

# Metrics Meeting II – Northern Michigan CHIR

October 3, 2019

## Meeting Notes

After assessing health and wellbeing in Northern Michigan over the past year, we know that creating a thriving community will require focus on Mental Health, Substance Use, and Basic Needs of Living. At the meeting, we drafted shared, community-wide Visions and measures: the beginning pieces of a Community Health Improvement Plan (CHIP). We will need continued input to refine these Visions and measures and add to the plan with shared strategies and project measures. We will need input from everyone working on these issues and those whose lives are affected by them. In the end, we will have a robust, community-wide, action-oriented plan with a role for everyone to play in building our thriving community.



# Transportation

**Vision:** Every person has equitable and reliable transportation to live, work, play, and be physically active.

**Measures:**

% of people reporting transportation barriers

% of people reporting they have reliable transportation options that get them where they want to go

% of people who are physically active

**Goals for Change:**

Sustain and expand affordable and reliable transportation options regionally

**Measure (progress toward goal):**

# of communities that have expanded affordable/ reliable transportation options

**Goals for Change:**

Advocate for built environment that supports active transportation

**Measure (progress toward goal):**

# of communities with built environment policies

**Goals for Change:**

Increase equitable physical activity opportunities regionally

**Measure (progress toward goal):**

# of people reporting barriers to participate in physical activity



# Housing

**Vision:** Every person has safe, affordable, and accessible housing.

**Measures:**

% of people experiencing homelessness

% of households spending >30% of income on housing, or >45% of income on housing + transportation & utilities

% of people who report severe housing quality issues

% of people reporting their housing is “safe”

% people reporting a supportive, trusted network

**Goal for Change:** Expand eviction diversion court program throughout the 10 counties

**Goal for Change:** Develop and enforce a quality standard of housing that all rental properties and landlord assoc. must meet

**Goal for Change:** Increase affordable housing units

**Measure (progress towards goal):** % of people evicted from their home, by county

**Measure (progress towards goal):** # of communities enacting quality standards for rental housing

**Measure (progress towards goal):** % change in additional affordable housing units

**Strategy:** Engage landlords & tenants to agree to a repair/maintenance exchange (if able) as part of (or to offset) rental cost

**Strategies:** Convert unused buildings into housing (e.g. malls) -  
State/local incentives for efficiencies improvements



## Food

**Vision:** Every person consumes healthful food and beverages.

**Population Measure:** % of people who consume at least 5 servings of vegetables and fruits per day

**Population Measure:** % of people who report they have increased consumption of veggies & fruits

**Population Measure:** % of people who reduce consumption of unhealthy food and beverages

**Goal for Change:** Advocate for a healthful food environment

**Goal for Change:** Increase access to healthful food

**Goal for Change:** Enhance healthful food culture

**Measure (progress towards goal):**  
# of institutions that implement a healthful food policy

**Measure (progress towards goal):**  
: % of population reporting access to healthful food

**Measure (progress towards goal):**  
% of population reporting positive attitudes, perceptions and beliefs about healthful food

**Strategy:** Facilitate Health in All Policy work related to healthful food

**Strategy:** Leverage natural touch points where residents go to get support, to increase healthful food access

**Strategy:** Establish resident board to seek ongoing community engagement on attitudes perceptions and beliefs around healthful food

**Project Measure:** # of food access points that offer healthful food options

**Project Measure:** # of opportunities for education and navigation in support of healthful food



## Poverty/ Economic Security

**Vision:** Every household is economically self-sufficient.

**Measures:**

- % of people in poverty
- % of households above ALICE threshold

- % of people reporting ability to meet basic needs
- % of people moving out of ALICE
- % of households moving out of generational poverty
- Median household income

<p><b>Goal for Change:</b></p> <p>Reduce stigma regarding income security</p> <p><b>Measure (progress towards goal):</b></p> <p>% of community members who report negative perception of poverty</p>	<p><b>Goal for Change:</b></p> <p>Reduce Unintended pregnancy</p> <p><b>Measure (progress towards goal):</b></p> <p>#/rate of unintended pregnancies</p>	<p><b>Goal for Change:</b></p> <p>Community supports in place for all income levels</p> <p><b>Measure (progress towards goal):</b></p> <p>% of people who report they received services when they needed them</p>	<p><b>Goal for Change:</b></p> <p>Increase livable wage employment opportunities</p> <p><b>Measure (progress towards goal):</b></p> <p>#/% of employers paying livable wage</p>	<p><b>Goal for Change:</b></p> <p>Increase job readiness</p> <p><b>Measure (progress towards goal):</b></p> <p># of unfilled positions/untrained workforce</p>	<p><b>Goal for Change:</b></p> <p>Improve access to financial empowerment &amp; education</p> <p><b>Measure (progress towards goal):</b></p> <p># of people referred to services</p> <p># of people self-identifying they have achieved financial empowerment</p>
	<p><b>Strategies:</b></p> <p>Increase preventative services</p> <p>Increase awareness of available services</p>				



## Mental Health

**Vision:** Every person experiences mental well-being.

**Measures:**

% of youth at risk of suicide

Avg. # of poor mental health days per month

Avg. # of good mental health days per month

Number & rate of suicides (adult and youth)  
 % of people who screen for SDoH who identify mental health as a need  
 # of mental health emergency room calls to CMH (needs to be reviewed by CMH)

<p><b>Goal for Change:</b> Enhance sense of community</p> <p><b>Measure (progress towards goal):</b></p>	<p><b>Goal for Change:</b> Advocate for/Increase Funding</p> <p><b>Measure (progress towards goal):</b> % change in funding</p>	<p><b>Goal for Change:</b> Fewer Community ACEs exposure</p> <p><b>Measure (progress towards goal):</b> Rates of ACEs exposure % of community who report a trusted support person</p>	<p><b>Goal for Change:</b> Increase access to mental health care</p> <p><b>Measures (progress toward goal):</b> % of adults &amp; youth reporting they receive mental health care when needed</p>
	<p><b>Strategy:</b> Identify current mental health funding sources</p>		<p><b>Strategy:</b> Increase # of integrated specialty health providers (by a variety of methods)</p>



## Substance Use Disorders

**Vision:** Every person is free from harm from substance use.

**Population Measures:**

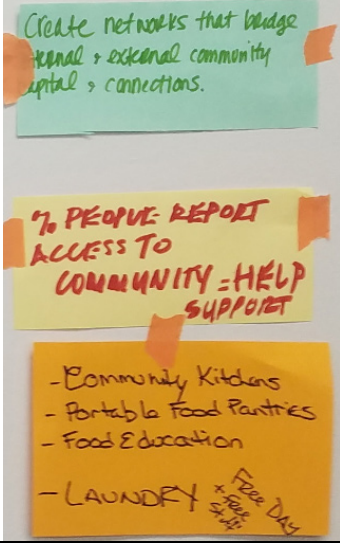
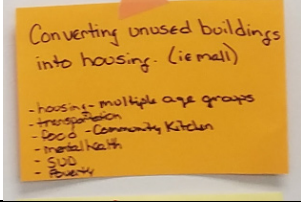
# and rate of overdose deaths  
 % of families who report substance use impacts quality of life  
 % of adults abusing substances  
 % of youth initiating substance use within the past 30 days

<p><b>Goal for Change:</b> Increase resilience &amp; reduce ACEs</p>	<p><b>Goal for Change:</b> Reduce exposure to tobacco, alcohol, and vaping advertising (e.g. through local ordinances)</p>	<p><b>Goal for Change:</b> Increase awareness of SUD risk factors</p>	<p><b>Goal for Change:</b> Increase access to continuum of services for those currently dealing with Substance Use Disorders (e.g. treatment &amp; harm reduction resources)</p>
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<b>Goal Progress Measure:</b> # of families that identify presence of resilience factor(s)	<b>Goal Progress Measure:</b> # of communities that have adopted an ordinance limiting/prohibiting ad space	<b>Goal Progress Measure:</b> # of people trained in SUD risk factors % of individuals reporting increased knowledge of risk factors (e.g. through pre/post testing)	<b>Goal Progress Measure:</b> % of people who report they have access they need # of people being served/treated at service providers # of integrated specialty health providers
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Powerful strategies address multiple goals, cutting across sectors.

<b>Goals Addressed</b>	<b>Strategies</b>
<b>Substance Use:</b> Increase resilience & reduce ACEs <b>Mental Health:</b> Fewer community ACEs exposures	Identify and enhance “trauma-informed” protocols & programs for children & families using effective & evidence-based models
<b>Substance Use:</b> Increase resilience & reduce ACEs <b>Economic Security:</b> Increase livable wage employment opportunities <b>Mental Health:</b> Fewer community ACEs exposures	Explore the impact of living wages on ACEs “protective factors”
<b>Transportation/Physical Activity:</b> <b>Goal for Change:</b> Advocate for a healthful food environment	Transportation reps at planning and zoning commissions
<b>Transportation/Physical Activity:</b>	Embed transportation considerations into cross-sector decision-making
<b>Economic Security:</b> Reduce unintended pregnancy <b>Transportation/Physical Activity</b>	Reduce transportation barriers to pregnancy prevention services
<b>Substance Use:</b> Increase access to continuum of services for those currently dealing with Substance Use Disorders (e.g. treatment & harm reduction resources) <b>Economic Security:</b> Community supports in place for all income levels	Employment retention specialists/success coaches at workplace (employer-sponsored)  (Measure: # of employers who implement a best-practice policy to assist/retain employees with SUD)
<b>Economic Security:</b> Community supports in place for all income levels	Expand # of organizations providing navigation to all income levels (Policy: Medicaid reimbursement)

<p><b>Substance Use:</b> Increase access to continuum of services for those currently dealing with Substance Use Disorders</p> <p><b>Mental Health:</b> Increase access to mental health care</p> <p><b>Food:</b> Increase access to healthful food</p>	
<p><b>Mental Health:</b> Increase access to mental health care</p> <p><b>Substance Use:</b> Increase access to continuum of services for those currently dealing with Substance Use Disorders</p>	<p>Increase # of integrated specialty health providers (by a variety of methods)</p>
	
	
<p><b>Mental Health</b></p> <p><b>Housing</b></p>	<p>More friendly dogs</p>

Synergies with Substance Use Goals

- Mental Health
  - Sense of Communities
  - ACES & Resiliency

- Transportation (needed for access)
- Economic Security (need living wages)
- Mental Health & Econ
  - Reducing Stigma
- Housing
  - Access & Affordability
  - Bridging Connections
  - Community Supports in place for all income levels
- Food
  - Social Connectedness is key

### Synergies with Food Goals

- Living Wage
- Poverty Stigma
- Correlation with SUD & Mental Health
- Social Connectedness (Sense of Community)
- Access – Transportation, Housing
- Built Environment Policies
- Financial/Resource Management & Literacy
- ACE's = Food Insecurity

### Synergies with Housing Goals

- Transportation
  - Access to Options for Physical Activity
  - Access to Options for Transit
- Food
  - Access to Healthy Options
  - Eliminate “Food Deserts”
  - “Health In All Policies” Adoption
- Mental Health
  - ACES Exposure
  - Stigma
- Poverty
  - Community Supports – All Income Levels
- SUD
  - Less Advertising Presence
  - ACES

### Synergies with Transportation Goals

- Getting to Services (Mental Health, SA, Poverty, Food)
- Access to Housing and Food
- Living Wage, Affordable Housing
- Access to PA (relation to ACES, SA, MH, Food)
- Safe Built Environments (Housing)



- Stigma w/Public Transportation

### Synergies with Mental Goals

- Reducing ACES/↑ Protective Factors
- Stigma
- Access

Interdependent:

- Physical Activity
- Nutrition
- Housing
- Living Wage
- Transportation
- Substance Use

### Synergies with Economic Security Goals

- Perception, Community
- Access to Existing & Evidence-based Resources including:
  - Transport
  - SUD tx/Mental Health
  - Housing Options
  - Food Security
- Advocacy
- Community Supports
- ACES & Resiliency: Generational Poverty

\*We need everyone

### Questions we still have

- How avoid fighting for funds?
- Who is going to do the work?
- How do we get buy-in from policy makers?
- How do we do this without ↑ overwhelm?
- What's the timeline?
- Why – attending & inequity?
- Who's missing?
- Who is accountable?

### How do we avoid fighting for resources given this collaboration?

- By making sure there is synergy and collaboration going forward.
- Intention – moving forward

- Pooled community wellness fund
- Identify organizational strengths
- Identify what organization is best leader
- Develop trust, accountability
- Support from top management
- Intentional change management
- Conflict resolution process

#### How do we make sure there is synergy and coordination going forward?

- Communication – update where synergies might lie
- Keeping synergy top of mind
- Agreement for working together
- Coordination plan w/mutual accountability
- Use cross-sector Local Action Teams to ground the work

#### Who is not here? How do we engage them?

- Faith Community
- Parks & Trails
- Local Government
- Employers/Business
- Policy Makers
- Transportation Organization
- Community Collaborative Coordinators
- Community Voice
- Law/Judicial System
- CMH
- NMRE
- Payors
- Funders
- Aging Network

\*Also focus on retention

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- Technology
  - Feedback/input opportunities beyond meeting
  - “why” statement
  - Share widely
  - Highlight successes
  - One-on-one conversations
  - Strong meeting facilitation
  - Length of meeting → 1/2 day
  - Town Hall focused discussions

## How do we bring an equity/inequity lens into the work?

- Investigate where/how status quo/inequities are intentional
- How power operates – who benefits from status quo?
- Residents not at the table
  - Paid for their time
  - Go to their table (move the table)
  - What strategies have residents already cultivated that we haven't listened to?
- Will our strategies actually reach the people who need it most?

## \*Build into process – Keep re-examining

- “Targeted Universalism”
  - What does our power structure look like?
  - Where do residents/affected populations fit?
  - Do they have power of decisions/strategies?
- We need a common understanding of equity
- When appropriate, disaggregating data to identify those most affected?
- Hear from residents what they need/want
- Pay attention to power dynamics in our meetings
- Ask to be guests where people are already talking about those issues.
- Gathering residents – personal invitation to affected populations, provide food, gas card, child care
- Shifting power from top-down (sharing power)
- Publicize/communicate findings & invite/solicit feedback (and act on it)
- Budgetary decisions resource allocation →those impacted

## Who is going to do the work?

- Seek funding for a project coordinator
- Leverage people already doing the work
  - Asset map & action analysis
- In kind contributions, volunteers, consolidate resources
- Build resident capacity (ex: retirees?)
- Build initiatives into community master plans
- Involve the population we are impacting
- Designate action teams
- Research best practices & successful models

## How do we pursue our goals without adding overwhelm?

- Steering Committee including residents – equal power.
- Prioritize goals & build on existing initiatives.
- Celebrate success.
- Begin with easily attainable goal.
- Communicate with Community often.

- Innovative work plan, agencies share staff, responsibilities and wages.