Community Health Improvement Partnership of Hennepin County

2019-2023 Community Health Improvement Plan

February 2019

COMMUNITY HEALTH
Improving health across Hennepin County, together.
IMPROVEMENT PARTNERSHIP

February 2019

To our communities and colleagues,

We are pleased to present this plan for the Community Health Improvement Partnership (CHIP) of Hennepin County.

The foundation for this plan evolved from 2016 to 2018 in partnership with healthcare organizations, health plans, mental health organizations and practitioners, affordable housing developers and providers, community and economic development partners, community organizations, and residents throughout Hennepin County. Partners reviewed data, talked with community members, requested and reviewed more data, and focused in on our priorities.

The goal in developing this CHIP plan was to create a framework for addressing the community health priorities most important to our residents. This plan focuses on mental well-being along with housing stability and affordability as a social determinant of that well-being. After much effort and many discussions, the two priorities for the years 2019-2023 are:

1. Community mental well-being
2. Housing stability

Our work is still evolving; therefore, this plan is a snapshot in time based on recommendations to date from our communities and action teams. It will continue to advance as a living document that guides our work and provides opportunities to partner with communities to address barriers for those living with the greatest health disparities.

We are committed to moving the dial on disparities in both health outcomes and the social determinants that impact equitable outcomes for our residents. Our partnership already has broad representation and we are committed to engaging new partners with unique perspectives and lived experiences.

For more information about the Community Health Improvement Plan and our partnership, we encourage you to visit our CHIP website at http://www.hennepin.us/chip.

Sincerely,

Susan Palchick, Ph.D., MPH   Gretchen Musicant, BSN, MPH   Bonnie Paulsen, DNP, MSN
Hennepin County   Commissioner of Health   Public Health Administrator
Public Health Director   City of Minneapolis   City of Bloomington

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Executive Summary

Hennepin County is the most populous county in Minnesota, comprising 22 percent of the state's population. It also is the most racially diverse county in the state particularly in portions of Minneapolis and several suburbs including Brooklyn Center, Brooklyn Park, Hopkins, Richfield and Saint Louis Park. County data show that racial disparities in health outcomes exist in our communities of color.

The Community Health Improvement Partnership (CHIP) of Hennepin County was created in 2012 to foster alliances and target community health issues together for greater impact. This community health improvement plan and its community priorities for action are the result of many months of planning, collective work, willingness to learn and adapt, and shared expertise and lived experiences by CHIP partners and communities.

CHIP executive committee members identified racism, historical trauma, and unjust policies and practices as issues to target in their work and this plan. CHIP principles, roles, and focus on health and racial equity also reflect this desire.

Based on data and community input, CHIP partners overwhelmingly determined that community mental well-being was the top community priority for action among Hennepin County residents. Housing stability has been a recurrent topic of concern around the Twin Cities metropolitan area as people struggle to find and maintain safe, affordable housing. Thus, housing stability became CHIP's second priority.

CHIP partners recognize that this plan is a continuous work in progress. Updates will be necessary as major deliverables, such as logic models and measurable outcomes are written and approved by the executive committee, action teams and CHIP collaborative.

Introduction

This Community Health Improvement Plan, CHIP 2.0, and its community priorities for action are the result of many months of planning, collective work, willingness to learn and adapt, and shared expertise and lived experiences. Its development was first led by the CHIP 1.0 steering committee in 2016 and 2017, and continued under the CHIP 2.0 executive committee throughout 2018.

All work has been carried out with communities and organizations impacted by or working to reduce health disparities in Hennepin County. After intense prioritization sessions with diverse stakeholders, the two priorities agreed upon for the second iteration of CHIP are:

1. Community mental well-being
2. Housing stability

The work of CHIP 2.0 and the communities we serve is still in progress, so this plan reflects our work to date and future plans for the years 2019-2023 as of January 2019.

Hennepin County Demographics

Hennepin County is the most populous county in Minnesota, comprising 22 percent of the population of Minnesota. It is located in the western portion of the Twin Cities metropolitan area and encompasses 607 square miles, 554 square miles in land and 53 square miles in water. It has 45 municipalities, with the City of Minneapolis as the county seat. The county is composed of urban, suburban, exurban and rural communities, as well as several small city centers with vibrant downtowns. Hennepin County is somewhat unique in that five Community Health Boards (CHBs) serve residents within Hennepin County. These CHBs are Hennepin County and the cities of Minneapolis, Bloomington, Edina, and Richfield.

The seven-member elected Board of County Commissioners is the legislative body of the county. Each member represents a specific district within the county. Hennepin County is home to 1.2 million residents. In 2017, 422,331 people (nearly 31 percent) of the county's population lived in Minneapolis, which is the largest city in the county and in Minnesota. The 2017 populations of the other community health board cities were: Bloomington, 85,866; Edina, 51,958; and Richfield, 36,151.

Hennepin County is the most racially diverse county in Minnesota. With large populations of immigrant and refugee families, Minneapolis is home to one of the largest resettlements of Somali residents in the United States. The county population is 12 percent black/African American, seven percent Asian, less than one percent American Indian/Alaskan Native, three percent two or more races, and seven percent Hispanic/Latino. Nearly 12 percent of the population lived below the poverty level in the past 12 months. Racial diversity is concentrated in portions of Minneapolis and a few suburbs, including Brooklyn Center, Brooklyn Park, Saint Louis Park, and Richfield. Brooklyn Center and Brooklyn Park are the most racially diverse communities in Hennepin County, with half or more of the population identifying as populations of color or American Indian.

CHIP Background and early planning for CHIP 2.0

The Community Health Improvement Partnership (CHIP) of Hennepin County was formed in 2012 to foster alliances across public and private organizations to target community health issues together for greater impact. It was founded by the Community Health Boards of Hennepin County, Minneapolis, Bloomington, Edina, and Richfield, along with their cross-sector partners. CHIP's guiding document for its first five years was a Community Health Improvement Plan adopted in 2012, and CHIP was led by a steering committee.

In 2016, CHIP convened a planning committee, composed of a subset of CHIP steering committee partners, to begin planning the next iteration of CHIP. This new iteration was and is now called CHIP 2.0. While developing the framework for CHIP 2.0, the steering committee also convened a data group to guide the revision of the joint Community Health Assessment (CHA). The CHA was jointly completed in January 2017 by Hennepin County Public Health, the Public Health Alliance of Bloomington, Edina and Richfield represented by Bloomington Public Health Division, and the Minneapolis Health Department.

In February 2017 the CHIP 2.0 planning committee convened representatives from local public health departments, hospitals, health plans, community-based organizations, and other entities that had previously been involved in CHIP, to discuss the data and provide context on community priorities for action for CHIP 2.0. Over several months, the CHIP Steering committee discussed the feedback received from communities, and participated in facilitated prioritizing activities using data from the CHA and the Community Health Needs Assessments from area hospitals and health plans. CHIP partners overwhelmingly determined that mental health and well-being was the top community priority for action among Hennepin County residents.

Snapshot of CHIP supporting data

The figures below are a representative snapshot of data found in the joint CHA and other documents that support mental health and well-being. They also show the thought process around the importance of the social determinants of health (SDOH) that impact well-being.

Figure 1 below highlights the health inequity for frequent mental distress by race and ethnicity.

1: Percent of adults who experienced frequent mental distress by race/ethnicity, Hennepin County 2014 (Population 25 years and older)
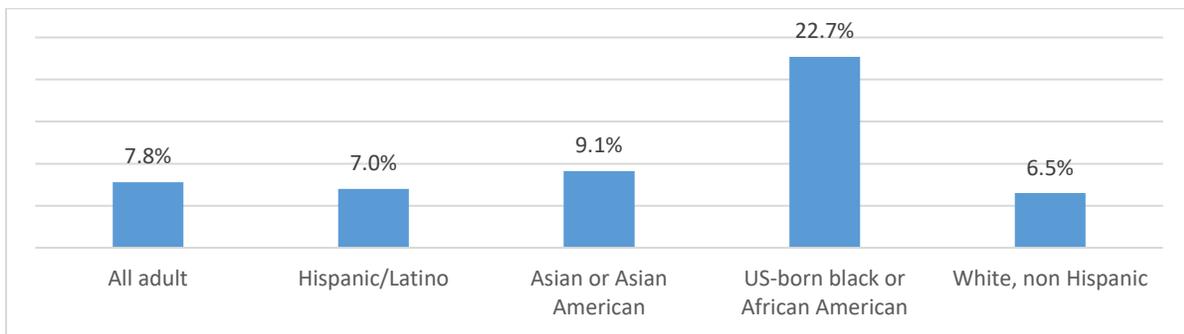
Data Source: Metro SHAPE 2014 Adult Survey

Note: American Indian, foreign-born black, and other groups not reported separately due to small numbers of respondents identifying as members of those populations.

Figure 2 below highlights the health inequity in frequent discrimination by race and ethnicity.

Figure 2: Percent of adults who experienced frequent discrimination by race/ethnicity, Hennepin County 2014 (Population 25 years and older)
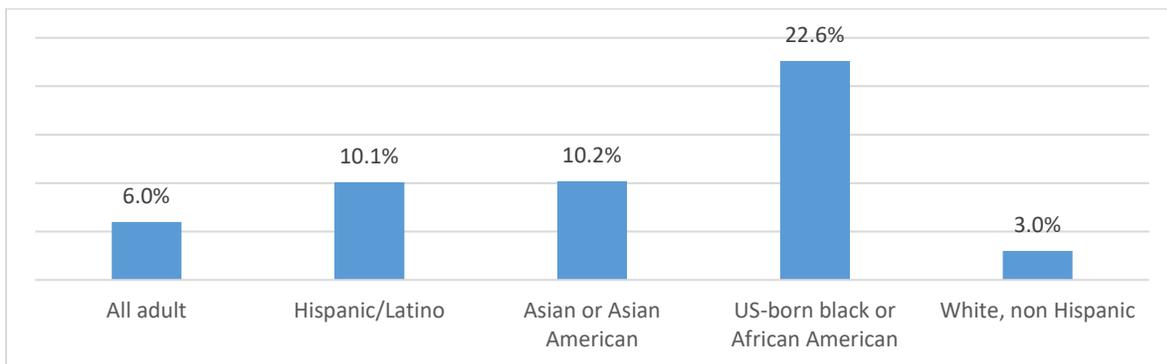

Data Source: Metro SHAPE 2014 Adult Survey

Note: American Indian, foreign-born black, and other groups not reported separately due to small numbers of respondents identifying as members of those populations.

Social determinants of health

In order to narrow down CHIP's focus to a single SDOH, a series of meetings was held from January through March 2017. Mental health and well-being was further defined as community mental well-being, with emphasis on communities experiencing historical trauma.

During CHIP 2.0 planning sessions conducted with the CHIP steering committee in spring 2017, five SDOH were identified as causing a negative impact on mental health outcomes. Significant disparities exist in these five SDOH identified:

1. Criminal justice
2. Education
3. Housing
4. Poverty
5. Transportation

Criminal justice

Figures 3 and 4 below are new data that were unavailable at the time of the CHA data collection and review. They are included here because criminal justice was a SDOH that the CHIP steering committee determined was influential on individual and community well-being and also housing stability.

Figure 3 shows the percent of adults by race currently on supervision and in the Hennepin County workhouse compared to the county's overall population, and highlights the disparity by race and ethnicity. Supervision includes all adults who have been court ordered to the county's Department of Community Corrections and Rehabilitation, from those on administrative probation (they only check in when something changes), to traditional probation with a probation officer, to those coming out of prison.

Figure 3: Adult Supervision and Correctional Facility population by race (January 9 2019)
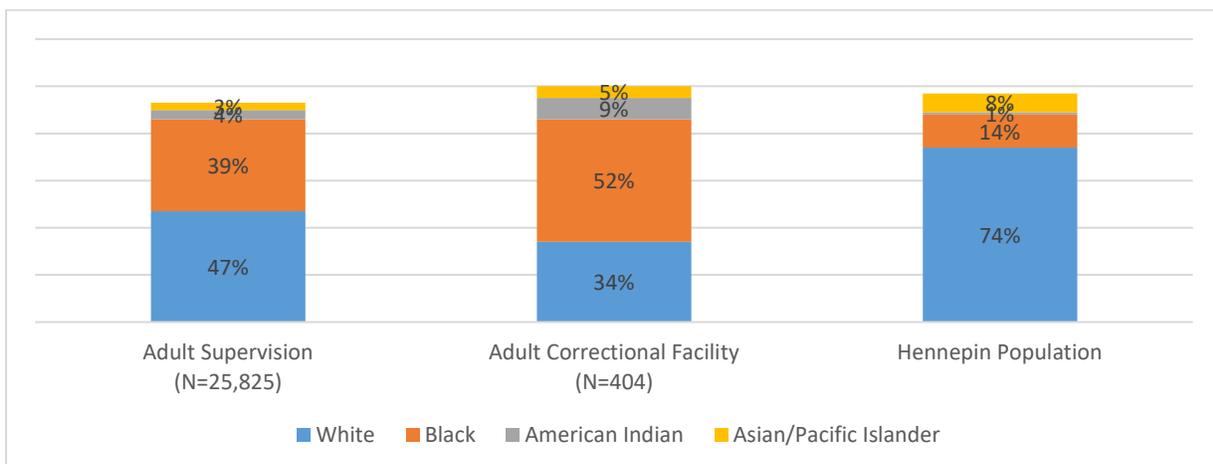
Data Source: Hennepin County Department of Community Corrections and Rehabilitation 2019

Figure 4 below shows the bookings of youth by race into the Hennepin County Juvenile Detention Center in 2017 and highlights the disparity by race. Booking is the process used to register a person believed to have violated the law and typically includes taking a photograph or "mug shot" and fingerprints.

Figure 4: Youth corrections – Count of bookings of youth into the Hennepin County Juvenile Detention Center, 2017
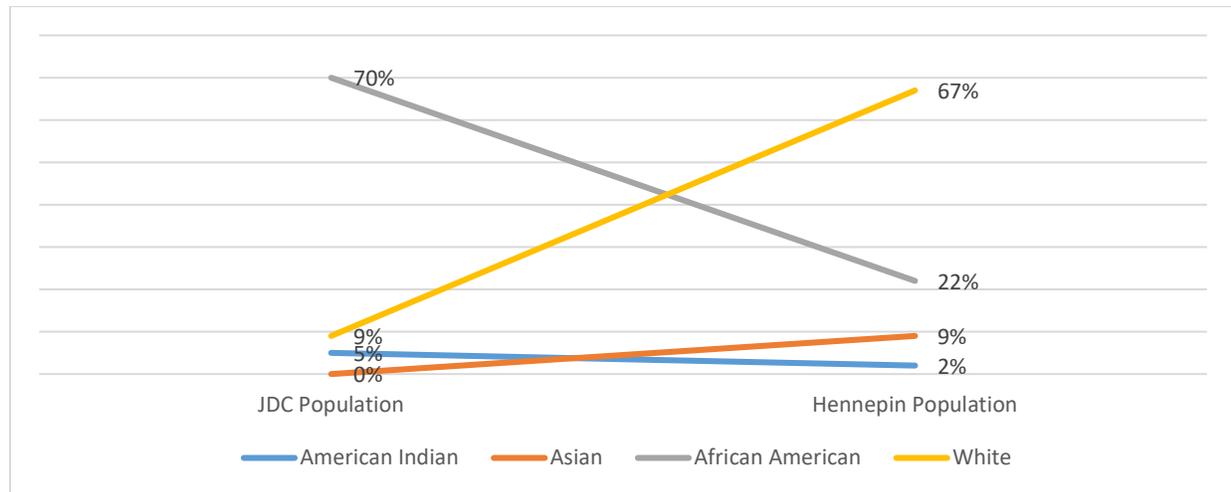
Data Source: Hennepin County Department of Community Corrections and Rehabilitation 2019

Education

Figure 5 below highlights the inequity in educational attainment by census tract in Hennepin County. Persons with a higher level of education tend to have greater socioeconomic resources available to have a healthy lifestyle, and a greater relative ability to live and work in environments with resources and built environment for healthy living. The National Center for Health statistics found in 2012, that at age 25, U.S. adults without a high school diploma can expect to die nine years sooner than college graduates. The map highlights a higher concentration of persons who have not graduated high school or earned a General Education Diploma (GED) in Minneapolis and first ring suburbs including Brooklyn Center, Brooklyn Park, Richfield, and one census tract in Bloomington, in comparison to other areas in Hennepin County.
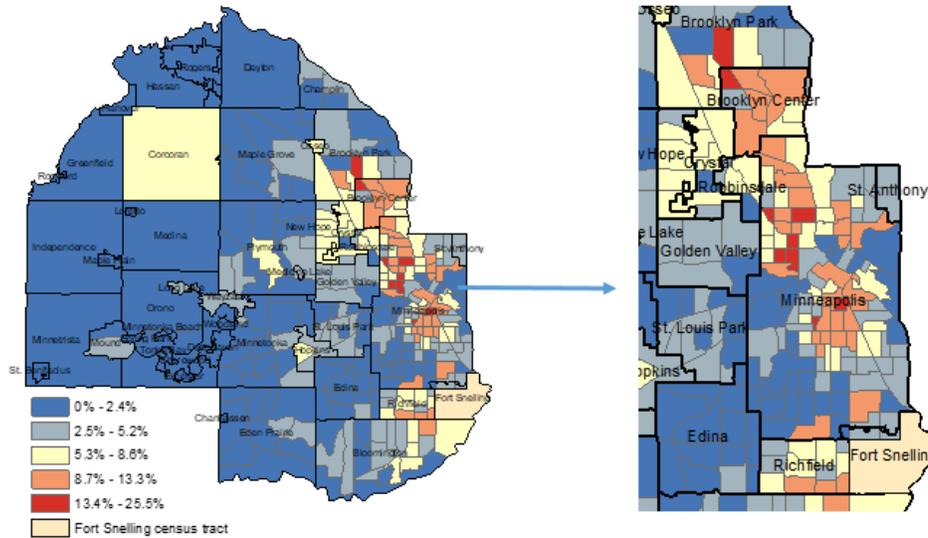
Data Source: 2010-2014 American Community Survey (ACS) 5 year estimates

Graduation Rate

In comparison to the 2010/2011 school year, graduation rates (figure 6) improved overall from 66 percent to 77 percent of all students, but also among each racial/ethnic group and for both males and females. Even though there were gains overall and in each group, disparities between groups still exist particularly between Hispanic, non-Hispanic black, American Indian/Alaskan Native students and non-Hispanic white and Asian/Pacific Islander students.

Figure 6: Graduation rate – percentage of students graduating in four years by race/ethnicity and gender in Hennepin County, 2011 vs 2015
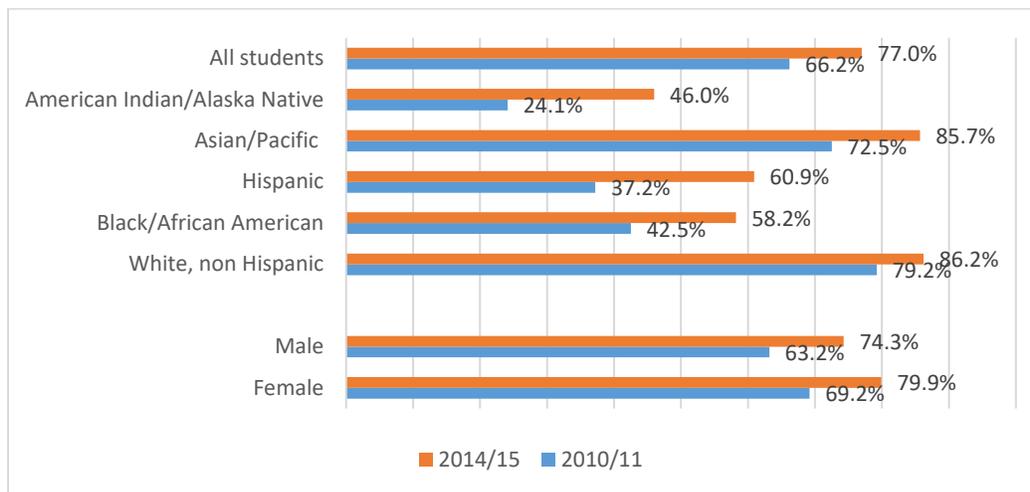
Data Source: Minnesota Department of Education, 2010/11, 2014/15

Burden of housing

Despite housing in Hennepin County being more affordable than in other parts of the country, it still is not affordable enough for many residents. This is recognized as a crisis in our county, particularly for low income populations.

Individuals or families who pay more than 30 percent of their income toward housing are considered burdened. This burden may result in difficulty affording necessities such as food, clothing, transportation and medical care.

Figure 7 below highlights a higher concentration of housing cost burden in Minneapolis and first ring suburbs such as Brooklyn Center, Brooklyn Park, Richfield, Hopkins and areas of Bloomington, New Hope and St. Louis Park in comparison to the outer ring suburbs, with the exception of Shorewood, Tonka Bay and Excelsior.

Figure 7: Burden of housing costs – occupied housing (owner & renter) where costs equal 30% or more of income, 2012-2016 ACS estimates, Hennepin County
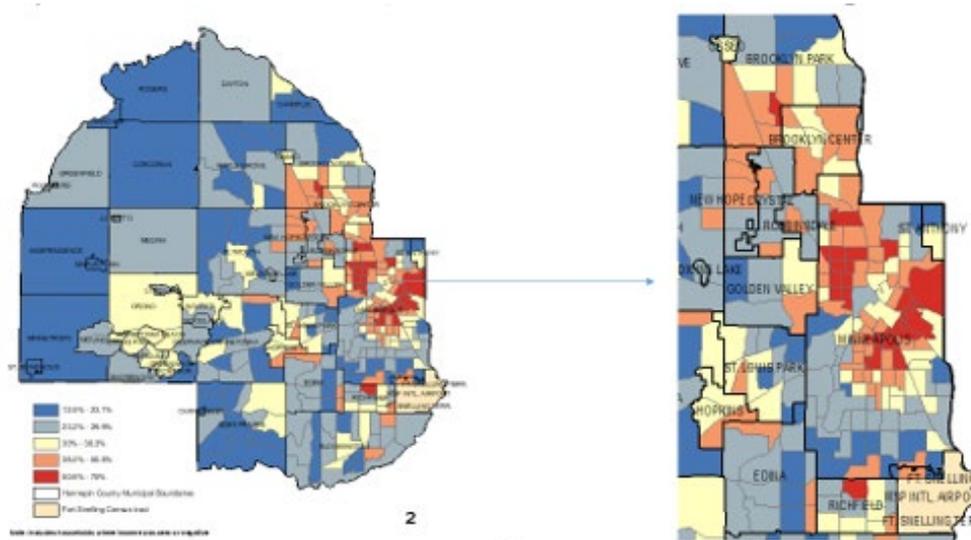
Source: 2012-2016 ACS estimates

Renter and owner occupied housing units are combined in the map due to a small number of total rental units in certain tracts, resulting in percentages that were artificially high, particularly in the western part of the county.

Figure 8 below highlights the disparity in home ownership by race and ethnicity in the City of Richfield in Hennepin County Minnesota.

Figure 8: Racial inequity in home ownership – rent vs. own status in Richfield MN, 2012-2016
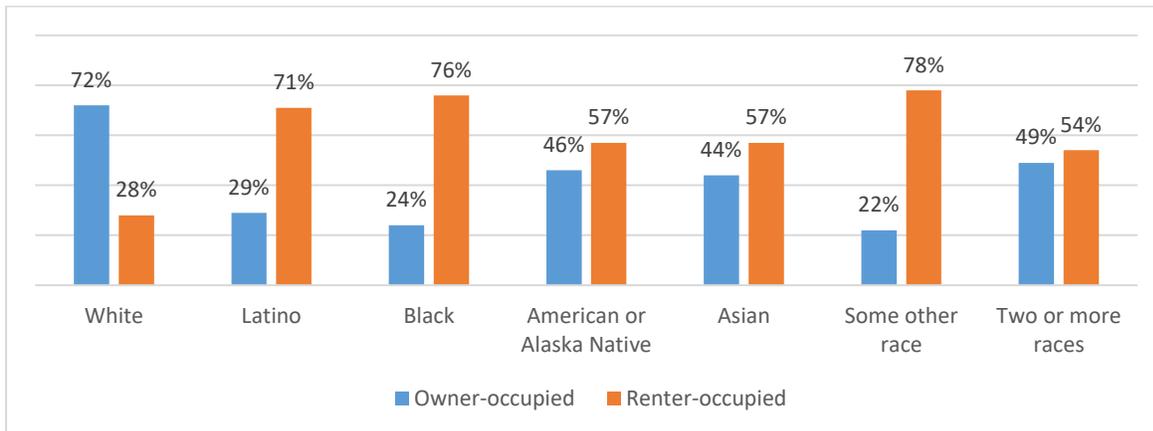
Data Source: US Census Bureau, 2012-2016 ACS 5 year estimates, Table B25003

Figure 9 below highlights the disparity in health behaviors between renters and owners in Minnesota. Renters tend to earn less than owners and have higher housing costs such as in Richfield where renters earn half the income that owners do and pay roughly $100 more per bedroom per month than their owner counterparts. This leaves much less income available to spend on health promoting activities and preventive care.

Figure 9: Differences in health and health behaviors between renters and owners, Minnesota 2016
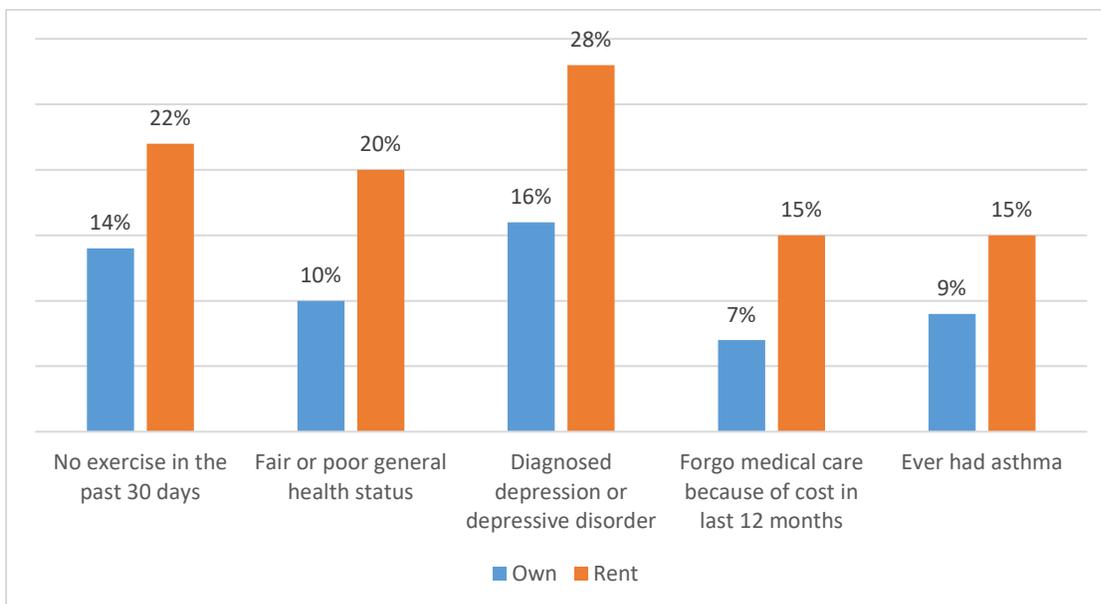
Data Source: Minnesota Behavioral Risk Factor Surveillance System, 2016

Families in Poverty

The distribution of families in poverty highlighted in figure 10 below is similar to that of low income persons (percent of the population whose income is under 200 percent of the Federal Poverty Level) though not as widespread. Those areas with the highest percent of families living in poverty are located primarily in Minneapolis, with a few tracts in the first ring suburbs including Brooklyn Center, Brooklyn Park, Hopkins, and Richfield having more than 1/3 of families with children under 18 living at 100 percent of the poverty level.

Figure 10: Families in poverty – percent of families with children under 18 that are at or below 100% of federal poverty level

Legend:
- 0% - 6%
- 6.1% - 16.9%
- 17% - 33.3%
- 33.4% - 55.1%
- 55.2% - 100%
- Fort Snelling census tract
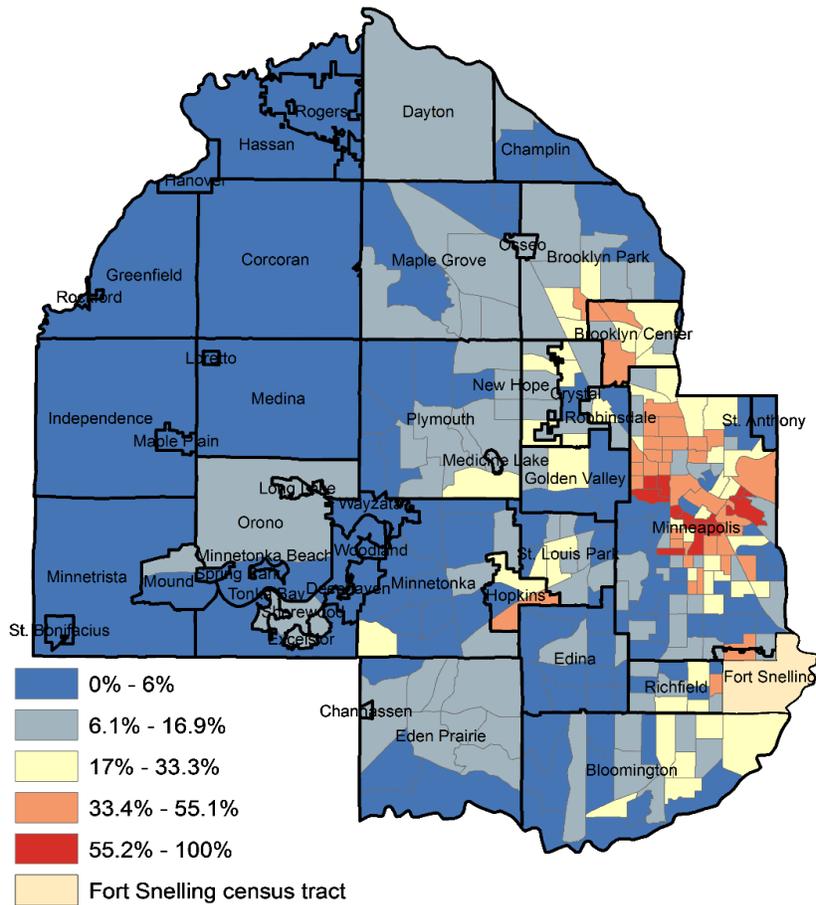
Data Source: 2010-2014 American Community Survey 5 year estimates

Transportation

Figure 11 below shows households of two or more people with no vehicle. Census tracts with the greatest disparities are located in Minneapolis, with the exception of Brooklyn Park, Richfield and St. Louis Park. Jobs, technical colleges, and universities are spread throughout the Twin Cities region, which makes it difficult and expensive for those with limited vehicle access to reach potential jobs, schools and other destinations of daily life.

Figure 11: Percent of two or more person households with no vehicle, by tract, Hennepin County 2013-2017
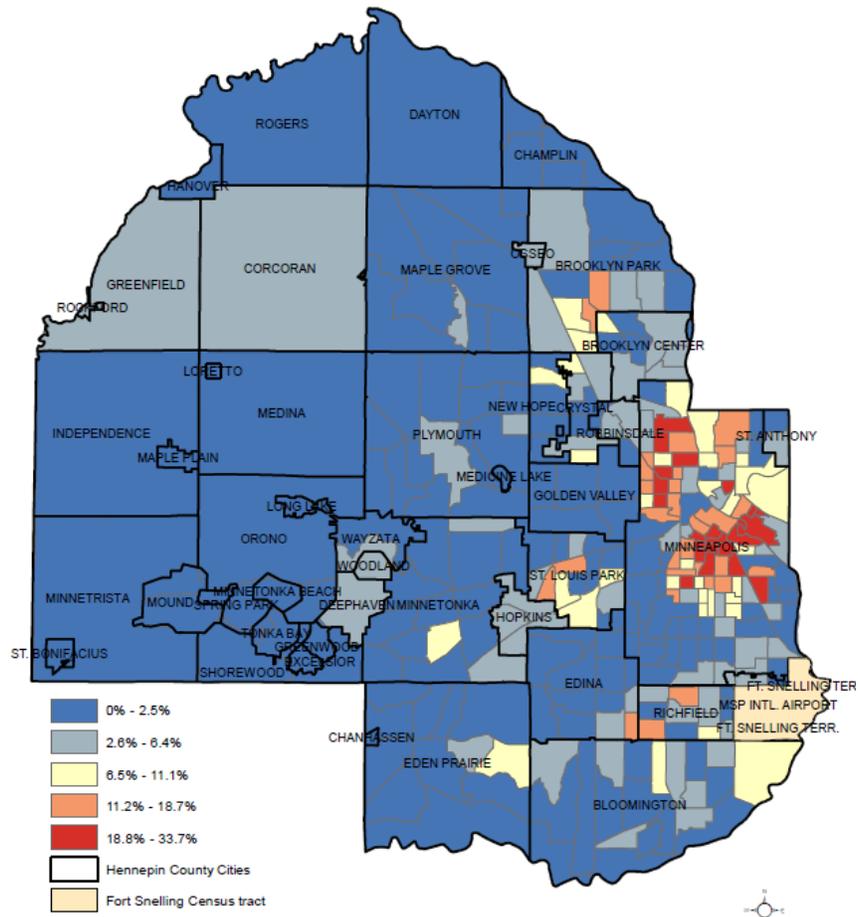
Data Source: ACS 2013-2017 5 year estimates

Selection of Housing Stability as the second priority

Housing stability has been a recurrent topic of concern around the Twin Cities metropolitan area as more and more people struggle to find and maintain affordable and safe housing. Therefore, not only was the CHIP partnership poised to work on this, there was a regional readiness as well.

This readiness evoked a sense of urgency in the CHIP partnership. Members discussed the connections between homelessness and healthcare, particularly among homeless patients cycling in and out of emergency departments for various health concerns created or exacerbated by their lack of housing stability. Not only is this a cost driver, it is produces a poor outcome for some of our most vulnerable residents. Therefore, CHIP was ready to determine its niche at the intersection of housing stability and community mental well-being. Because of this, housing stability became CHIP's second priority.

Thus, in April 2017, CHIP 2.0s two community priorities for action became:

1. Community mental well-being
2. Housing stability

Shift from CHIP 1.0 to CHIP 2.0

As the two new community priorities for action were identified, CHIP partners realized that significant changes were needed in CHIP leadership and decision-making to better align our work for greater impact. In particular, the number of health care organizations needed to decrease to make room for expanded cross-sector CHIP partners. The CHIP 2.0 planning team developed a recruitment plan that broadened cross-sector participation. Partners representing mental health, housing, community development and cultural communities were recruited during the fall of 2017. Duplicative CHIP 1.0 partners bowed out at the November 2017 CHIP steering committee, and CHIP 2.0 formally kicked off in December 2017 under the leadership of a new CHIP executive committee.

Executive committee members quickly embraced shared responsibility and accountability to our communities, and engaged in sessions to outline mutual processes for decision making. Each member agreed to the new executive committee structure, and as their work unfolded, accepted accountability to principles, and individual vision statements for community mental well-being and housing. This included accountability for action teams, outcomes, and responsibility for a significant rewrite of this CHIP plan using an iterative community process.

CHIP 2.0 structure

The structure developed for CHIP 2.0 includes three distinct groups, each with its unique roles and responsibilities for creation and implementation of this CHIP plan:

1. **The executive committee** drives CHIP's work and is ultimately responsible for the CHIP plan's strategic direction and ensuing decisions
2. **The CHIP collaborative** ensures accountability to the communities CHIP serves
3. **Two action teams** coordinate and implement each strategy:
    1. Community mental well-being
    2. Housing stability

Executive Committee

CHIP is led by an executive committee composed of action-oriented leaders representing several of Hennepin County's 45 cities, housing and mental health experts, communities of spirituality and faith, cultural and ethnic communities, and the five community health boards located within the county. This committee serves as the decision-making body for CHIP 2.0 and has accepted responsibility for implementing strategies. Its members are listed in Appendix A.

Members of the executive committee actively engage one another, learn together, and are accountable for CHIP. The committee kicked off in December 2017 and has carried out this work thus far:

1. Agreed to CHIP's committee structure (Appendix B) – December 2017
2. Created and adopted CHIP principles (Appendix C) – April 2018
3. Created and adopted CHIP purpose and roles (Appendix D) – December 2017
4. Adopted a health and racial equity statement (Appendix E) – winter 2018
5. Conducted key informant interviews (Appendix F) – January – May 2018
6. Created a vision statement and logic model for community mental well-being (Appendix G) – July-August 2018
7. Created a vision statement and logic model for housing stability (vision statement is Appendix H) – May-July 2018
8. Launched a CHIP collaborative – October 2018
9. Launched CHIP action teams – November 2018

Executive committee members determine all content and language of statements and documents, and accept overall responsibility for the work these documents lay out and the justification behind them.

Note: It is important to CHIP executive committee members that racism – both internal to ourselves and in the structures of the systems we work for – is named and called out in documents. CHIP principles, roles, and focus on health and racial equity reflect this desire.

CHIP Collaborative

The CHIP collaborative ensures accountability back to our communities and helps CHIP 2.0 achieve its goals by reviewing draft plans, and providing feedback, advice, recommendations and new ideas. This group includes CHIP executive committee members, action teams, community organizations, community members, CHIP 1.0 partners who continue to be engaged, and anyone with an interest in the goals and work of CHIP. This group met for the first time in October 2018 and will be convened twice per year. Plans already are underway for the next meeting in April 2019.

A complete description of the CHIP collaborative is included as Appendix B to this plan.

Action Teams

CHIP action teams coordinate and implement strategies, and are accountable to the executive committee. Co-chairs participate on the executive committee and are accountable for the work carried out on their action team(s). The work of the action teams is reviewed at the CHIP collaborative meetings to ensure that community feedback is sought and incorporated into action team strategies and outcomes.

Complete descriptions of each of these groups, along with their roles and responsibilities, are included as Appendix B to this plan.

CHIP 2.0 plan to date

Planning for CHIP 2.0 and its communities is currently ongoing for 2019-2023, so this plan reflects our work and future plans as of January 2019.

Priority 1: Community mental well-being

Development of this priority began in spring 2018 when the executive committee members conducted 23 key informant interviews to learn directly from communities about the challenges they face around community mental well-being and housing stability. Key informants provided knowledge, perspectives, effective strategies, challenges, and advice for CHIP, all of which have been used to inform the content of this plan. A comprehensive report on these interviews was completed and is included as Appendix F to this plan.

The executive committee's focus is on policy and system level changes for the alleviation of identified causes of health inequity. These policy changes will target historical trauma, racism, and biases in our systems that perpetuate racial inequities and health disparities. The executive committee worked with the key informant report over several meetings to develop the vision statement, inputs and resources, activities, outputs, and short-, medium-, and long-term outcomes for a logic model.

The vision statement for community mental well-being is below and reflects the intentionality of the CHIP partners to lead this work collectively. The draft logic model for community mental well-being is included as Appendix G to this plan.

> **Vision of impact**: *We envision leading equitable policy and systems changes that promote physical, social, and racial well-being and honor self-determined communities*

The two strategies for community mental well-being are below.

1. Becoming trauma informed governments and organizations

- What we hope to achieve:
    - a) Demonstrate to our communities that we are willing to examine and change our own policies and practices which perpetuate systemic racism
    - b) Proactively address racial and health disparities in our communities
- Why we are doing this:
    - a) To understand the negative impact of historical trauma, racism and bias on community mental well-being, and consistently act on that knowledge to improve ourselves and our organizations
    - b) To enact lasting changes in our policies and systems that negatively impact our communities

- What we will do:
    a) Conduct needs assessments focused on racism and bias in our organizations
    b) Use best practices to conduct bias training in our organizations
    c) Use appropriate tools and trauma informed templates to review and revise policies and systems
    d) Review progress at CHIP collaborative gatherings and make revisions based on community recommendations

The community mental well-being action team has been tasked with review and revision of the logic model, and for development of a work plan.

And, as noted in the first paragraph of this section on community mental-well-being, the executive committee recognized that policy and system level changes were needed to alleviate health inequities. In order to catalyze these changes, CHIP partners must first demonstrate a willingness to examine biases in our own systems and change organizational policies that perpetuate racial inequities and health disparities. That work is beginning as of January 2019 and will necessitate shared understanding of key terms and language, knowledge of policies and tools, and engagement of the appropriate level of government or other organizations responsible for the desired policy change.

Questions to discuss include:

1) Where should we focus in terms of systemic, historical trauma?
2) Which policies should we work on in our own organizations? Which could we draft and advocate for as a partnership?
3) What initial actions should we take through April 2019 when the CHIP collaborative meets again?
4) What do we plan to accomplish by December 2019?
5) What are our first steps?
6) What do you see as your organization's role in this work?
7) How might our work relate to the action teams as they plan actions around historical trauma, and vice versa?
8) Who or which organizations are already working on this and could help inform our process?

2. Partnering with spiritual and faith communities
- What we hope to achieve:
    a) Support spiritual and faith organizations/leaders whose communities rely on them for mental and emotional assistance
    b) Build trust and collaboration between spiritual and faith communities, and those working in mental health services and resources
    c) Increase access to mental health services and resources

- Why we are doing this:
  a) To support what's already working for non-clinical community and spiritual leaders and recognize their effectiveness in helping people in their communities
  b) To increase mental well-being and resiliency in communities
  c) To reduce the stigma of asking for mental and emotional support, particularly in communities of color
- What we will do:
  a) Respect and learn from spiritual, faith, non-clinical community leaders whose communities rely on them for mental and emotional support
  b) Ask these leaders to share their stories, challenges, fears, and successes to help us understand barriers for supporting mental health and well-being work they do with their communities
  c) Engage a broad coalition of spiritual, faith, non-clinical community leaders and medical, healthcare and insurance systems to identify and work for policy and systems change

These proposed actions were reviewed by the CHIP collaborative in October 2018. The community mental well-being action team is in the process of revising the logic model based on committee discussions and community recommendations.

Priority 2: Housing stability

Development of this priority began in spring 2018 when the executive committee members conducted 23 key informant interviews to learn directly from communities about the challenges they face in community mental well-being and housing stability. Key informants provided knowledge, perspectives, effective strategies, challenges, and advice for CHIP, all of which have been used to inform the content of this plan. As noted above under community mental well-being, a comprehensive report on these interviews was completed and is included as Appendix F to this plan.

The executive committee's efforts under housing stability focus on policy and system level changes for the alleviation of identified causes of health inequities related to housing as a social determinant of health.

These changes will target historical trauma, racism, and biases in our systems that perpetuate racial and health disparities related to housing stability and affordability. The same process was used by the executive committee to flesh out this priority. The executive committee members worked with the key informant report over several meetings to draft the vision statement, inputs and resources, activities, outputs, and short-, medium-, and long-term outcomes for a logic model.

> **Vision of impact:** *All people have equitable opportunity for stable affordable housing in vibrant communities.*

Note: As of January 2019, the housing action team began the process of completely rewriting the strategies below. This is based on passionate feedback and recommendations from the CHIP collaborative participants in October 2018, and the housing action team that began its work in November 2018. The strategies are included below as originally written for purposes of this plan only and are undergoing a significant shift as of the time of this writing.

1. Training for landlords to be successful in their work and relationships with tenants
   - What we hope to achieve:
     a) More consistent tenant selection criteria (screening) that are equitable and inclusive
     b) Fewer evictions and/or mutual lease terminations
     c) More positive relationships among renters, landlords and their communities
   - Why we are doing this:
     a) To reduce screening barriers and increase housing options for people of color
     b) To reduce disparities in evictions and mutual lease terminations for people of color
     c) To foster stable, cohesive communities in resident buildings/complexes
   - What we will do:
     a) Learn more about screening criteria, evictions and mutual lease terminations, and their true cost to both landlords and tenants
     b) Work with landlords to determine training needed, to include:
        1. Racial equity, unconscious bias and cultural competency
        2. Multifamily housing law and best management practices
        3. Mental health or psychological first aid

2. Training for tenants to be successful renters
   - What we hope to achieve:
     a) Fewer evictions and/or mutual lease terminations
     b) More positive relationships among renters, landlords and their communities
     c) Exploration of how to set up anchor/mentor tenants who help other tenants
   - Why we are doing this:
     a) To reduce screening barriers and increase housing options for people of color
     b) To reduce disparities in evictions and mutual lease terminations for people of color
     c) To foster stable, cohesive communities in resident buildings/complexes
   - What we will do:
     a) Build relationships with renters and their communities
     b) Work with renters and their communities to determine training needed
     c) Assess potential for anchor/mentor tenants who help and guide other tenants

Participants provided considerable feedback on the strategies noted above for housing stability, and recommended a shift away from training toward partnership with communities and advocacy for increased understanding of and resources for affordable, supportive housing. The comments

below are a sampling of those made in response to tenant training and demonstrated clear pushback on training as a strategy:

- Feels like you're putting burden on tenants
- Communication – don't be condescending to renters – fault/blame
- Don't put the onus on tenants. The problem is the system.
- What is the pathway out from barriers to safe housing?
- What part of this is building a better profile for the tenant?
- Landlords must loosen the screening criteria!

The housing stability action team, composed of subject matter and community experts, kicked off in November 2019 and came to the same conclusion. At the time of this writing, that action team is using the recommendations from the CHIP collaborative as well as high-potential policy and advocacy strategies identified in 2017 workshops to reframe the housing stability logic model and proposed work plans. They will be developed further through the spring of 2019, brought back to the CHIP collaborative in April, revised as needed and then adopted by the executive committee for housing stability under CHIP 2.0.

Evaluating our work

At the time of this writing, both logic models are still in development and the housing stability strategy is undergoing a significant shift. Goals and draft objectives are noted below. Outcomes, strategies and activities will be developed once strategies have been agreed to by the executive committee and housing stability action teams, and affirmed by the CHIP collaborative.

Goal 1: Residents of Hennepin County have improved mental well-being, especially among:

1. Populations of color
2. Those experiencing housing insecurity

Objective		Baseline	Data Source
1.1	By December 31, 2023, increase the proportion of Hennepin County people of color and American Indians who report good or better mental health to align with the Healthy People 2020 goal of 80%.	22.5% of African Americans versus 6.5% of white residents in Hennepin County reported frequent mental distress in 2014	Hennepin County SHAPE* Survey
1.2	By December 31, 2023, increase the proportion of people experiencing housing insecurity who report good or better mental health to align with Healthy People 2020 goal of 80%.	24.4% of people versus 7% of those who are not experiencing housing insecurity in Hennepin County reported frequent mental distress in 2014	Hennepin County SHAPE Survey

* Survey of the Health of All the Population and Environment

Goal 2: Residents of Hennepin County have increased social connectedness, especially among:

1. Populations of color
2. Those experiencing housing insecurity

Objective		Baseline	Data Source
2.1	By December 31, 2023, increase social connectedness reported by people of color and American Indians by 10%.	32.5% of African Americans versus 18.1% of white residents talk to their friends/ neighbors monthly or less	Hennepin County SHAPE Survey
2.2	By December 31, 2023, increase social connectedness reported by families/ households experiencing housing insecurity by 10%.	30.8% of those experiencing housing insecurity versus 20.6% of those who are not experiencing housing insecurity talk to their friends/ neighbors monthly or less	Hennepin County SHAPE Survey

An evaluation planning process is just getting underway as of January 2019. This will be supported by the five Community Health Boards serving residents within Hennepin County: the cities of Minneapolis, Bloomington, Edina, Richfield, and Hennepin County. The executive committee will adopt this plan, and the action teams will carry out much of the work to be evaluated. This work will be shared semi-annually with the CHIP collaborative as part of our accountability to the communities we serve. Sharing our work will demonstrate that we are working on measurable, positive change toward greater health and racial equity.

Conclusion

This document is a living plan created by partners across multiple jurisdictions, sectors and organizations, with strong accountability back to the communities served for outcomes based on our CHIP principles.

The partners of the Community Health Improvement Partnership of Hennepin County realize that however much time this process takes, it is necessary to embrace collaboration if this CHIP plan is to be reflective of our communities to whom we are accountable. CHIP partners also recognize that this plan is a continuous work in progress. Updates will be provided as major deliverables, such as logic models and measurable outcomes, are written and approved by the executive committee, action teams and CHIP collaborative.

Appendices

A. List of executive committee members

B. CHIP committee structure

C. CHIP Principles

D. CHIP purpose and roles

E. CHIP's commitment to health and racial equity

F. Key informant interview report

G. Community mental well-being vision and logic model

H. Housing stability vision statement

Appendix A

List of executive committee members

Community Health Improvement Partnership of Hennepin County Executive Committee 2018			
Name	**Title**	**Organization**	**Email Address**
Adair Mosley	President and CEO	Pillsbury United Communities	AdairM@pillsburyunited.org
Alison Pence, *CHIP co-chair*	Director of Community Engagement, West Metro	Allina Health	Alison.Pence@Allina.com
Bonnie Paulsen	Public Health Administrator	Bloomington Public Health	bpaulsen@BloomingtonMN.gov
Estela Villagrán Manancero	Director, Office of Latino Ministry	Archdiocese of Saint Paul & MPLS	mananceroe@archspm.org
Gretchen Musicant	Commissioner of Health	Minneapolis Health Department	Gretchen.Musicant@minneapolismn.gov
Jeff Brown	Community Health Administrator	Edina Public Health	jbrown@EdinaMN.gov
Jeff Westbrook	Interim VP, Resident Connections & Supportive Housing	Aeon	JWestbrook@aeon.org
Kersten Elverum	Director of Planning & Development	City of Hopkins	kelverum@hopkinsmn.com
Kim McCoy	Program Director	Stratis Health	KMCCOY@stratishealth.org
Lisa Wilcox-Erhardt	Executive VP, Housing & Services	CommonBond Communities	Lisa.Wilcox-Erhardt@commonbond.org
Mark Sander	Clinical Psychologist	Minneapolis Public Schools/ Hennepin County Human Services	Mark.Sander@hennepin.us

Patrick Dale	Chief Executive Officer	Headway Emotional Health Services	Pat.Dale@headway.org
Patina Park	Executive Director	Minnesota Indian Women's Resource Center	ppark@miwrc.org
Scott Redd	Executive Director	St. Stephen's Human Services	sredd@ststephensmpls.org
Steve Knutson	Executive Director	Neighborhood Health Source	knutsons@neighborhoodhealthsource.org
Susan Palchick*, CHIP co-chair*	Public Health Director	Hennepin County Public Health	Susan.Palchick@hennepin.us
CHIP Planning Team			
Cindy Jean-Baptiste	STAFF	Bloomington Public Health	cjeanbaptiste@BloomingtonMN.gov
Karen Nikolai, CHIP coordinator	STAFF	Hennepin County Public Health	Karen.Nikolai@hennepin.us
Margaret Schuster	STAFF	Minneapolis Health Department	Margaret.Schuster@minneapolismn.gov
Molly Schuman	STAFF	Hennepin County Public Health	Molly.Schuman@hennepin.us

Appendix B

Community Health Improvement Partnership
CHIP Committee structure, Hennepin County

CHIP Executive Committee

This committee serves as the decision-making body for CHIP and includes organizations with experience and expertise in CHIP's priorities and the communities we serve. It is composed of a subset of the CHIP collaborative and action teams.

Roles and responsibilities

1. Oversee CHIP implementation:
   a. Serve as a liaison between CHIP and your organization to: 1) identify and implement opportunities that support CHIP strategies, 2) identify and implement opportunities that support the communities we serve, 3) inform and prepare your organization's leadership regarding CHIP priorities, decisions, or recommended policy change needed to support CHIP principles.
   b. Provide guidance and decision making to accomplish CHIP priorities
2. Participate in monthly executive committee meetings, along with smaller planning groups as needed.
3. Participate on an action team or delegate participation to someone within your organization
4. Participate in CHIP Collaborative workshops twice per year. (See CHIP Collaborative below for more information.)
5. Come prepared to meetings having read advance materials. Be prepared to discuss and vote on decisions as needed. If unable to attend a meeting:
   a. Let Karen Nikolai know prior to the meeting
   b. Review materials and provide input on any decisions to be made at that meeting and have a backup from your organization participate on your behalf
   c. If you are an action team co-chair, ensure that updates and decisions are conveyed to the Exec Committee by your other co-chair

CHIP Action Teams

CHIP Action Teams will coordinate each strategy, and each action team will be accountable to the Executive Committee. Executive Committee team members will participate on each action team. Action team co-chairs will participate on the Executive Committee and be accountable to that group for the work carried out on their action team(s).

Roles and responsibilities

1. Serve as a liaison between CHIP and your organization to: 1) identify and implement opportunities that support CHIP strategies, 2) identify and implement opportunities that support the communities we serve, 3) inform and prepare your organization's leadership regarding CHIP priorities, decisions, or recommended policy change needed to support CHIP principles.
2. Nominate another co-chair for your action team who will partner with the Executive Committee team member.
3. Review, revise and finalize draft action plans.
4. Participate in Action Team meetings, conference calls and/or smaller planning teams.
5. Commit and be accountable to implement the actions that fall under your Action Team's strategy.

CHIP Collaborative

This group is composed of all CHIP action team and executive committee members, as well as community organizations and others invested in the goals and priorities of CHIP. This group helps CHIP achieve its goals by reviewing semi-annual progress toward plans and priorities, providing input and recommendations. This group will be convened twice per year.

Roles and responsibilities

1. Help guide CHIP's plans and priorities, and provide meaningful input and feedback on the work of CHIP's executive committee and action teams.
2. Keep abreast of CHIP work through workshops and emails from CHIP staff.
3. Discuss actions planned for the coming six months and recommend actions.
4. Participate on an action team if desired and your time allows. See below for more information.

We look forward to your participation!

November, 2018

Appendix C

CHIP Executive Committee Principles

CHIP Principles

The Executive Committee engaged in small and large group conversations, over two meetings, to formulate principles that the partnership will use in planning and executing its work. The key concepts and phrases from those discussions are captured in the guiding principles below.

Guiding principles:

1. We understand that racism is at the core of racial and economic disparities, and the systems that perpetuate these inequities must be dismantled.
2. We recognize the harm our systems have caused, and we will shift our organizations' business decisions to prevent harm.
3. We will listen as communities define their own goals, then partner with them to achieve shared success.
4. We will act collectively upstream, harnessing the power and resources of this partnership to create equitable processes, policies, and collaborations.

Appendix D

Community Health Improvement Partnership of Hennepin County Fall, 2018

CHIP Purpose:

The Community Health Improvement Partnership (CHIP) was formed in 2012 to foster alliances across public and private organizations to target important community health issues together for greater impact. We recently closed out the first 5 years of CHIP and reorganized to expand our capacity. **CHIP's two priorities for this new time period are:**

       1) Community mental wellbeing

       2) Housing stability

The core of our work is health, but the majority of factors that impact health, such as housing, are beyond the purview of most healthcare organizations which is why CHIP consists of a broader group of organizations and communities to bring these important perspectives to the table.

CHIP Roles

Convene – Bring different sectors and organizations together to move toward action

Catalyze and collaborate – Learn from experts and impacted communities, align interests and resources, and act toward mutual goals to move the dial on community mental wellbeing and housing stability

Advocate – Get to shared decision-making and action with people who don't traditionally have a voice. Advocate for change together with them

Adopt policies – Lead policy change within partner organizations, and work externally with political bodies to adopt policies that move the dial on disparities related to CHIP's priorities

Use data, including health/racial equity data – Data will help inform (but not drive) our direction, decisions and actions, and will be used to measure progress and outcomes

Appendix E

Community Health Improvement Partnership
of Hennepin County Fall, 2018

Statement on Health and Racial Equity

Health and racial equity are at the core of our work. Because of this, we will focus on the ways structural and institutional racism and also bias, impact outcomes for people of color. We will use a racial equity lens to focus our intent, which will bring us all to a shared understanding, language, and definitions on race and bias as we catalyze and carry out our work.

Appendix F

Hennepin County
Community Health Improvement Partnership

Key Informant Interviews

Final Report, July 2018

Table of Contents

Introduction

Background on CHIP and its roles

The Community Health Improvement Partnership (CHIP) was formed in 2012 to foster alliances across public and private organizations to target community health issues together for greater impact. It was founded by the Community Health Boards of Hennepin County, Minneapolis, Bloomington, Edina, and Richfield and their partners.

In 2017, CHIP closed out its first five years and began planning for the next five, calling it CHIP 2.0. Planning included data collection and community input that were incorporated into the community health needs assessments completed by the health systems and a joint Community Health Assessment carried out by public health. Two priorities rose to the top: 1) mental wellbeing in communities and 2) housing stability as a determinant of mental and physical health.

Planning continued throughout 2017 to narrow down these two broad priorities into strategies and potential actions. CHIP hosted learning sessions on 1) historical trauma and structural racism, 2) mental wellbeing in communities, and 3) housing stability as a social determinant of wellbeing. A diverse group of stakeholders was invited to each learning session including community partners, local government, foundations, cultural communities, and topic area experts. CHIP members then targeted potential partners with expertise or lived experience in the chosen priorities and established a new decision-making body called the CHIP Executive Committee. That committee kicked off in December 2017.

At that initial meeting, the new Executive Committee had a robust discussion regarding community input and participation in CHIP 2.0. Members decided that key informant interviews would help committee members learn from organizations and individuals with intimate knowledge of the two priorities above, and that their expertise was needed to more clearly determine and drive our direction.

Executive Committee members conducted 23 interviews from January through June 2018 with individuals representing various types and sizes of communities, businesses and organizations. Key informants provided their knowledge and perspectives on both priorities. This report is a compilation of advice, findings, potential models and impassioned quotes from those interviews.

Mental Wellbeing in Communities

Mental Wellbeing in Communities Advice for CHIP

1. Help impact things at a structural level. Create tangible evidence of the community being able to affect policy through inclusion in the process.
2. Create a seamless ecosystem of support – one program ends and another picks up with shared targets, goals, communication, language.
3. Be intentional with collaboration. It's frustrating having these conversations about community health and wealth without showing that this isn't just an exercise. If you're going to talk about Public Health issues ... but don't have the most impacted people at the table, what sense does that make?
4. It is myopic to simply have discussions that relate to issues. There are always going to be new issues in terms of interest and urgency. Your picture needs to be much bigger, to build resilience and capacity in communities.
5. Partner with and fund community based organizations that already have community trust.
6. Engage faith communities. They want to get involved and are doing great things. Tap them!
7. Talk to people when you see them no matter how they look. They need to feel like a part of our community in a positive way. Mental health is robbing people of their communities.
8. You need to look at mental health and housing together – don't pull them apart. There's been lots of lip service to this, but we need to make the model work.

Theme: Youth

I.Main concerns/special challenges
1. Perception that youth are joining gangs because of lack of parent involvement and programs not having the funding they need to succeed.
2. Concern about homelessness for young people, and the accompanying mental issues, lack of support, or whatever caused youth to leave home. They drop out of school, so their disparities in education are huge. They make poor choices with relationships and peers. It's a downward spiral that's hard to get out of.
3. Immaturity and hopelessness play a big part. Kids don't care if they live or die, so they say "why should I even bother to learn skills on my own?"
4. Young people with felonies have kids when they're kids themselves, and that's our future. How do we get these young people to feel like they're a part of our community and tell them that they're going to live, they're going to be prosperous, and that gangs and drugs do not need to be part of their lives?

II.Most effective strategies
1. Help youth to start believing and hoping that through education, good health, and good nutrition they can be successful. Help them avoid making the poor choices that keep their lifestyle and character in decline, choices like holding a gun and thinking it's fun to shoot and kill.

2. Connectors can cause an epidemic. Vice gang leaders in North Minneapolis have strong personalities that resonate with people. Give them a good vision and change this epidemic from negative to positive.
3. Youth leadership and development can bring youth to your table to change cities and systems.

III.<u>Quotes</u>
1. Bishop Richard Howell, Shiloh Temple: Youth feel they have permission to live any way they want. They're planning on dying before they are 30, so their despair and hopelessness has created this live large, live wild, live short mentality. Very Sad.
2. Heather Huseby, Executive Director, Youthlink: Have some cohort studies. Too often people are just sitting around the table – let's TRY some things and show some results and have some evaluation around it to share.

Theme: Desire for a Vibrant Community

I.<u>Main concerns/special challenges</u>
1. The community isn't what it used to be. If you see a kid doing something and his momma's right there, she'll say mind your business. If you see someone get shot, you have to mind your own business.
2. The concept of feeling safe in my neighborhood when out walking is not equally shared in some of our communities. The spiral of violence and unsafe outdoor spaces cause stress. We need to provide safe parks and or/spaces in our environment that foster improved health and wellbeing. There's a strong connection between mental health and safe spaces in our environment. This is a community and civic issue.
3. Gentrification – there's a relationship between people moving out of places they've lived for a long time and their sense of health, connectedness, and things that help people be in good emotional and mental places to make decisions about their lives.

II.<u>Most effective strategies</u>
1. Build community capacity and resiliency. It has to be intentional.
2. Work toward a sense of connectedness to other people and to places and a sense of stability that I know where I'm going to be and I'm not guessing at it and am not worried about where I'm going to sleep, my kids are not going to be moving to another school.
3. Create predictability in that connection.
4. Rethink stability. In the black community you can have a kid who lives 6 months with mother, 3 months with grandma and 3 months with auntie. That is still stability and predictability in that family.
5. Find the strength of the family and build upon that. Parents are leaders in their communities; provide pathways for them to achieve their goals.
6. Recognize the wisdom in the community and celebrate that. Identify community healers who may not be recognized by title or degree, but are incredibly valuable to their communities.

7. Create opportunities that are safe for children and families (including and beyond community violence). Strive for a community that is thriving and doing well.
8. Foster cooperative ownership: Mental wellbeing happens when people who own businesses, provide service, and work with you are people who look like you. This shifts people from trying to get by – to success, and they end up buying homes in that same community and having a senses of place.
9. Historical institutions – Use the power of the Black church [and other faith communities] as a platform to bring initiatives together. For Black folk, the church is an effective strategy, not that different than what Martin Luther King did.

III. Quotes
1. Abdullah Kiatamba and Fata Acquoi, African Immigrant Services, joined by Imam Mohammed Dukuly and Pastor Holdo from Ebola Taskforce: When you bore the hole in your ear you need to put an earring in or it will be for naught. Know of the issues. What are the resources?
2. Antony Stately, CEO, Native American Community Clinic: Community Wellbeing is a sense of community; a sense of place and space; a community that helps one another.
3. Jen Polzin, CEO, Tubman: The most effective strategies are realizing intersection of all social determinants of health. It's simplistic but huge! Also the prevention aspect and working upstream. The ability to see the both/and. Use a public health aspect and viewpoint.
4. Kelly Chatman, Pastor, Redeemer Lutheran Church and Center for Life: The health equity work we did on the Bottineau Line was very empowering, data was very interesting and told a story. The work involved learning from each other and developing partnerships. That's a very effective strategy.
5. Repa Mekha, President and CEO, Nexus Community Partners: What if the properties near Plymouth where Jamar Clark was killed were owned by the people who live there? Would that have happened?
a) VJ Smith, President, MAD DADS: If a person gets shot right there on Lake Street and you and me see it, they'd just cover the body and tell us to stay out of the way but if it happened in Edina, they'd provide mental health counseling to us.
b) Yvette Hewitt, volunteer nurse, Black Nurses Association: With the Clipper Clinics [free preventative health care screenings in underserved communities] we're face to face and on their turf, so we've been impactful. It's at their beauty or barbershop. People might be traumatized by an institution but having community based representatives from that community who give that information and assistance builds trust.

Theme: Trauma and Racism

I. Main concerns/special challenges
1. The underpinning of trauma to the health and wellbeing of Native American people. Addiction (to changing substances) is a significant issue.
2. Violence and hopelessness is a pandemic among African American youth.
3. Lack of knowledge around trauma informed care in dealing with People Of Color (POC).

4. Disorders of Despair is tied to a history of colonization and disrupted natural ways of healing. The community has been denied the resources needed to help itself. We need both intervention and prevention, spiritual too.
5. How white culture responds to trauma and inequities is a concern.
6. Trauma increases the likelihood of mental health concerns (i.e. Post-Traumatic Stress Disorder or PTSD, depression, anxiety), yet acknowledging these concerns might negatively impact (stigmatize) a person who may be fighting in family court for custody of their children, for example.
7. People are not steady enough to make good decisions about themselves, their families and extended families and it shows up as mental health, and it's just the complexity of the lack of stability.
8. Petty laws that add up to disproportionate traumatic impact in communities of color.
9. Your community cannot be in the game if large portions of your population are incarcerated.

II.<u>Most effective strategies</u>
1. Target racial equity issues to solve for change as opposed to simply maintenance.
2. Post-Traumatic Stress Disorder (PTSD) and undiagnosed mental health issues are extremely common. Awareness training of what trauma looks like, how it presents itself in behavior, and training on trauma-informed sensitivity and responses all help staff be better equipped.
3. Mental wellness is not just a health issue, it's a sense of hope and possibility as much as it is about addressing health related things like stress. Hope is medicine. It is wellness.
4. Build capacity to understand trauma and promote resiliency. City staff carry trauma in their work with community. Police get traumatized as well.
5. Educate the general population that trauma is a causative factor for many mental health issues as well as on Adverse Childhood Experiences (ACEs) and that children who experience trauma have much greater struggles moving through this world than those who do not.
6. Emphasize "anchors" – people as anchors to others in communities.

III. <u>Quotes</u>
1. Ebony Adedayo, Program Manager, ReCAST: Communities of color have a lot of historical trauma that manifests in different decision making strategies when trauma strikes. We need to see this as more than just cultural responses.
2. Michelle Wincell O'Leary, Vice President of Housing, Clinic and Fitness, Touchstone Mental Health: What's needed is a trauma-Informed skill set, and same day flexibility to address issues on the spot. If a client has to come back, they will likely be lost.
3. Repa Mekha, President and CEO, Nexus Community Partners: A community cannot be stable when so many people are scooped up, held, and then put back in again. The capacity and resiliency of the person, family and community gets lessened each time. The person doesn't know how to act and be in relationship, family doesn't know how to accept them back, and community can't absorb them well. And technology leaves them behind while they're in prison.

4. VJ Smith, President, MAD DADS: When it comes to mental health, this phone goes off 24/7 but for the white orgs they can go click and turn off their phones. In my community there's so much trauma that we don't have that luxury. And not everybody needs to go to the psych ward. They may just need someone who cares, who listens and is understanding.

Theme: Stigma and Stereotypes

I.Main concerns/special challenges
1. Stigma causes some POC to avoid therapy or similar services. People don't want people to talk about them so they won't ask for help.
2. The separation between health and mental health is a problem. You need to bring them together and take a more holistic approach.
3. Mental health services are not well utilized and providers are not very diverse. There's a lack of knowledge around trauma informed care, and when you're dealing with POC there's some type of trauma to be addressed.
4. People are afraid or distrustful of systems; they're not sure where to get help. If they've gone through the system they may feel that they haven't gotten what they needed.
5. Jails are now hospitals. That's where organizations are doing much of their case management. Sheriffs are frustrated with being mental health providers and hospitals don't have any beds.

II.Most effective strategies
1. Destigmatizing mental health concerns and treatment would be effective for persons who fear that acknowledgement of having mental health issues could harm them in courts and in the work world.
2. Consider terminology around PTSD for use on the ground. It's not just with veterans. These things need to be marketed and told in layperson's terms so people understand and are comfortable seeking help.
3. If we're going to do this right, really, we've got to fund the people who are doing the work so we can keep doing what we're doing.

III.Quotes
1. Mary Martin, Director of Outreach, Dignity Center: One thing that works for us is that we know everyone by name. At the end of the day we discuss caseloads and who's doing what and how they're doing. It's building that trust.
2. Ruth Pauley, Director of clinical programs, Jewish Family and Children's Services: The separation between health and mental health is a problem. Bring them together and take a more holistic approach.
3. Yvette Hewitt, volunteer nurse, Black Nurses Association: People don't want to be the Guinea pig. They don't want to be the test. People also don't want to get their hopes up too much. They come here and get what they need and then they leave. The systems that come in who are proposing this (CHIP), hopefully they have lay persons on the ground rather than people at the corporate level.

Successful Models

1. Downtown 100 looked at youth who are arrested in downtown Minneapolis. They are the highest group arrested there. Groups are working collaboratively to do something different. Arrests have dropped by 70% - take a look at this model – collaborative bundled approaches. They're doing a Return On Investment (ROI) on 2011 Downtown 100 cohort (6 year study) now to show that youth are working and that they are an investment versus charity.

2. Next Step is a hospital-based violence intervention program at HCMC that connects youth and young adult victims of violent injury to resources and support. The program, which started as a pilot in 2016, aims to help interrupt the cycle of community violence. The one-year pilot program was funded through grants from the City of Minneapolis Health Department, Minnesota Office of Justice Program. Additional funding has been secured for another two years at $140,000 per year, and it is expanding to North Memorial. Cities in other metropolitan areas like Chicago and Baltimore have similar programs. The goals of Next Step are to:
   a) Reduce re-injury and re-hospitalization for youth victims of violent injuries.
   b) Support positive development and holistic healing for youth and families affected by violence.
   c) Help interrupt the cycle of community violence.

3. Community Wealth Building: Cooperative ownership of businesses and housing to create more opportunities. Brooklyn Park has adopted this model for its community work such as with retiring business and property owners. In the near future, older owners could sell to employees or residents to become cooperatively owned, many by people of color, rather than sell in the open market.

Housing stability

Housing Advice for CHIP

1. Advocate for policies that would give priority to communities to purchase properties within their community ahead of outside investors. Examples: tax breaks, housing co-ops, community benefit grants.
2. Advocate at the federal level to revise Rapid Re-housing (RRH) eligibility standards (length of subsidy, need for long-term case management, etc.). Current experience of some landlords is that it does not set up the renter and landlord for success. Clients can cycle in and out of shelter with different landlords making it potentially significantly more expensive than Sec. 8 voucher system.
3. Advocate for and create awareness on the need for systemic changes on the correlations between housing, minimum wage and health. Many of our communities are voting on these issues.
4. Develop expanded and consistent screening criteria for landlords so they don't screen the majority of low income or section 8 people out from getting into housing. Most landlords won't rent to someone if they've had an eviction filing in the last 3 years.
5. Review and revise emergency assistance eligibility at the county to better serve clients in advance of eviction notices.
6. Review and revise crime free/drug free and domestic violence ordinances and responses in cities to better serve families.
7. Work with the Government Alliance on Race and Equity (GARE) to develop a legislative platform for housing.
8. Collaborate with organizations such as the Suburban Hennepin housing coalition, the Minnesota Multi Housing Association, Minnesota Housing Partnership and the Governor's Task Force on Housing as well as St. Stephen's, Catholic Charities and the Minnesota Assistance Council for Veterans.
9. Partner with and fund community based organizations that already have community trust.
10. Have the most impacted people at the table!
11. Consider the benefits of communal environments/living in community for some populations as a cultural preference and/or to help them get their feet on the ground.

Theme: Affordable Housing Issues and Availability

I.Main concerns/special challenges
1. Community organizations don't know what resources exist and where to find them to help their clients.
2. There is not enough affordable, safe housing in the community. This is keenly felt by survivors of domestic and sexual violence.
3. The affordable housing that's available does not match the needs of families (most affordable housing units are 1 bedroom).

4. Individuals are one crisis away from homelessness and the impacts can last for years. For example, people are still homeless in 2018 from the May 2011 tornado in North Minneapolis.
5. We are seeing an outmigration to the north and west suburbs because families can't find affordable housing. But they don't know what kinds of services are available there.

II.<u>Most effective strategies</u>
1. Advocate for gradual increases in rent to wean people off assistance rather than spikes.
2. A portion of rent could be placed in a separate account for people as an incentive to move toward better housing (qualify and move from subsidies at 30% or 50% Area Median Income (AMI) housing to 80% AMI, etc.)
3. Have more emphasis on "anchors" – housing, and social determinants of health.
4. Streamline the information and referral process for affordable housing and communicate that share website links, etc.
5. Short (ST) and long term (LT) solutions are very different. ST is the county or a non-profit paying the rent that's due or in arrears. That only works for 30 days. LT is preventing the issue from happening.

III.<u>Quotes</u>
1. Alfred Babington-Johnson. Founder, President and CEO, Stairstep Foundation: If you increase home ownership for African Americans, is that your hooray moment? If so, how does that change the disparity and the critical issues people are facing?
2. Andre Dukes, Director of Organizational Learning and Practice, Northside Achievement Zone: Families don't come in pieces. You need to think about how to address the entire family. CHIP should align with all the supports that a family needs – and be intentional with collaboration.
3. Chuck Peterson, Executive Director, Clare Housing: Wouldn't it be amazing if a doctor could write a prescription for housing and Medicaid would pay to get that person housed?
4. Gordon Goodwin, Midwest Project Manager, Government Alliance on Race and Equity (GARE): If you don't have stability or certainty about your housing, it puts a number of things in jeopardy: physical and mental wellbeing; ability to count on social networks, education and economic opportunities, etc. Whether renting, owning, or sharing – if it's not stable and livable, you are at risk for not being healthy, not being part of the community. It's foundational.
5. Linda Bryant, VP of Community Based Services, Emerge: Trauma is probably linked to why they're homeless in the first place, then there's trauma at the shelter, past history comes up so they can't get housing, and if you can't get housing for you and your kids, a pillow for your head, that's trauma. It's about stability. There might be mental illness or chemical dependency issues, and they struggle with that at the same time they're figuring out how to pay the rent each month.

Theme: Housing Stigma and Stereotypes that Impact Renters

I.Main concerns/special challenges
1. There is an underrepresentation and misrepresentation of tenants, including at housing court, and Unlawful Detainers and felonies follow you for life.
2. People are afraid that the system will attach a label that will be used against them, of being in court trying to get their kids back and they can't because they have been labeled a felon or mentally ill.
3. People who know about emergency services know it can only be used once a year. Maybe they wait until they need it, but many people use it once a year like clockwork.
4. There's a lack of confidence that housing and human services system priorities help families. It is not transparent and seems to set people up to fail. For example, a woman can't get her children back without an apartment but she doesn't qualify for a section 8 apartment without them.
5. Change happens incrementally for most persons, so adequate time must be given to people dealing with mental health and housing crises. It seems like when someone begins to make some headway, they're penalized by losing childcare or having other benefits cut.

II.Most effective strategies
1. Expungement of Unlawful Detainers (UD). If there's not one already, set up an alternative mediation court system like they do with child custody and support, etc. District court would have to embrace that to do it. Ask the District Court GARE team if this is something they would / could help with this.
2. Pairing services with housing for longer time periods. Client follow through (monthly home visit is strongly recommended) by community health workers or other entry level staff. This would provide consistency and success for more families at a lower cost.

III.Quotes
1. Cheryl Kolb-Untinen, Community Advocacy & Training Manager, Cornerstone: Recognize that almost 40% of women that are homeless, are homeless due at least in part to domestic violence and the impact that trauma has on an individual's mental/emotional health.
2. Derek Burrows Reise, Executive Director, St. Louis Park Emergency Program: A person's current landlord is much less likely to renew someone's lease if they've filed against them during the current lease period, and then most landlords won't rent to someone if they've had an eviction filing in the last 3 years.
3. Jake Gale, Director of Operations, People Serving People: When proposing changes, it is effective to engage the families we serve and meet with people to give them a voice. Seeking input is time-consuming and challenging, but so valuable to long-term outcomes around housing.
4. Linda Bryant, VP of Community Based Services, Emerge: At Collaborative Village we had mental health services right in the building. There's such a stigma for people of color to receive mental health services and co-located services helped with that.

Theme: Tenant Education and Skills Training

I.Main concerns/special challenges
1. Many people in affordable housing have never learned how to be a successful tenant.
2. We need to this next generation (youth) to teach them about housing and home ownership, to be successful tenants or owners.
3. Young, single parents are juggling so many things – kids, several jobs, multiple assistance programs with different requirements, paying rent, food and other things – that it would be challenging for anyone to manage them all.

II.Most effective strategies
1. Create a place / venue for education that will teach soft and social skills, to train people for the future, develop families that will be sustainable.
2. Help people/clients/communities be accountable for their behavior and in order for this to happen, they need to feel welcome and motivated to get help.

III.Quotes
1. Asher Gavzy, Director of Operations, Property Solutions & Services, LLC: There are people who don't know how to vacuum or mop the floor and don't have one. We try to help and tell them to go to Goodwill and get one.
2. VJ Smith, President, MAD DADS: People have never been taught how to maintain a household and how to fix a toilet, regulate heat and put plastic in their windows in winter. People have the window open because they're hot but they have the heat on because they've never been taught to not do that. They don't know how much soap and bleach to put in the laundry too. Have them come to a class. Tt would save a lot of cost and pain.

Theme: Landlord Issues, Training and Competency

I.Main concerns/special challenges
1. Many owners of Naturally Occurring Affordable Housing (NOAH) properties are running very tight budgets and need rental income to pay the mortgage and live off of. It may be challenging for them to rent to people with perceived risks.
2. Some landlords don't want to rent to persons perceived to possibly bring issues with them, especially domestic violence, drugs, mental illness.
3. Landlords' don't understand historical and current trauma and their impact on renters.
4. You can't assume building managers will see value in getting training. Who would pay for their time spent attending training? For profit landlords will be concerned.
5. PTSD, chemical health, and undiagnosed mental illness are extremely common issues and often trigger eviction.
6. Mom and pop landlords probably don't have a good relationship with government in general because it's perceived to be the landlord's fault if the police are called, so they don't want to take any chances on renters. There's tension between landlords and government.

II. Most effective strategies
1. Landlords must participate in the conversation or you won't be able to move forward.
2. Mental Health First Aid, Psychological First Aid, trauma informed response, cultural awareness, sensitivity and competency could help landlords.
3. Loop landlords into the domestic violence system more so they have greater understanding of its impact on women and children, and know how and where to get help. Also work with police so they don't wear uniforms on these calls (like they are starting to do for mental health crises) so people are more comfortable in difficult situations.
4. A discount on rental licensing by the city might incentivize landlords to attend training, as would real estate credits for fair housing. Robin Williams specializes in housing law for owners and teaches fair housing classes.

III. Quotes
1. Linda Bryant: Landlords have so much control over people's lives. What I mean is that if you get an Unlawful Detainer (UD), your life could be destroyed for 10 years and it may have been because you had a landlord who shouldn't have been a landlord in the first place. The tenant doesn't have access to a lawyer and that is a problem.
2. Lynette Chambers, Multifamily Housing Coordinator, City of Richfield: City staff spend significant time working with a handful of residents struggling who just need a supportive ear.

Successful Models
1. Collaborative Village Initiative (CVI) – houses families such as those with two parents and eight children. It saves money on shelter costs, social services, etc. Services include employment and career counseling, on-site mental health counseling, advocacy and intervention, after school programming, support groups, and anchor family mentoring for new tenants.
2. "Anchor/mentor tenants" in housing complexes who act as positive role models and provide support for their neighbors have been found very helpful to tenants.
3. Clustered housing units can create a collective or village atmosphere to facilitate social connectedness and safety.
4. Staff who employ intensive engagement strategies can motivate tenants to utilize services as needed to maintain housing and keep their children safe.
5. Fathers and Children Together (FACT) – [24-month transitional housing and family development program serves about 45 homeless families, mostly single fathers with legal custody of their children, administered by Emerge in partnership with local agencies] works with men living with their kids to get them into jobs and successful in there. Those men became mentors.
6. The City of Richfield has a 48-month rental assistance program for families with children called Kids @ Home. Families must fit the criteria to enter the program and maintain these criteria to continue to receive rental assistance under the program. St. Louis Park has a similar program called Kids in the Park.

Conclusions and Next Steps

This interview process began last December to increase community inclusion in the work and development of outcomes of the Community Health Improvement Partnership (CHIP) of Hennepin County. It became a six-month endeavor to include as many voices as possible and capture words spoken as closely as possible to ensure intent.

The advice, concerns, effective strategies, successful models and poignant quotes shared by interviewees have been invaluable to the CHIP Executive Committee as it further prioritized its principles and roles in the areas of mental wellbeing in communities and housing stability. Vision statements and work plans based in part on these interviews have been created for each priority and are being fine-tuned by small teams of Executive Committee members throughout the summer of 2018.

There is much more work to be done:

1) Action teams will be launched in the fall of 2018. These will be composed of community partners, public health, health plans and hospitals, and subject matter experts. Key informants and others who took the time to share their knowledge and personal experiences will be encouraged to participate on an action team.
2) A "CHIP Collaborative" workshop will be held in September/October 2018. This will be the first of annual or semi-annual collaborative workshops to help the partnership to monitor, review, and potentially revise CHIP priorities and actions:
    a. The purpose of each workshop will be to ensure transparency and accountability back to the many communities, businesses and organizations within Hennepin County on CHIP's priorities:
        1. Mental Wellbeing in Communities
        2. Housing Stability
    b. All key informants and others interested in this work will be invited and encouraged to attend.
    c. The goal of each workshop is to see if CHIP's work is on track, and if not, to get the input needed to revise the strategies to improve health and racial equity, refine future direction, and report progress toward long term outcomes.

Thank you again to all who took the time to be interviewed by our partners. Your input is invaluable! The list of key informants is below.

For more information or questions, please contact Karen Nikolai, CHIP coordinator, at 612-348-8089 or karen.nikolai@hennepin.us.

Key Informants

1) Abdullah Kiatamba and Fata Acquoi, African Immigrant Services, joined by Imam Mohammed Dukuly and Pastor Holdo from Ebola Taskforce
2) Alfred Babington-Johnson. Founder, President and CEO, Stairstep Foundation
3) Andre Dukes, Director of Organizational Learning and Practice, Northside Achievement Zone
4) Antony Stately, CEO, Native American Community Clinic
5) Asher Gavzy, Director of Operations, Property Solutions & Services, LLC
6) Bishop Richard Howell at Shiloh Temple
7) Cheryl Kolb-Untinen, Community Advocacy & Training Manager, Cornerstone
8) Chuck Peterson, Executive Director, Clare Housing
9) Derek Burrows Reise, Executive Director, St. Louis Park Emergency Program
10) Ebony Adedayo, Program Manager, ReCAST Minneapolis
11) Gordon Goodwin, Midwest Project Manager, Government Alliance on Race and Equity (GARE)
12) Heather Huseby, Executive Director, Youthlink
13) Jake Gale, Director of Operations, People Serving People
14) Jen Polzin, CEO, Tubman
15) Kelly Chatman, Pastor, Redeemer Lutheran Church/Redeemer Center for Life
16) Linda Bryant, VP of Community Based Services, Emerge
17) Lynette Chambers, Multifamily Housing Coordinator, City of Richfield
18) Mary Martin, Director of Outreach, Dignity Center
19) Michelle Wincell O'Leary, Vice President of Housing, Clinic and Fitness, Touchstone Mental Health
20) Repa Mekha, President and CEO, Nexus Community Partners
21) Ruth Pauley, Director of clinical programs, Jewish Family and Children's Services
22) VJ Smith, President, MAD DADS
23) Yvette Hewitt, volunteer nurse, Black Nurses Association

Appendices

CHIP Executive Committee

Community Health Improvement Partnership (CHIP) for Hennepin County

Key informant interviews

January 2018

Purpose

Collect information from a wide range of people, including community leaders, professionals, or residents who have first-hand knowledge about the community and provide insight, ideas and recommendations.

Interviews:

<u>Introduction:</u>

Explain who you are and the organization you represent (your own and CHIP – see CHIP info below) and your area of expertise.

Background on CHIP:

Explain that the Community Health Improvement Partnership (CHIP) was formed in 2012 to collaborate across public and private organizations **to target important community health issues <u>together</u>** for greater impact. We recently closed out the first 5 years of CHIP, came to consensus on new priorities, and reorganized to expand our capacity (new Executive Committee with broader representation).

The **<u>goal</u> for the next 3-5 years is increased mental health and wellbeing in our communities**.

Two <u>overarching strategies</u> fall under this:

1) Build community supports for mental and emotional wellbeing

2) Address housing as a social determinant of mental health and wellbeing

Specific strategies and actions are being fleshed out following several workshops in the fall of 2017 and using the information we learn from these interviews.

Explain CHIP Roles

- ***Convene –*** *Bring different sectors and organizations together to move toward action*
- ***Catalyze and collaborate –*** *Learn from experts and impacted communities, align interests and resources, and act toward mutual goals to move the dial on mental health and wellbeing in communities*
- ***Advocate –*** *Get to shared decision-making and action with people who don't traditionally have a voice, and advocate for change together with them*
- ***Adopt policies –*** *Lead policy change within partner organizations, and work externally with political bodies to adopt policies that move the dial*
- ***Use data, including health/racial equity data –*** *Data will help inform (but not drive) our direction, decisions and actions, and will be used to measure progress and outcomes*

Share our commitment to health and racial equity

Health and racial equity are at the core of our work. Because of this, we will focus on the ways structural and institutional racism and bias impact outcomes for people of color. We will use a racial equity lens to focus our intent, which will bring us all to a shared understanding, language, and definitions on race and bias as we catalyze and carry out our work.

Let them know that our work is about health, but the majority of factors that impact health are issues like housing, transportation, education, criminal justice and having a good job or not. ***That's why we're reaching out to you today***. We want to know what you think about how these things influence mental health, particularly housing.

Questions:

When you talk about community, which community or communities do you feel you represent?

        a. <u>Geographic areas</u> in Minneapolis (North Mpls, Phillips, etc.) Bloomington, Brooklyn Park, Richfield, etc.
        b. <u>Faith communities </u>such as churches, synagogues, mosques, temples, etc.
        c. <u>Cultural communities such as </u>African American, American Indian, Hmong, Vietnamese, Latino, etc.
        d. <u>Specific groups of people</u> such as elders, women, youth
        e. <u>Representatives of specific organizations</u> such as elected officials at the State of MN, Hennepin County, or cities who work in areas that "touch" residents in mental health or housing

1. Tell me a bit about yourself, your role in your organization or community and what brought you to this work in mental health and/or housing (or activism if they're a community member).

2. You've been identified as someone who knows about mental health or housing. What are the main concerns in your community related to this?

3. What special challenges are there to **addressing** mental health and/or housing in your community?

4. Reflecting on your knowledge and experience in the community, what do you think are the most effective strategies to reach community members and impact mental health and/or housing? Least effective?

5. Thinking about CHIP as a potential partner in this work, what strategies or activities around mental health and/or housing could CHIP champion or align with that would be particularly effective in your community?

6. Can you recommend partners or resources that would help us? Is there anyone else in the community that I should speak with about this?

7. Summary: We talked about __, __ and __ and you had great ideas on __, __ and __. What other thoughts do you have that we might not have covered?

8. *Thank you* for your time and information! **Next steps are** that we plan to wrap up Interviews by mid-March. We will compile the interviews into a report to tease out specific issues, themes and recommendations, and hope to have this completed to share back with you by the end of April.

   In the meantime, please feel free to contact me with any additional thoughts or ideas, or to contact Karen Nikolai, our CHIP Coordinator, at either karen.nikolai@hennepin.us or 612-348-8089.

Thanks again for your time!

CHIP Executive Committee

CHIP Principles

The Executive Committee engaged in small and large group conversations, over two meetings, to formulate principles that the partnership will use in planning and executing its work. The key concepts and phrases from those discussions are captured in the guiding principles below.

Guiding principles:

1. We understand that racism is at the core of racial and economic disparities, and the systems that perpetuate these inequities must be dismantled.

2. We recognize the harm our systems have caused, and we will shift our organizations' business decisions to prevent harm.

3. We will listen as communities define their own goals, then partner with them to achieve shared success.

4. We will act collectively upstream, harnessing the power and resources of this partnership to create equitable processes, policies, and collaborations.

Appendix G

Community mental well-being vision and logic model

(see below)

CHIP Mental Wellbeing Logic Model

Who we serve:

Vision of impact: *We envision leading equitable policy and systems changes that promote physical, social, and racial wellbeing and honor self-determined communities*

INPUTS
Resources we need

1. Trauma informed CHIP partner governments & organizations
a) CHIP Principles
b) Funding/other resources
c) Data on current policies and their effect (gaps)
d) Government Alliance on Race and Equity (GARE)-based training curriculum
e) Henn. County's Health in All Policies (HiAP) toolkit
f) GARE racial equity tool
g) Trauma informed templates
h) Local Comprehensive Plans
i) Examples of trauma-informed organizations that have done this
j) Cultural competency tools
k) CHIP partners as pilot organizations

ACTIVITIES
Actions we will take

1. Trauma informed CHIP partner governments & organizations
a) Use CHIP principles to conduct needs assessments/analysis
b) Filter priorities based on racism & bias
c) Look nationwide to see who is doing this well (model orgs/practices)
d) Conduct bias training
e) Obtain and refine tools and trauma informed templates
f) Train CHIP partner orgs on tools/ templates to analyze policies/systems, and create organizational policy shift
g) Leverage one organization's wins toward friendly competition to spur other organizations to make changes
h) Select CHIP partner and potentially other pilots to be trauma informed
i) Connect pilots to potential mentors doing this (People Serving People)
j) Complete pilots and expand more broadly

OUTPUTS
Things we will measure

1. Trauma informed CHIP partner governments & organizations
a) Recommendations for policy and process changes are completed and shared
b) Group consensus on priorities based on what's actionable
c) Environmental scan of model practices
d) Training curriculum
e) Tools / templates
f) New/revised policies and processes
g) Fun competition!
h) Revised workflow as needed
i) Pilots completed-usable qualitative/quantitative data
j) Number of mentors/peer supporters
k) Data/stories or narrative

OUTCOMES

Short Term
Knowledge (12 to 18 mo.)

1. Trauma informed CHIP partner governments & organizations
a) Realization of system barriers that our organizations create that obstruct the fostering of socially connected and stable communities
b) Understanding of what needs to change and how to change it
c) Understanding of racism/trauma
d) Increased overall cultural sensitivity in Organizations
e) Community of practice
f) Understanding/ Awareness/ Engagement

Intermediate Term
Behavior-PSE (1 to 3 years)

1. Trauma informed CHIP partner governments & organizations
a) CHIP orgs proactively address the gaps between outcomes & our collaborative activities
b) CHIP orgs share stories (Seattle street light example)
c) Elected, appointed and hired officials who lead our orgs, are held accountable for this work and these outcomes
d) CHIP orgs use chosen tools & priorities to make ongoing changes to daily business
e) Leadership & staff have a foundational understanding of the importance of recognizing the impact of white dominant culture, racism and bias
f) community of practice is convened for organizations seeking to be trauma informed
g) CHIP orgs have an increased synergistic engagement with community

Long Term
System (3-5 years)

1. Trauma informed CHIP partner governments & organizations
a) Government, businesses and community organizations understand the influence of historical trauma and racism on community wellbeing, and consistently act on that knowledge to close gaps and increase equity
b) Government, businesses and community organizations enact sustainable policies

Assumptions: Our principles will guide our work

External Factors:

CHIP Mental Wellbeing DRAFT Logic Model, page 2

Vision of impact: *We envision leading equitable policy and systems changes that promote physical, social, and racial wellbeing and honor self-determined communities*

INPUTS
Resources we need

2. Partnering with spiritual and faith communities

a) Spiritual and faith community organizations that are already addressing mental wellbeing (MWB) and mental health (MH) in their communities

b) Empathy based and human centered approach

c) Examples of strategies and interventions that are already working

ACTIVITIES
Actions we will take

2. Partnering with spiritual and faith communities

a) Engage spiritual and faith community orgs to better understand their challenges and opportunities

b) Engage established collaborations (e.g., Downtown Congregations to end Homelessness, Isaiah, etc.)

c) Promote and learn from what's already working (e.g. People's Center/Fairview hiring chaplains & imams)

d) Implement recommendations such as mental health crisis training/education among spiritual and faith communities

e) Conduct pilots

f) Spread what works!

OUTPUTS
Things we will measure

2. Partnering with spiritual and faith communities

a) Number and types of organizations engaged

b) Recommendations developed

c) Pilots conducted

d) Broader implementation carried out

e) Recommendations implemented

f) Learning is documented

OUTCOMES

Short Term
Knowledge (12 to 18 mo.)

2. Partnering with spiritual and faith communities

a) Increased understanding of how to support mental wellbeing for community members

  i. Support they themselves can provide

  ii. Knowledge of available MH services and resources and how to connect to them

Intermediate Term
Behavior-PSE (1 to 3 years)

2. Partnering with spiritual and faith communities

a) CHIP partners advocate for spiritual and faith orgs/leaders in their work

b) Spiritual and faith orgs/leaders effectively support mental wellbeing

c) Spiritual and faith orgs/leaders consistently make appropriate and timely referrals when needed

Long Term
System (3-5 years)

2. Partnering with spiritual and faith communities

a) Trust is built among spiritual and faith communities, and MH services and resources

b) Increased mental wellbeing and resiliency in communities

c) Stigma is reduced

d) Reduction in stress, mental distress and untreated mental health conditions

Assumptions: Our principles will guide our work

External Factors:

Appendix H

CHIP of Hennepin County Housing Vision of Impact

Vision of impact:

All people have equitable opportunity for stable, affordable housing in vibrant communities.