 3. Income & Employment	FA 1: Access to Coverage & Care FA 3: Behavioral Health Cross-cutting: Workforce	• Equitable access & affordability (Medical Financial Assistance, Medi-Cal) • Culturally competent workforce development • SDOH investment in community organizations • Nutrition security (food banks, food access)	Workforce development investment supports CHW / Promotora pipeline across all focus areas	Chronic disease & disability Climate & environment Housing (standalone)
MarinHealth Medical Center IS Period: 2026–2028				
CHNA Priorities	CHIP Focus Areas	Key Programs & Strategies	Cross-Cutting Role	Not Addressed
1. Access to care 2. Chronic disease & disability 3. Housing & homelessness 4. Mental health & substance use	FA 1: Access to Coverage & Care FA 2: Chronic Disease & Disability FA 3: Behavioral Health Cross-cutting: Housing	• Financial assistance for uninsured / underinsured • Transportation & Rx medication support • MarinHealth Network Clinics (primary / specialty) • SDOH screening & referrals • Braden Diabetes Center • Integrative Wellness Center • BH Substance Use Navigator (ED-based) • ASPIRE IOP for adolescents (ages 12–17) • Housing navigation & care coordination • Community grant program (all needs)	Only hospital IS addressing all four CHIP focus areas plus housing cross-cutting commitment; ED-based navigator bridges acute care and community behavioral health	Climate & environment Income & employment
Novato Community Hospital (Sutter Health) IS Period: 2025–2027				
CHNA Priorities	CHIP Focus Areas	Key Programs & Strategies	Cross-Cutting Role	Not Addressed
1. Access to care 2. Mental & behavioral health including substance use	FA 1: Access to Coverage & Care FA 3: Behavioral Health Cross-cutting: Housing	• Short-term residential care for housing-insecure patients (heal & transition to stable housing) • Case management & wraparound services (health-related social needs) • Coordinated BH / SUD network: prevention, crisis care, post-stabilization, housing support, workforce development • Trauma-informed, culturally responsive service delivery	Short-term residential care is a direct hospital contribution to housing cross-cutting commitment; BH network investment spans prevention through post-stabilization	Housing & homelessness (standalone) Climate & environment Chronic disease & disability

Hospital Highlights: Programs with Direct Community Health Improvement Plan (CHIP) Synergy

Kaiser Permanente San Rafael Medical Center

Kaiser's IS focuses community benefit investment on three aligned priorities that map directly to CHIP Focus Areas 1 and 3. Its culturally competent workforce development strategy, investing in health professions education, training pipelines, and career exposure programs, directly supports the bilingual and bicultural workforce capacity that CHIP Access Strategy 3 (CHW/Promotora infrastructure) requires. Kaiser's SDOH investment in community organizations, through charitable contributions and technical assistance to safety-net providers and community-based organizations, supports CHIP cross-sector access strategies. Its income and employment priority reinforces the CHIP's cross-cutting economic security commitment, with particular relevance for Canal and Marin City residents.

MarinHealth Medical Center

MarinHealth's IS addresses all four CHIP focus areas plus the housing cross-cutting commitment. Three programs have direct CHIP strategy alignment:

1. **The Behavioral Health Substance Use Navigator Program** operating in the emergency department serves as an access point for uninsured and underinsured residents experiencing behavioral health or SUD crisis, bridging acute clinical care and community-based follow-up services that CHIP Behavioral Health Strategy 6 is designed to strengthen.
2. **The ASPIRE Intensive Outpatient Program** for adolescents ages 12–17 addresses the youth mental health gap targeted in CHIP Behavioral Health Strategy 3 and supports referral pathways from school-based identification.
3. **The Braden Diabetes Center and Integrative Wellness Center** providing free public nutrition classes and diabetes education, extend chronic disease prevention into clinical settings and complement community-based strategies in Focus Area 2.

Novato Community Hospital (Sutter Health)

NCH's IS includes two strategies with direct relevance to the CHIP's housing cross-cutting commitment. It's investment in short-term residential care for patients experiencing housing insecurity, supporting recovery from illness or injury and transition to stable housing, bridges acute clinical care and housing stability, directly supporting the CHIP's cross-cutting housing commitment. NCH's case management and wraparound services strategy, addressing health-related social needs in clinical and community settings, reinforces CHIP Access Strategy 3 (CHW/Promotora infrastructure) and supports clinical-community care coordination. Its coordinated BH/SUD network investment, spanning prevention through post-stabilization and including housing and vocational support, addresses the full continuum of behavioral health needs that CHIP Behavioral Health strategies target.

Coverage Analysis: Where Hospital Strategies Align with the Community Health Improvement Plan

Together, the three hospitals address all four CHIP focus areas, reflecting strong alignment between hospital community benefit investment and county health priorities. Two focus areas are led primarily by non-hospital partners, consistent with their programmatic strengths:

- **Focus Area 2: Chronic Disease & Disability:** MarinHealth directly addresses chronic disease through its IS priorities; Kaiser incorporates chronic disease through related IS strategies; NCH's priorities focus elsewhere. Primary implementation responsibility rests with MCPH, Aging and Adult Services, and community-based organizations — partners with deep expertise and infrastructure in this area.
- **Focus Area 4: Climate Action:** Climate and environmental health strategies are led by Community Resiliency Teams, OEM, and public health — entities best positioned to mobilize community assets and coordinate cross-sector response. Hospital partners have noted limited capacity to lead in this domain, reflecting a reasonable and appropriate division of effort.

This distribution of implementation roles reflects complementary strengths across the CHIP partnership rather than gaps in coverage. The Steering Committee should confirm these alignments annually and revisit assumptions as hospital IS priorities evolve.

This crosswalk will be reviewed annually by the CHIP Steering Committee to surface opportunities to align community benefit investment with mid-cycle CHIP findings and shifting community needs.

The three hospitals together have adopted IS strategies that collectively address every CHIP focus area and cross-cutting commitment. The HMP Steering Committee — with hospital representatives at the table — is the governance mechanism to move from aligned investment to coordinated strategy: identifying shared indicators, co-funding promising programs, and reducing duplication. The 2026 governance launch creates structural conditions for this coordination to happen systematically.

Implementation Strategy References

The following documents are the sources for this appendix. All are publicly available.

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