2022-2024

Community Health Improvement Plan

CLINTON * EATON * INGHAM

Healthy!CapitalCounties℠
a community approach to better health

Acknowledgements

We would first like to acknowledge and thank the agencies, community coalitions, residents, and organizations that contributed to the goals, objectives, and action items in this Community Health Improvement Plan (CHIP) for the Capital Region. A successful CHIP is dependent upon community participation, and we are tremendously grateful to each community partner and resident who participated. A complete list of stakeholders can be found at the end of the report.

We also acknowledge the hard work and dedication of the members of the Healthy! Capital Counties collaborative (Eaton Rapids Medical Center, McLaren Greater Lansing, Sparrow Health System, Barry-Eaton District Health Department, Ingham County Health Department, and Mid-Michigan District Health Department). While Healthy! Capital Counties has served as the regional Community Health Profile and Health Needs Assessment since 2012, 2022 is the first time since 2015 the collaborative worked on a truly region-based Community Health Improvement Plan (CHIP). We look forward to working together in this expanded and re-focused tri-county approach to community health improvement.

Contact Information

For more information on this report, contact:

Barry-Eaton District Health Department
Aurelia Peña · apena@bedhd.org · (517) 541-2630

Ingham County Health Department
Amanda Darche · adarche@ingham.org · (517) 887-4311

Mid-Michigan District Health Department
Kara Trimbach · ktrimbach@mmdhd.org · (989) 224-2195

This document was prepared by Healthy! Capital Counties
www.healthycapitalcounties.org
Published February 2023.

Table of Contents

Introduction

Every three years, the Capital Region undergoes a Community Health Assessment (CHA) which informs a Community Health Improvement Plan (CHIP). This cycle, the fourth since Healthy! Capital Counties launched in 2012, was conducted in the midst of the COVID-19 pandemic. The pandemic posed many challenges to Capital Region community partners, the local health departments, and the health systems that lead this project. Traditional, in-person meetings were held virtually. Survey participants were recruited via the internet and through essential community gatherings (food pantries and vaccine clinics). The staffing capacity of local public health departments and health system partners was reduced, but work continued.

The three local health departments, which have worked together on Healthy! Capital Counties for the past decade, found themselves working more closely than ever as work mounted in COVID-19 response and new regional initiatives. This, in part, led them to the decision to produce a regional CHIP (in the two previous cycles, each local health department produced its own CHIP for each of the tri-counties). A regional CHIP made sense not only because of increased collaboration, but also due to limited staffing capacity which continued into 2022, as well as the expressed desire of community partners to address challenges at a regional level.

The 2021-22 CHA/CHIP cycle saw the inclusion of two new priority areas: “Community Safety” and “Safe and Affordable Housing,” as community partners gave greater consideration not only to the Social Determinants of Health (SDOH) but also the root causes of those inequities: systems such as racism, classism and sexism. These new priorities were joined by “Health Care Access and Quality” and “Behavioral Health” which have been priorities in previous cycles. Updated priorities brought new community partners to the table while existing partners remained engaged in long-standing priorities. Together, 19 community partners committed to 105 activities to advance the Capital Region.

CHIP Priorities for 2022-2024 are:

- **Health Care Access and Quality**
- **Community Safety**
- **Behavioral Health**
- **Safe and Affordable Housing**

Vision

The vision of **Healthy! Capital Counties** is that all people in Clinton, Eaton and Ingham counties live:

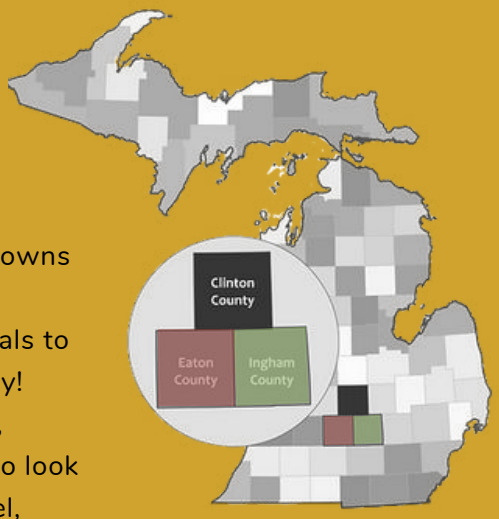
in a physical, social and cultural environment that supports health.

in a safe, vibrant and prosperous community that provides many opportunities to contribute and thrive.

with minimal barriers and adequate resources to reach their full potential.

Geographic Area

Many people living in Clinton, Eaton and Ingham counties view themselves as residents of a greater “Capital Area”, which is centered around the urban core of Lansing/East Lansing. These capital counties include a wide variety of communities — from East Lansing, home to Michigan State University, to downtown neighborhoods in Lansing, to inner suburban communities surrounding the urban core, to small towns and villages scattered through the countryside. The hospital systems serving the area range from small community hospitals to large tertiary care centers. The jurisdiction covered by Healthy! Capital Counties includes all of the residents living in Clinton, Eaton, and Ingham counties. Healthy! Capital Counties aims to look broadly at the region as a whole, at the individual county level, while also viewing smaller communities as closely as possible.



Tri-County Capital Area

Geography	Total Population	Median Age	Total Households	Median Household Income	Live Births	Deaths
Clinton	78,895	41.2	30,835	$76,161	724	774
Eaton	108,972	41.1	44,895	$72,173	1,114	1,276
Ingham	285,660	32.7	114,732	$58,226	2,815	2,598
Tri-County	473,527	36.0	190,462	$64,417	4,653	4,648
Source:	**2021 ACS 5-year Estimates**	**2021 ACS 5-year Estimates**	**2021 ACS 5-year Estimates**	**2021 ACS 5-year Estimates**	**2021 MDHHS Vital Statistics**	**2021 MDHHS Vital Statistics**

About the Plan

Description of the Process

The purpose of this community health improvement plan (CHIP) is to describe how the three local health departments, community partners, and stakeholders will work together to improve the health of the Capital Region in four priority areas: Health Care Access and Quality, Community Safety, Behavioral Health, and Safe & Affordable Housing. These priorities were identified in October 2021 following the completion of the 2021 Community Health Needs Assessment (CHNA/CHA). This plan, the resulting CHIP, was developed for 2022-2024. Tracking and reporting of its implementation will take place every six months, with data updated annually. The work is funded by area health systems and local health departments.

This is the first time since 2015 the local health departments have produced a regional CHIP rather than individual, county-focused plans. With increased regional projects and planning, and reduced staffing capacity due to COVID-19, a joint plan was deemed most appropriate and feasible for the tri-counties. Work began in January 2022 and concluded in December 2022.

The model of engagement aligned with the national model of Mobilizing for Action through Planning and Partnership (MAPP) model.[1] Where there were data gaps in some of the priority areas, the subcommittees sought supplemental data sources to understand needs and address them accordingly.

Source:

[1]National Association of County and City Health Officials. (2021). Mobilizing for Action through Planning and Partnerships (MAPP). NACCHO. https://www.naccho.org/programs/public-health-infrastructure/performance-improvement/community-health-assessment/mapp

About the Plan

Health Equity, Social Justice, and Social Determinants of Health

A healthy community cannot exist without equity, defined as a fair and just distribution of resources and opportunities to achieve well-being. It is both a cornerstone and a goal in each CHA/CHIP cycle. The Healthy! Capital Counties collaborative strives to keep equity values central in its work; specifically as it grows, builds and expounds upon the work each cycle in response to the community. The CHA/CHIP shines a light on some of the poor population health outcomes and health inequities occuring in the Capital Region and asks the community to act. Actions address not only immediate needs, but also causes.

Poor outcomes and health inequities do not exist independently. They are driven by external factors that influence behavior and allocate opportunity. These are Social Determinants of Health (SDOH)– the conditions in which people are born, grow up, live, and age, including- household income and wealth, educational opportunities, neighborhood characteristics, social inclusion, and access to medical care. Social Determinants of Health are the economic and social conditions that influence the health of individuals, communities, and jurisdictions as a whole. Strategies in priority areas may directly or indirectly address SDOH or may go deeper still, working to address root causes and pushing the region toward social justice, which is the absence of unfair advantage or privilege based on racial classifications, ethnicity, gender, sexual orientation, gender expression or other forms of difference. In moving toward a healthy Capital Region, action at all levels is necessary.

CHIP Terminology

- **Evidence-based:** Strategies that are backed by research and scientific findings, and recommended by trusted sources.
- **Goals:** Broad or general statement of desired change or end state; Can refer to a population's (or sub-group's) health status; Can refer to characteristics of the public health system; Should be measurable, but does need to have means to measure it embedded.
- **Lead Role:** The partner on a specific strategy for one of the priority areas, that will be the primary contact for monitoring of tactics and implementation of that strategy. They may collaborate on data collection, the priorities and the plan, but each partner has flexibility to tackle the priorities and implement actions for which they are best suited.
- **Objectives:** Measurable statement of specific desired change/end state. Contains an “Outcome Indicator/Measure” that quantifies achievement of the objective. SMART objectives are a common framework. Specific, Measurable, Attainable, Relevant, and Time-bound.
- **Outcome Measure:** Objectives documented with Outcome Indicators reflecting the data. Can be short, intermediate and/or long-term. Question to ask: What can we track at the highest level, to measure whether or not we are moving the needle and making a difference in this priority?
- **Performance Indicators / Measurement:** Measures that quantify how well a strategy’s tactic(s) are working, or “performing.”
- **Strategic Priority Area:** One of a few community health and/or public health system needs or assets identified during a data analysis process, as the targets/subjects of a Community Health Improvement Plan. Determination of the region's strategic priority areas are based on a combination of factors.
- **Strategy:** A general approach or coherent collection of actions which has a reasoned chance of achieving desired objectives.
- **Tactic:** Specific programmatic, policy or other action that implements or “operationalizes” a strategy.

Priority Areas

01. Health Care Access and Quality

GOAL: Promote Health Through Better Access to Quality Health Care.

02. Community Safety

GOAL: Improve community safety and awareness through policies, systematic change, and environmental solutions.

03. Behavioral Health

GOAL: Improve mental health in adolescents and adults, and reduce substance misuse in adolescents.

04. Safe and Affordable Housing

GOAL: Promote health through safer and more affordable housing.

Health Care Access and Quality

GOAL: Promote Health Through Better Access to Quality Health Care.

Current Situation

Based on the 2017-2029 five-year estimates from the American Community Survey, the percentage of adults 19-64 years old without health insurance decreased in most geographies.[2] Clinton County's rate of uninsured adults has remained fairly consistent between 5.5% and 6.1% between 2017 and 2019, and has since decreased to 5.4% as of 2020.[2] Eaton and Ingham Counties rates of uninsured adults have decreased each year from 2017 to 2019.[2] Eaton County decreased from 9.1% to 6.1% and Ingham County decreased from 9.2% to 6.9%.[2] Racial and ethnic minorities, individuals with lower education, and individuals with lower incomes are more likely to be uninsured.[4] Individuals without health insurance are less likely to get medical services and medications they need and are more likely to experience poor health outcomes due to a delay in seeking care when they are sick or injured.[1] Individuals without health insurance are also more likely to be hospitalized for chronic conditions such as diabetes or hypertension.[1]

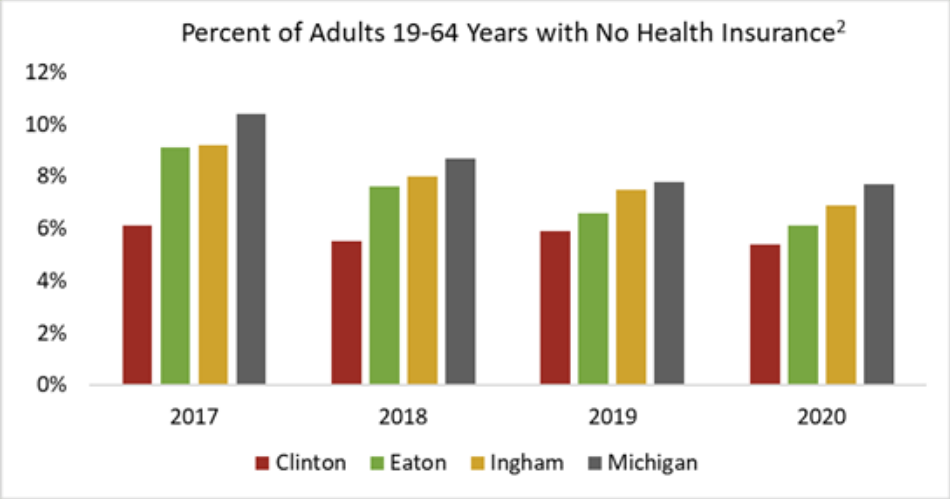
The rate of preventable adult diabetes hospitalizations have been steadily increasing from 2013 to 2019 in Ingham County, resulting in a rate of 36.8 per 100,000 persons in 2019.[5] Eaton County experienced a steady increase between 2013 and 2018 followed by a slight decrease, resulting in 31.1 per 100,000 in 2019.[5] Between 2016 and 2019, Clinton County preventable adult diabetes hospitalizations have remained steady between 24.1 and 27.5 per 100,000.[5]

Between 2016 and 2019, rates of adults reporting they do not have a Primary Care Provider (PCP) or health care provider increased from 11.4% to 13.6% in Clinton County.[3] In 2019, 18.8% of Eaton County adults and 24.4% of Ingham County adults reported they do not have a personal doctor or health care provider compared to 16.3% for the state of Michigan.[3] Access to a PCP is important for early detection and treatment of disease.[1] Individuals with a regular source of care are more likely to receive recommended preventive services such as screenings and immunizations.[1] It is crucial to address barriers to accessing a PCP and health insurance, both of which may help reduce disparities and reduce the risk of poor health outcomes.

Health Care Access and Quality

What are the problem areas?

- Rates of low-income residents without health insurance
- Percentage of residents without a PCP
- Increasing rates of preventable adult diabetes hospitalizations



Areas to consider when addressing this priority:

- Health insurance coverage for adults and children
- Number of Primary Care Providers in each county
- Racial and ethnic disparities for individuals without a PCP
- Disparities in the LGBTQIA+ population for uninsured and those without a PCP
- Preventable hospitalizations (asthma, congestive heart failure (CHF), and diabetes)
- Access to dental care

Objective 1 Reduce the rate of uninsured adults aged 19-64 years old by 2024						
Outcome Indicator H!CC	**2020 Baseline**	**2021 Update**	**2022 Update**	**2023 Update**	**2024 Goal**	**Data Source**
Clinton	5.4%				3.8%	ACS[2]
Eaton	6.1%				3.6%	ACS[2]
Ingham	6.9%				5.1%	ACS[2]

Action Plan			
Program Activities	**Person/Group Responsible**	**Timeline**	**Performance Indicator**
Identify and enroll eligible participants for Medicaid-funded programs to increase residents receiving primary care	Barry-Eaton District Health Department, Eaton County	December 2024	Number of people enrolled for Medicaid
Increase awareness of Ingham Health Plan (IHP) with business community by identifying business partners that may not be offering health benefits to employees	Ingham Health Plan Corp, Ingham County	December 2024	Number of contacts
Increase awareness of IHP with strategic community partners by identifying community partners serving eligible populations such as new Americans, emergency services only (ESO) and spend down, and uninsured	Ingham Health Plan Corp, Ingham County	December 2024	Number of contacts
Develop process for notifying those who may be over income for Medicaid when the redeterminations start	Ingham Health Plan Corp, Ingham County	December 2024	Number of contacts made
Agency Eligibility Specialists to provide outreach into the community to assist with healthcare coverage applications. Develop more partnerships in the community to provide this service. Certify Eligibility Specialists on supplemental security income (SSI) and Medicare	Community Mental Health Authority of Clinton-Eaton-Ingham, Tri-County	December 2024	Number of Eligibility Specialists certified in SSI and Medicare

Program Activities	Person/Group Responsible	Timeline	Performance Indicator
Develop internal systems to prevent people we serve from losing healthcare coverage (Medicaid) once re-determinations are reinstated	Community Mental Health Authority of Clinton-Eaton-Ingham, Tri-County	Ongoing through December 2024	Number of Medicaid applications completed by Eligibility Specialists
Pathways to Care Community Health Workers (CHWs) to assist residents in understanding Medicaid eligibility and/or the process for obtaining Medicaid	Ingham County Health Department: Pathways to Care Program, Ingham County	Ongoing through December 2024	Number of interactions regarding Medicaid eligibility or process
Health and Resource Navigators to assist residents in exploring health plan options and completing applications for Medicaid, Ingham Health Plan and Marketplace health plans	Ingham County Health Department: Health and Resource Navigation Team, Ingham County	Ongoing through December 2024	Number of residents supported by Health and Resource Navigators

---

Objective 2 Reduce the rate of Adults in each county who report not having a personal doctor/health care provider by 2025				
Outcome Indicator H!CC	**2019 Baseline**	**2022 Update**	**2025 Goal**	**Data Source**
Tri-County	21.3%		19.3%	CABRFSS[3]

Action Plan			
Program Activities	**Person/Group Responsible**	**Timeline**	**Performance Indicator**
Assess if patients have a PCP and if they have seen their PCP in the last 12 months	Ingham Health Plan Corp, Ingham County	December 2024	Number of members that report not having a PCP and/or have not seen their PCP in 12 months
Assist with scheduling an appointment to establish care with new PCP	Ingham Health Plan Corp, Ingham County	December 2024	Number of appointments completed
Pathways to Care Community Health Workers (CHWs) and Health and Resource Navigators to assist residents in finding doctors/health care providers and scheduling medical, dental or mental health appointments	Ingham County Health Department: Pathways to Care Program & Resource Navigation Team, Ingham County	Ongoing through December 2024	Number of residents that CHWs and Navigators assisted making different health appointments
Utilize data within our electronic medical records (EMR) to determine who does not have an identified PCP. Follow up with those individuals to problem solve/connect to PCP	Community Mental Health Authority of Clinton-Eaton-Ingham, Tri-County	December 2024	Number of individuals with a PCP
Establish provider practices in areas that show a need for specialty care	Sparrow, Tri-County	December 2024	Number of provider practices
Continue implementation and expansion of telehealth, e-visits, and other virtual health options among Sparrow Medical Group PCP practices	Sparrow, Tri-County	December 2024	Number or percentage of telehealth/virtual visits
Implement referrals from Sparrow Medical Group primary care to Population Health Referral Coordinators to assist patients facing SDOH barriers to care	Sparrow, Tri-county	Ongoing through December 2024	Average monthly referrals to population health coordinators
Evaluate succession planning and work with current residents on retention	McLaren, Tri-County	December 2024	Percentage of residents retained
Assess capacity and recruit providers as needed	McLaren, Tri-County	December 2024	Number of new providers recruited

Objective 3 Reduce the rate of preventable adult diabetes hospitalizations per 10,000 persons by 2024						
Outcome Indicator H!CC	**2020 Baseline**	**2021 Update**	**2022 Update**	**2023 Update**	**2024 Goal**	**Data Source**
Clinton	22.7				19.7	MDHHS[5]
Eaton	12.3				10.3	MDHHS[5]
Ingham	26.2				22.2	MDHHS[5]

Action Plan			
Program Activities	**Person/Group Responsible**	**Timeline**	**Performance Indicator**
CHW provides diabetes prevention education	Ingham Health Plan Corp, Ingham County	December 2024	Number of education modules completed
Refer clients to Diabetes Self-Management programs	Ingham Health Plan Corp, Ingham County	December 2024	Number of referrals
Refer clients to PATH Diabetes	Ingham Health Plan Corp, Ingham County	December 2024	Number of referrals

Objective 4 Improve healthcare access and quality for LGBTQIA+ individuals by increasing staff training and services that are offered			
Outcome Indicator H!CC	**2022 Update**	**2023 Update**	**2024 Goal**
Clinton			2 trainings: All staff, Clinical
Tri-County			2 trainings: All staff, Clinical

Action Plan			
Program Activities	**Person/Group Responsible**	**Timeline**	**Performance Indicator**
Update intake form for sex/gender/sexual orientation changes	Mid-Michigan District Health Department, Clinton County	December 2024	Updated form being used in clinics
Update educational (pamphlets, posters, etc.) materials for 2020 or older documents to include LGBTQIA+ information	Mid-Michigan District Health Department, Clinton County	December 2024	Percent of LGBTQIA+ educational materials updated
At least 1 staff nurse in each office receive updated LGBTQIA+ training for medical issues (HRT, transitioning medical issues, mental health first aid for queer issues)	Mid-Michigan District Health Department, Clinton County	December 2024	Number of staff in each office that received training
All staff receive pronoun, sexuality, and general LGBTQIA+ training	Mid-Michigan District Health Department, Clinton County	December 2024	Number of staff who have received training on LGBTQIA+ topics
Promote LGBTQIA+ organizations on MMDHD's social media	Mid-Michigan District Health Department, Clinton County	December 2024	Number of posts per month promoting LGBTQIA+ organizations
Place inclusivity signs/decals in the MMDHD offices	Mid-Michigan District Health Department, Clinton County	December 2024	Number of offices with signs or decals
Identify existing resources to mobilize to educate and support clinical providers to offer HRT	Ingham County Community Centers, Capital Area Health Alliance, Tri-County	December 2024	Number of resources identified
Identify video and written resources to train support staff and use in onboarding	Ingham County Community Centers, Capital Area Health Alliance, Tri-County	December 2024	Number of providers who complete training
Provide LGBTQIA+ education for all staff	Ingham County Community Centers, Capital Area Health Alliance, Tri-County	December 2024	Number of trainings provided to all staff on LGBTQIA+ topics
Develop a compendium of LGBTQIA+ educational resources for providers and administrators to use for reference	Ingham County Community Centers, Capital Area Health Alliance, Tri-County	December 2024	Number of resources identified

Objective 5 Increase access to healthcare through the development of new accessible services and facilities in the community			
Outcome Indicator H!CC	**2022 Update**	**2023 Update**	**2024 Goal**
Eaton			2 services
Ingham			1 service
Tri-County			5 services; 2 facilities

Action Plan			
Program Activities	**Person/Group Responsible**	**Timeline**	**Performance Indicator**
Serve as a link between the community and various medical and social services to streamline healthcare access	Barry-Eaton District Health Department, Eaton County	December 2024	Number of community connections made through events and partnerships
Improve access to preventive health services to benefit the overall health and wellness of our community	Barry-Eaton District Health Department, Eaton County	December 2024	Number of people provided access to preventative health services
Find sustainable funding for BEDHD Connections Program: Contact health plans to seek contractual funding for CHWs, use Medicaid reimbursement, research grant opportunities, and network with other CHWs & programs to collaborate and share information	Barry-Eaton District Health Department, Eaton County	December 2024	Number of health plan contracts secured, hours billed to Medicaid, grant opportunities found, and connections made with other CHWs, programs & networks
Actively participate in community collaboratives that seek to increase health equity and access to quality health care; Eaton Continuum of Care	Barry-Eaton District Health Department, Eaton County	December 2024	Number of collaboratives, community partnerships & meetings attended that focus on improving health equity and access to care

Program Activities	Person/Group Responsible	Timeline	Performance Indicator
Reconvene the Eaton Oral Health Coalition	Barry-Eaton District Health Department, Eaton County	December 2024	Number of coalition meetings held
Organize pre-Kindergarten dental screenings	Barry-Eaton District Health Department, Eaton County	December 2024	Number of children ages 3-5 offered dental screenings
Partner with mobile dental health clinic staff in Eaton County	Barry-Eaton District Health Department, Eaton County	December 2024	Number of mobile dental health clinics offered
Reimburse providers for telehealth	Ingham Health Plan Corp, Ingham County	December 2024	Number of telehealth claims paid
Inform IHP members the benefits of telehealth	Ingham Health Plan Corp, Ingham County	December 2024	Percentage of members utilizing telehealth
Implement Mobile Health Clinic (MHC) visits throughout the tri-county region	Sparrow, Tri-county	March 2022-November 2024	Number of visits per month
Create urgent care affiliation agreement and educate the general public of its benefits	McLaren, Tri-County	December 2024	Educate the general public on the benefits of an affiliation agreement with urgent care

Program Activities	Person/Group Responsible	Timeline	Performance Indicator
Asthma Care Pathway for children. Identifying asthma diagnosis, obtaining the Asthma Action Plan from PCP, administering asthma control tests, behavioral interventions/education as appropriate, referral to RN Care Manager as needed	Community Mental Health Authority of Clinton-Eaton-Ingham, Tri-County	December 2024	Families Forward to develop/implement internal data monitoring system & feedback loop for process adjustment and improvement
Hepatitis C Care Pathway for adults in substance use disorder (SUD) residential placement. Screening for risk factors. Linking to testing and/or PCP and follow up. Education for those not tested	Community Mental Health Authority of Clinton-Eaton-Ingham, Tri-County	December 2024	Provide Hepatitis C Screening for 100% of people admitted to House of Commons and stay at least 14 days
Hypertension for adults with a serious mental illness. Blood Pressures, behavioral interventions/education as appropriate, linking and/or coordination of care with PCP for individuals with a hypertension diagnosis	Community Mental Health Authority of Clinton-Eaton-Ingham, Tri-County	December 2024	Adult Mental Health Services will implement the Hypertension Care Coordination Project to one new unit every year
Hold ICHD Mobile Health Unit (MHU) events in high Social Vulnerability Index (SVI) census tracts	Ingham County Health Department: Resource Navigation Team, Ingham County	Ongoing through December 2024	Number of MHU events per year held in high SVI census tracts
Offer flu vaccine at community events, REDI-care, family practices etc.	Eaton Rapids Medical Center (ERMC), Tri-County	Ongoing Sept. to May (flu season) through December 2024	Number of flu shot clinics/events ERMC supports
Earlier ID of service members, veterans and their families allow for proactive referrals prior to a crisis. Encourage organizations to incorporate asking, "Have you or a member of your household served in the military?" to each new case/interaction in the intake process	Michigan Veterans Affairs Agency, Tri-County	Ongoing through December 2024	Number of veterans connected to a veterans service organization (VSO), Veteran Navigator, or Veterans Affairs (VA)
Encourage organizations to do the following: • Post free veteran service materials within their lobbies banners on their websites and have business cards available in high trafficked areas • Pledge to become a MI Veteran Connector • Pledge to ask patients/clients/customers if they served	Michigan Veterans Affairs Agency, Tri-County	Ongoing through December 2024	Number of MI Veteran Connectors; Number of referrals to 1-800-MICH-VET from organizations

Note: The CHIP will be reviewed and updated as needed every 6 months to reflect updated data and changes to organizational goals. To join us, contact Aurelia Pena at apena@bedhd.org.

Sources

Health Care Access and Quality

[1]Access to primary care: Healthy People 2030. (n.d.). Health.gov. Retrieved December 14, 2022, from https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/access-primary-care

[2]American Community Survey (ACS), 2020 5-Year Estimates, https://www.census.gov/programs-surveys/acs/data.html

[3]Capital Area Behavioral Risk Factor Surveillance System (CABRFSS), 2017-2019

[4]Health insurance: Healthy People 2030. (n.d.). Health.gov. Retrieved December 14, 2022, from https://health.gov/healthypeople/objectives-and-data/browse-objectives/health-insurance

[5]Michigan Resident Inpatient Files via Michigan Department of Health and Human Services (MDHHS), 2013-2019, https://www.michigan.gov/mdhhs/inside-mdhhs/statisticsreports/vitalstats

Community Safety

GOAL: Improve community safety and awareness through policies, systematic change, and environmental solutions.

Current Situation

The condition of our communities can have a major effect on our individual health. The social determinants of health have major impacts on health, well being, and quality of life. For example, air quality can impact our risk for lung cancer, inadequate mental health facilities can impact rates of suicide, and the overall safety of a neighborhood can impact a myriad of health outcomes including hypertension, suicide, asthma, cancer, stroke, poor quality of sleep, substance misuse, poor mental health (including depression), access to healthy high-quality foods, and life expectancy.[1,2,4,7,12,17] Injuries are the leading cause of death in the United States for those between 1-44 years old.[10] Individuals who live in unsafe areas or are exposed directly or indirectly to violence may face the numerous health outcomes listed above.

The economic impacts of violence are significant and often cascade into fostering further violence. Companies are less willing to invest in communities with higher violent crime rates which increases the unemployment rate since there are less jobs for community members and fewer community amenities to those residents. Consumers also take crime rates into consideration when deciding whether to visit a business because the perception of violence and the risk of victimization, induced by crime incidents, scares off consumers, potentially making businesses less profitable.[8]

The public health approach to community safety focuses on preventing crime by addressing the root causes of why crime happens. The biological-psychological-social model of health recognizes the complex influence the environment has on community safety.[14] Public health organizations play an important role in supporting and accelerating efforts to strengthen community safety.[16]

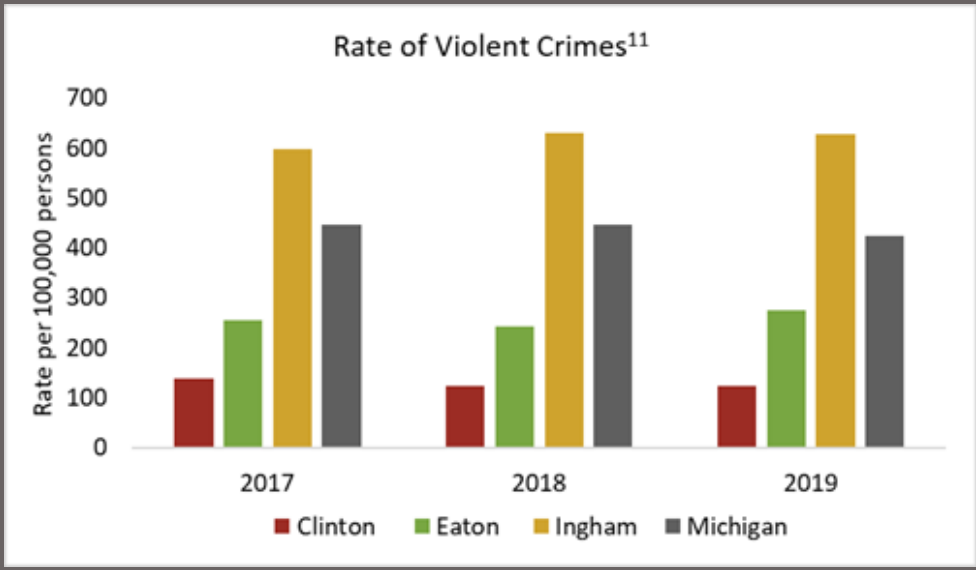
The communities which face higher rates of violence and exposure to violence are the same communities that have been systematically oppressed through structural racism, including a lack of investment.[7] Historical and systemic inequities have allowed violence to persist. These inequities, reflected in the social determinants of health, negatively impact residents ability to live a healthy life.[9] As a result, public health can, and must, work on these efforts to improve the health of communities. Inequalities can be seen when looking at health outcomes by race, economic status, or even zip code. Some of the outcomes impacted are birth weight, life expectancy, obesity, cancer rates, etc.[3] By intentionally focusing on those facing higher rates of violence, we will see a decrease in other health inequities. These efforts will create a safer community for all residents which allows people to reach their fullest potential and live healthier lives.

High levels of violent crime in a community compromise the physical safety and psychological well-being of all residents. Crime rates can deter residents from pursuing healthy behaviors. Emerging evidence suggests that increased stress levels can lead to obesity, even after controlling for diet and physical activity levels.[15] The built environment also plays a role in strengthening community safety; neighborhoods need safe sidewalks and parks as amenities for residents to further a healthy living. However, many of these facilities do not get used if that area has high rates of burglaries or shootings. Community safety can be strengthened through adopting Crime Prevention Through Environmental Design (CPTED) strategies and tactics. CPTED suggests that you can alter an individual's behavior by altering the design of the environment. The goal is to reduce crime and fear, and improve quality of life.

Strong social cohesion and trust among people within a neighborhood or community have been associated with better health outcomes.[10] However, areas with high rates of crime report lower social cohesion due in part to social isolation, distrust, and fear caused by violence.[6] Children in more closely-knit neighborhoods are more likely to receive guidance from multiple adults and less likely to engage in health damaging behaviors like smoking, drinking, drug use or gang involvement.[5] In neighborhoods where residents share mutual trust and a willingness to intervene have been linked with lower homicide rates.[13]

Of the three Capital-Area counties, the violent crime rate is highest in Ingham County, which includes the majority of the region’s urban core. Ingham County has a rate twice as high as Eaton County and approximately six times that of Clinton County. Eaton and Clinton Counties both have lower rates of violent crime when compared to Michigan. In 2019 the rate of violent crime decreased in Michigan. In the tri-county area, Clinton County and Ingham County had approximately the same rates in 2018 and 2019. The rate in Ingham County continues to be far higher than the rest of the Capital Area. Eaton County saw an increase in the violent crime rate from 2018 to 2019 (244.0 to 276.6 per 100,000 residents).

Community Safety



Areas to consider when addressing this priority:

- Promoting a general feeling of community safety (ex. clean parks, visually appealing buildings, bright or well-lit areas, etc.).
- Reducing violent crimes (gun violence, assault and battery, domestic violence, etc.).
- People of a community are able to enjoy community amenities (grocery stores, parks, bus stops) without fear of becoming a victim of crime.
- Anti-racism and justice initiatives (Disability, Equity and Inclusion (DEI) initiatives, anti-racism initiatives, other methods to build community trust).

Objective 1 Reduce rate of violent crimes in each county by 1%				
Outcome Indicator H!CC	**2019 Baseline**	**2023 Update**	**2024 Goal**	**Data Source**
Ingham	628.9 per 100,000 people		1% reduction for calculation	Michigan State Police, Michigan Incident Crime Reporting[11]
Eaton	276.6 per 100,000 people		1% reduction for calculation	Michigan State Police, Michigan Incident Crime Reporting[11]
Clinton	123.1 per 100,000 people		1% reduction for calculation	Michigan State Police, Michigan Incident Crime Reporting[11]

Action Plan			
Program Activities	**Person/Group Responsible**	**Timeline**	**Performance Indicator**
Implement the Advance Peace Lansing / Ingham Initiative (AP)	Ingham County, Ingham County / MPHI, Ingham County	Y1 ends Feb.28 2023. Project ends 12.31.2024	Gun violence rates
Explore Advance Peace applications for counties other than Ingham	Eaton, Clinton, and Ingham County / MPHI, Tri-County	July 2023	Number of areas where AP is implemented
Identify workgroup, including members from all health departments, to work on priority area	Policy Analyst, Ingham County	March 2023	Number of meetings held by workgroup
CPTED (Crime Prevention Through Environmental Design) strategies explored to determine how to add this as a lens to policy making, programming, etc.	Policy Analyst, Ingham County Others tbd at other departments, Tri-County	September 2023	Workgroups formed, templates created, additional certifications obtained, training provided
Analyze the levers available for Public Health to influence crime prevention policy and programs	Workgroup, Tri-County	July 2023	Report created

Program Activities	Person/Group Responsible	Timeline	Performance Indicator
Health departments will identify how they can monitor the problem by developing systems that provide up to date information regarding the "who," "what," "when," "where" and "how" associated with violent crime	Epidemiology Teams at each Health Department, Tri-County Workgroup, Tri-County	December 2023	Percentage of health departments that have published a data dashboard
Create public facing documents, available on all tri-County Health Departments websites, that are resources for the community to use	Policy Analyst, Ingham County Health Analysts, Tri-County Graphic / Communication teams at each health department, Tri-County Website content creator teams at each health department, Tri-County	January 2024	Percentage of health department website where these documents are published
Develop materials for health clinics that provide resources for how to talk about violence and trauma with children to assist in processing trauma and minimizing potential negative outcomes	Health Educators, Tri-County Policy Analyst, Ingham County Health Analysts, Tri-County Communication Staff, Tri-County	January 2024	Number of materials published

Objective 2
Host 3 community conversations, each in a different county, to establish shared concerns and priorities for collective action on the subject of community safety.

Outcome Indicator H!CC	2022 Update	2023 Update	2024 Goal
Clinton			1 event
Eaton			1 event
Ingham			1 event

Action Plan			
Program Activities	**Person/Group Responsible**	**Timeline**	**Performance Indicator**
Identify workgroup, including members from all health departments, to organize event	Policy Analyst, Ingham County	February 2023	Workgroup formed
Connect with other Counties or Cities who have hosted community conversations on violence to hear best practices	Workgroup, Tri-County	March 2023	Number of workgroup meetings held
Conduct landscape analysis of the current organizations and individuals working on this topic in the area	Workgroup, Tri-County	April 2023	Report completed
Establish methods for engagement including in person meetings, digital meetings, and online polls	Workgroup, Tri-County	March 2023	Schedule created
Identify meeting spaces for in person meetings	Workgroup, Tri-County	April 2023	Locations secured
Identify facilitation, IT, Childcare, mental health staff and other staff that will be present at events	Workgroup, Tri-County	May 2023	Vendors in place
Create external facing event calendar for all methods of engaging	Workgroup, Tri-County	June 2023	Calendar
Publicize events	Workgroup, Tri-County	June 2023	Number of marketing campaigns or social media posts promoting events
Host Events in person and digitally	Workgroup, Tri-County	July 2023	Number of meetings held
Create an action plan to share with participants for how the findings from the research literature and data from needs assessments, community surveys, key collaborator interviews, and focus groups will be used for designing prevention strategies	Workgroup, Tri-County	June 2023	Number of meetings for community members to share project plans

Objective 3 One Sheriff, Police, or other law enforcement department in each county (3 total) shall adopt Anti-racism approaches to their work on community safety.			
Outcome Indicator H!CC	**2022 Update**	**2023 Update**	**2024 Goal**
Clinton			1 Policy, Procedure, or Training completed
Eaton			1 Policy, Procedure, or Training completed
Ingham			1 Policy, Procedure, or Training completed

Action Plan:			
Program Activities	**Person/Group Responsible**	**Timeline**	**Performance Indicator**
Identify workgroup including members from all health departments, and the health equity council to work on objective	Tri-County Health Equity Council, Ingham County	February 2023	Workgroup formed
Community experts for Anti-racism approaches identified and recruited to join workgroup	Workgroup, Tri-County	March 2023	Number of community experts that attend meetings
Meetings with Sheriff, Police, or other law enforcement departments to understand the current scope of their anti-racism work	Workgroup, Tri-County	May 2023	Number of meetings held
Identify individuals at each Sheriff, Police, or other law enforcement department who will be responsible for adopting new practices	Workgroup, Tri-County	May 2023	Leaders selected
Research best anti-racism and Justice approaches for Sheriff, Police, or other law enforcement	Workgroup, Tri-County Policy Analyst, Ingham County	June 2023	Reports / Issue Briefs completed

Program Activities	Person/Group Responsible	Timeline	Performance Indicator
Facilitate a space for all departments to collaborate on this effort	Workgroup, Tri-County	June 2023	Digital workspace, meetings, email server, or other output decided by group
Identify what type of anti-racism or Justice effort will be adopted at each Sheriff, Police, or other law enforcement. Including but not limited to training, policy change, procedure change, and environmental change	Workgroup, Tri-County	October 2023	Initiative, project, program, training, etc. selected
Anti-racism and Justice efforts adopted at all departments	Workgroup, Tri-County	June 2024	Initiative, project, program, training, etc. adopted
Anti-racism approach for County Health Departments is present on website	Workgroup, Tri-County Graphic / Communication teams at each health department, Tri-County Website content creator teams at each health department, Tri-County	December 2023	Percentage of health department websites with this information on their website
Materials are prepared and sent to selected Sheriff, Police, or other law enforcement for website and other digital platforms to help explain this work to the public	Workgroup, Tri-County Graphic / Communication teams at each health department, Tri-County Website content creator teams at each health department, Tri-County	March 2024	Number of sheriffs, police, and law enforcement entities in the tri-county area that display these materials on their website
Evaluation conducted at each Sheriff, Police, or other law enforcement to determine the impact of selected intervention	Workgroup, Tri-County Sheriff, Police, or other law enforcement, Tri-County	September 2024	Evaluation report

Note: The CHIP will be reviewed and updated as needed every 6 months to reflect updated data and changes to organizational goals. To join us, contact Aurelia Pena at apena@bedhd.org.

Sources

Community Safety

[1]Casalino, L., Erb, N., Joshi, M., Shortell, S., (2015, June). Accountable care organizations and population health organizations. J Health Politics Policy Law. https://www.researchgate.net/publication/279456887_Accountable_Care_Organizations_and_Population_Health_Organizations

[2]Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) Fatal Injury Data. https://www.cdc.gov/injury/wisqars/

[3]City Health Data. 2022. https://www.cityhealthdashboard.com/data-access?chdash_survey_completed=true

[4]Cohen L, Davis R, Lee V, Valdovinos E. (2010, May). Addressing the intersection: preventing violence and promoting healthy eating and active living. Prevention Institute. http://www.preventioninstitute.org/component/jlibrary/article/id-267/127.html

[5]Cubbin, C., Pedregon, V., Egerter, S., & Braveman, P. (2008, September). Where We Live Matters for Our Health: Neighborhoods and Health. San Francisco ; commissionhealth.org.

[6]Cutrona, C.E., Russell, D.W., Hessling, R.M., Brown, P.A., Murry, V. (2000, December). Direct And Moderating Effects Of Community Context On The Psychological Well-Being Of African American Women. J Pers Soc Psychol. 2000;79(6):1088–1101. https://pubmed.ncbi.nlm.nih.gov/11138756/

[7]Egerter, S., Barclay, C., Grossman-Kahn, R., Braveman, P., (2011, May). Violence, social disadvantage and health. Exploring the Social Determinants of Health Issue Brief No. 10. Princeton: Robert Wood Johnson Foundation. http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2011/rwjf70452

[8]Fe, H., Sanfelice, V., (2022, May). How bad is crime for business? Evidence from consumer behavior. Journal of Urban Economics. https://www.sciencedirect.com/science/article/pii/S0094119022000250?via%3Dihub

Sources

[9]LaVeist, T., Gaskin, D., Trujillo, A., (2011, September). Separate Spaces, Risky Places: The Effects of Racial Segregation on Health Inequalities. Joint Center for Political and Economic Studies. https://nmpha.wildapricot.org/Resources/Documents/Segregated%20Spaces%20-%20Risky%20Places.pdf

[10]Levi J, Segal LM, Kohn D. (2015, June). The Facts Hurt – A State-by-State Injury Prevention Policy Report. Trust for America's Health. Robert Wood Johnson Foundation. https://www.tfah.org/releases/injuryprevention15/

[11]Michigan Incident Crime Reporting via Michigan State Police, 2019, https://www.michigan.gov/msp/divisions/cjic/micr/annual-reports/2019-annual-report

[12]Moffitt, T.E. (2013, November). Childhood exposure to violence and lifelong health: clinical intervention science and stress biology research join forces. Development Psychopathol. https://www.researchgate.net/publication/262045700_Childhood_exposure_to_violence_and_lifelong_health_Clinical_intervention_science_and_stress-biology_research_join_forces

[13]Sampson R.J., Raudenbush S.W., Earls F. (1997, August 15). Neighborhoods And Violent Crime: A Multilevel Study Of Collective Efficacy. Science.https://www.science.org/doi/10.1126/science.277.5328.918

[14]Swensen, K., Murza, G., Sulzer, S., Voss, M., Public Health Violence Prevention: Supporting Law Enforcement. Utah State University. https://extension.usu.edu/heart/research/violence-prevention-supporting-law-enforcement

[15]van der Valk, E. S., Savas, M., van Rossum, E. F. C.. (2018, April 16). Stress and Obesity: Are There More Susceptible Individuals?. Current Obesity Reports. https://doi.org/10.1007/s13679-018-0306-y

[16]Yen, I. H., Syme, S. L. (1999). The Social Environment And Health: A Discussion Of The Epidemiologic Literature. Annual Review Public Health. https://pubmed.ncbi.nlm.nih.gov/10352860/

[17](2011). APA policy statements on violence prevention. American Psychological Association. https://www.apa.org/pi/prevent-violence/resources/policy

Behavioral Health

GOAL: Improve mental health in adolescents and adults, and reduce substance misuse in adolescents.

Current Situation

Since the first Capital Area Behavioral Risk Factor Survey (BRFS) in 2008-2010, adults experiencing more than 14 poor mental health days each month has increased in each survey, except for Clinton County which had a small decrease from 2014-2016 to 2017-2019.[1] Overall, all counties have seen an increase from the 2008-2010 baseline.[1] Similarly, there has been an increase in all counties for adolescents experiencing symptoms of depression in the past year compared to baseline data in 2015-2016.[6]

Over the last three Michigan Profile for Healthy Youth (MiPHY) survey cycles, rates of binge drinking in high school students has remained steady between 8% and 10% in all geographies.[6] There are variations in binge drinking rates by racial and ethnic groups with white and Hispanic high school students having higher rates compared to Black and Arab students.[6]

Current cannabis use rates among adolescents are trending higher in Eaton and Clinton Counties while Ingham County had a slight decline from the previous MiPHY survey cycle.[6] In Clinton County, rates have increased from 8.1% in 2015-2016 to 14.6% in 2019-2020.[6] Rates have climbed in Eaton County as well, but at a slower rate than Clinton County, rising from 14.3% to 17.5% over the same time period.[6]

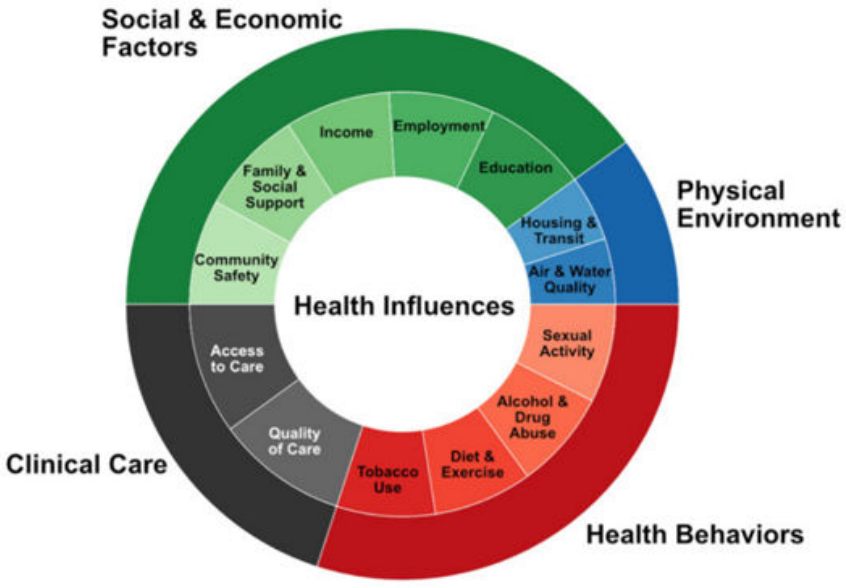
Trends of early cannabis use vary among the state, tri-County region and individual counties. Michigan had a considerable decrease from 2017 (8.6%) to 2019 (5.4%).[6] Clinton County has an early use rate of between 2.8% and 3.6% across MiPHY cycles.[6] Eaton County is showing a trend of increased early use of cannabis from 4.8% in 2015-2016 to 7.1% in 2019-2020.[6] Ingham County, on the other hand, has decreased from 5.7% to 4.3% over the same time frame.[6]

What's the Problem and why does it matter?

Overall health depends on both physical and mental well-being. Measuring the number of days when people report that their mental health was not good, i.e., poor mental health days represent an important facet of health-related quality of life. Improving access to behavioral health care can decrease the overall amount of days people report that their mental health was not good as they are able to receive treatment and converse about their mental health. Behavioral health is often impacted by outside factors including income, housing security, education, unemployment, child abuse and neglect, neighborhood conditions, and social support.[5] Improving these factors in the community can help to better mental health in the short and long term.

Binge drinking is a risk factor for a number of adverse health outcomes, such as alcohol poisoning, hypertension, acute myocardial infarction, sexually transmitted infections, unintended pregnancy, fetal alcohol syndrome, sudden infant death syndrome, suicide, interpersonal violence, and motor vehicle crashes.[2] Research shows that cannabis use can have permanent effects on brain function on the developing brain when use begins in adolescence, especially with regular or heavy use.[3] Frequent or long-term cannabis use is linked to school dropout and lower educational achievement. Reducing the rates of binge drinking and cannabis use among adolescents can help to decrease risky behaviors and long-term side effects.

Health Influences[4]



Objective 1 Reduce the number of adults experiencing poor mental health (bad mental health days) in adults by 2% across all racial and ethnic groups.				
Outcome Indicator H!CC	**2021 Baseline**	**2022 Update**	**2024 Goal**	**Data Source**
Clinton	12.0%		10.0%	CABRFSS[1]
Eaton	16.0%		14.0%	CABRFSS[1]
Ingham	19.7%		17.7%	CABRFSS[1]

Action Plan			
Program Activities	**Person/Group Responsible**	**Timeline**	**Performance Indicator**
Provide same-day access to services	Adult Mental Health Services in Ingham County	2022-2024	The No Show Rate for initial assessments decreasing
Implement Same Day Access	Families Forward (Children Services)	2022-2024	The No Show Rate for initial assessments decreasing
Development/Implementation of Crisis Stabilization Unit	Community Mental Health Authority Clinton-Eaton-Ingham Counties (CMHA-CEI)	2022-2024	Renovation of space to meet program needs, complete Certification process, hiring of staff, develop policy/procedures/guidelines for implementation, begin providing services to the community
Implementation of Zero Suicide for adults	CMHA-CEI	2022-2024	Develop the Zero suicide action plan
Participate in state-wide Michigan Crisis and Access Line (MiCAL) system	CMHA-CEI	2022-2024	Percentage of staff attending trainings and number of policies developed

Program Activities	Person/Group Responsible	Timeline	Performance Indicator
Expand utility of social media and Facebook toolkits across stakeholder groups to promote access to behavioral health services, trainings, resources, self-care, and community supports	CMHA-CEI	2022-2024	Expanded utilization of social media toolkit measured by the number of posts, number of post engagement, number of shares, and number of stakeholders who post these items
Enhance psychological wellness, resilience, and instill hope and inspiration	CMHA-CEI	2022-2024	Number of outreach events and number of outreach participants
Promote and share the free, anonymous, and online behavioral health screening platform with area networks and partners to expand utilization	CMHA-CEI	2022-2024	Number of screenings completed and number of visits to site
Establish and promote a menu of behavioral health related trainings and interventions offered to the public and professional workforce in the tri-county area and expand opportunities for community based trainings and workforce initiatives	CMHA-CEI	2022-2024	Number of workplaces or community organizations who received this information
Utilize the depression/anxiety screening tool and offer guidance to clients as needed	Barry-Eaton District Health Department (BEDHD)	2022-2024	Number of clients completing the depression/anxiety screening tool
Staff will be encouraged to participate in behavioral health trainings to include suicide prevention and awareness, silent crisis training, and seasonal affective disorder trainings	BEDHD	2022-2024	Number of staff attending trainings and number of different trainings attended

Objective 2 Reduce the percentage of high school students reporting symptoms of depression in the past year by 2% across all racial and ethnic groups. Reduce rates of binge drinking in adolescents across all racial and ethnic groups.				
Outcome Indicator H!CC	**2020 Baseline**	**2022 Update**	**2024 Goal**	**Data Source**
Clinton (depression)	39.1%		37.1%	MiPHY[6]
Eaton (depression)	42.7%		40.7%	MiPHY[6]
Ingham (depression)	39.5%		37.5%	MiPHY[6]
Clinton (drinking)	8.7%		7.7%	MiPHY[6]
Eaton (drinking)	8.4%		7.4%	MiPHY[6]
Ingham (drinking)	8.3%		7.3%	MiPHY[6]
Clinton (cannabis)	14.6%		12.6%	MiPHY[6]
Eaton (cannabis)	17.5%		15.5%	MiPHY[6]
Ingham (cannabis)	14.5%		12.5%	MiPHY[6]

Action Plan			
Program Activities	**Person/Group Responsible**	**Timeline**	**Performance Indicator**
Implementation of Zero Suicide for youth	CMHA-CEI	2022-2024	Zero suicide action plan developed
Participate in state-wide MiCAL system	CMHA-CEI	2022-2024	Participate in State required trainings/learning sessions, develop policy/procedure/guidelines for implementation, develop internal systems and processes for implementation
Provide outreach and engagement to youth/families in the community	CMA-CEI	2022-2024	Increase behavioral health outreach and engagement in the community (# of Youth engagement services, # of youth behavioral health screens, # unique youth contacts, engage with # partner sites)

Program Activities	Person/Group Responsible	Timeline	Performance Indicator
Expand utility of social media and Facebook toolkits across stakeholder groups to promote access to behavioral health services, trainings, resources, self-care, community supports, enhance psychological wellness and resilience and instill hope and inspiration	CMHA-CEI	2022-2024	Expanded utilization of social media toolkit. (# of posts, # of post engagement, and # of shares)
Continue to promote and share the free, anonymous, and online behavioral health screening platform with area networks and partners to expand utilization	CMHA-CEI	2022-2024	Increase numbers of individuals utilizing the online behavioral health screening tool (# of screenings completed and # of visits to site)
Establish and promote a menu of behavioral health related trainings and interventions offered to the public and professional workforce in the tri-county area and expand opportunities for community-based trainings and workforce initiatives	CMHA-CEI	2022-2024	Publication printed and promoted in community
BEDHD staff will participate in the Eaton Rapids Health Alliance regarding behavioral health needs with an emphasis on youth	BEDHD	2022-2024	Number of ERHA meetings attended and number of initiatives working on
Health Resource Advocates will continue to provide and improve behavioral health initiatives in participating Eaton County schools	BEDHD	2022-2024	Number of youth behavioral health initiatives and number of schools participating

Note: The CHIP will be reviewed and updated as needed every 6 months to reflect updated data and changes to organizational goals. To join us, contact Aurelia Pena at apena@bedhd.org.

Sources

Behavioral Health

[1]Capital Area Behavioral Risk Factor Surveillance System (CABRFSS), 2008-2021

[2]Centers for Disease Control and Prevention. (2022, November 14). Binge drinking. Centers for Disease Control and Prevention. https://www.cdc.gov/alcohol/fact-sheets/binge-drinking.htm#:~:text=Unintentional%20injuries%20such%20as%20motor,Sexually%20transmitted%20diseases.

[3]Chadwick, B., Miller, M. L., & Hurd, Y. L. (2013). Cannabis use during adolescent development: susceptibility to psychiatric illness. Psychiatry, 4(129). https://doi.org/10.3389/fpsyt.2013.00129

[4]County health rankings model. (n.d.). County Health Rankings & Roadmaps. Retrieved December 14, 2022, from https://www.countyhealthrankings.org/explore-health-rankings/county-health-rankings-model

[5]Deferio, J. J., Breitinger, S., Khullar, D., Sheth, A., & Pathak, J. (2019). Social determinants of health in mental health care and research: a case for greater inclusion. Journal of the American Medical Informatics Association, 26(8-9), 895-899. https://doi.org/10.1093/jamia/ocz049

[6]Michigan Profile for Healthy Youth (MiPHY) – Michigan Substance Use Disorder Data Repository. (n.d.). Retrieved January 31, 2023, from https://mi-suddr.com/michigan-profile-for-healthy-youth-miphy/

Safe and Affordable Housing

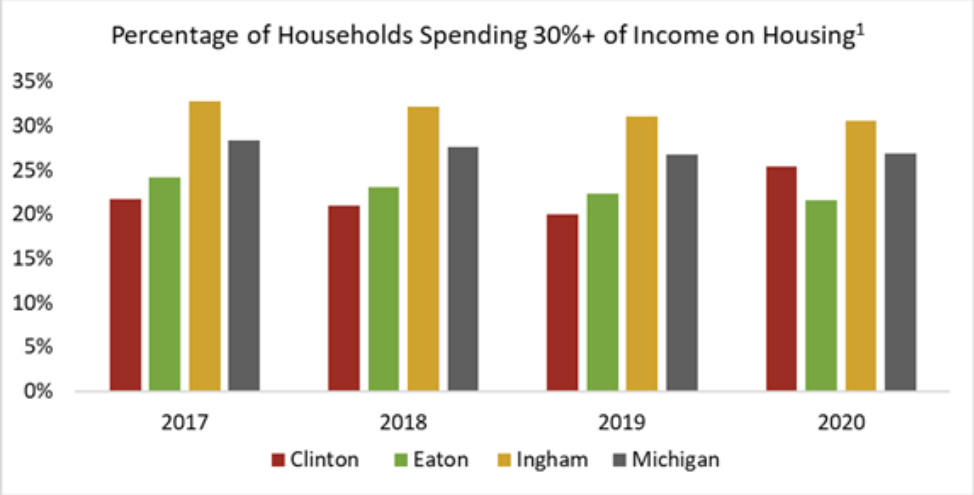
GOAL: Promote health through safer and more affordable housing.

Current Situation

The United States Census Bureau's American Community Survey[1] estimates the percentage of households that spend at least thirty percent of income on housing costs. Based on the five-year estimates from 2016 to 2020, this percentage has held relatively steady at the state level and across geographic areas within the Capital Area. With the region, the City of East Lansing demonstrated the highest proportion of households paying at least thirty percent of income on housing at nearly half—including Michigan State University students living off campus, but not those living in dormitories—and the City of Lansing saw the second highest proportion with over one third of households. Consequently, Ingham County's total proportion (approximately three of ten households in 2020) has been consistently higher than both Clinton County, where the proportion in 2020 was close to the state average of one in four households, and Eaton County, where the proportion was lowest in 2020 at about one in five.

Lack of affordable housing leads to housing instability: this includes issues such as overcrowding, moving often and/or frequent evictions, difficulty paying rent, and being cost burdened (households who spend more than 30 percent of their income on rent).[2] These problems can lead to poor mental health and loss of the social cohesion and support that often accompanies long term residence in one neighborhood. Low housing quality is also a concern because it can affect health through increased physical injuries due to an unsafe environment, as well as health hazards like mold, allergens, lead, or asbestos.[3] Remediating toxic exposures and maintaining homes in good repair can help mitigate these effects.

Percent of Households Spending 30%+ of Income on Housing				
	2017	2018	2019	2020
Michigan	28.3	27.6	26.7	26.9
Tri-County	29.0	28.2	27.2	27.6
Clinton	21.7	21.0	20.0	25.4
Eaton	24.2	23.0	22.3	21.6
Ingham	32.8	32.1	31.0	30.6
East Lansing	48.6	48.2	46.9	47.8
Lansing	36.5	35.5	35.0	34.5



What are the problem areas?

- Housing affordability
- Possible lead exposure
- Home repairs

Areas to consider when addressing this priority:

- Public Health influence on housing policy
- Present community efforts
- Existing partnerships
- Current data sharing practices

Objective 1 Apply for home repair funding for residents of Allen Neighborhood in Lansing by November 2022		
Outcome Indicator H!CC	**2022 Update**	**Goal**
Allen Neighborhood (Lansing)		1 Application

Action Plan			
Program Activities	**Person/Group Responsible**	**Timeline**	**Performance Indicator**
Agency to apply for Michigan State Housing Development Authority's Neighborhood Enhancement Program Round funds for residential home repairs	Allen Neighborhood Center, Allen Neighborhood (Lansing)	November 2022	Number of applications submitted

Objective 2 Rehabilitate two homes to serve as transitional housing for participants of Ingham County's Youth Diversion Program by December 2022		
Outcome Indicator H!CC	**2023 Update**	**Goal**
Ingham		2 Houses

Action Plan			
Program Activities	**Person/Group Responsible**	**Timeline**	**Performance Indicator**
Northwest Initiative will work with Ingham County Land Bank to obtain two homes near each other and identify funds to rehabilitate for transitional housing	Northwest Initiative, Lansing	December 2023	Number of houses obtained and rehabilitated

Objective 3 Complete the Housing Drives housing assessment for Tri-County region by December 2022		
Outcome Indicator H!CC	**2022 Update**	**Goal**
Tri-County		1 housing assessment

Action Plan			
Program Activities	**Person/Group Responsible**	**Timeline**	**Performance Indicator**
Tri-County Regional Planning Commission will complete the Housing Drives housing needs assessment for Clinton, Eaton, and Ingham Counties	Tri-County Regional Planning Commission, Tri-County	December 2022	Number of housing needs assessments completed

Objective 4 Remediate lead-based paint hazards from 189 Lansing homes by December 2024				
Outcome Indicator H!CC	**2022 Update**	**2023 Update**	**2024 Update**	**Goal**
Lansing				189

Action Plan			
Program Activities	**Person/Group Responsible**	**Timeline**	**Performance Indicator**
The City of Lansing's Lead Safe Lansing program will use Lead Based Paint Hazard Reduction grant funds from The US Department of Housing and Urban Development to remediate 189 homes in the City of Lansing	Lead Safe Lansing, Lansing	December 2024	Number of houses remediated for lead-based paint hazards

Objective 5 Complete activities in Community Information Exchange portion of the Michigan Department of Health and Human Services Social Determinants of Health planning grant by September 2023		
Outcome Indicator H!CC	**2023 Update**	**Goal**
Clinton		2 planning meetings
Eaton		2 planning meetings
Ingham		5 planning meetings

Action Plan			
Program Activities	**Person/Group Responsible**	**Timeline**	**Performance Indicator**
Identify housing partners and hold two meetings to determine community information exchange needs (independently or in conjunction with Eaton and Ingham Counties)	Mid-Michigan District Health Department, Clinton	September 2023	Number of planning meetings convened
Identify housing partners and hold two meetings to determine community information exchange needs (independently or in conjunction with Clinton and Ingham Counties)	Barry-Eaton District Health Department, Eaton	September 2023	Number of planning meetings convened
Identify housing partners and hold five meetings to determine community information exchange needs (independently or in conjunction with Eaton and Ingham Counties)	Ingham County Health Department, Ingham	September 2023	Number of planning meetings convened
A tri-county community Housing Summit will be held by the Healthy! Capital Counties Group to bring key stakeholders and members of the community together to address housing resources, gaps, and barriers	Mid-Michigan. District Health Department, Barry-Eaton District Health Department, Ingham County Health Department	September 2023	Number of stakeholders who attended the housing summit

Objective 6 Actively participate in Eaton Continuum of Care (CoC) efforts that seek to improve access to safe and affordable housing		
Outcome Indicator H!CC	**2023 Update**	**Goal**
Eaton Collaboratives		2 collaboratives
Eaton Community Partnerships		2 community partnerships
Eaton Meetings		1 meeting

Action Plan			
Program Activities	**Person/Group Responsible**	**Timeline**	**Performance Indicator**
Participation in Eaton CoC housing/shelter coalition Long-term Care Collaborative Council housing initiative	Barry-Eaton District Health Department, Eaton	December 2023	Number of meetings
Partner on Eaton CoC Equitable Results Team (CERT)Racial Equity Strategic Planning Project	Barry-Eaton District Health Department, Eaton	December 2023	Number of community partnerships
Attend MSHDA town hall meeting on affordable housing, rental development, & racial equity	Barry-Eaton District Health Department, Eaton	December 2023	Number of meetings

Note: The CHIP will be reviewed and updated as needed every 6 months to reflect updated data and changes to organizational goals. To join us, contact Aurelia Pena at apena@bedhd.org.

Sources

Safe and Affordable Housing

[1]American Community Survey (ACS), 2020 5-Year Estimates, https://www.census.gov/programs-surveys/acs/data.html

[2]Housing Instability - Healthy People 2030 | health.gov. (n.d.). Health.gov. https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/housing-instability

[3]Quality of Housing - Healthy People 2030 | health.gov. (n.d.). Health.gov. https://health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/quality-housing

Using the Plan

Nearly everyone can play a role in advancing health in the Capital Area. From individual residents to large companies to government officials, anyone can be a champion for health. Here are some ideas:

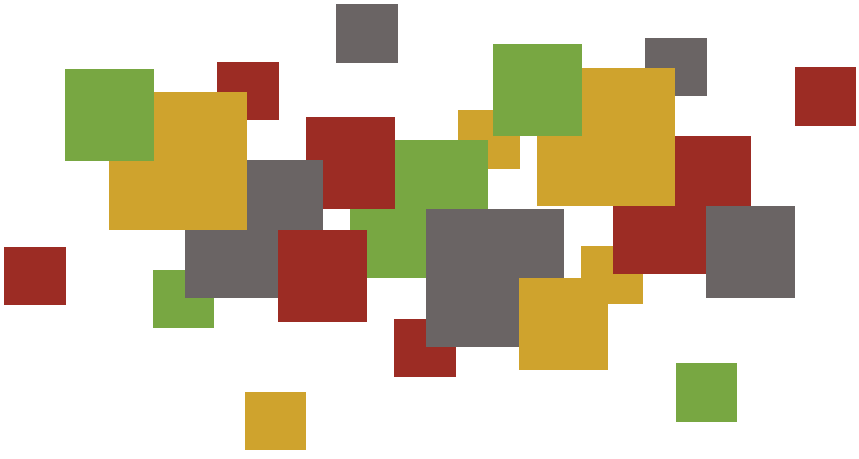
- **Residents**
  - Talk to people about health and the community when the opportunity arises
  - Use the plan to reflect upon and improve your health to the extent possible
  - Get involved in future CHA/CHIP activities by joining the email list on MailChimp
- **Employers**
  - Understand health issues that affect our community
  - Develop or review worksite wellness program
  - Consider the CHIP priorities when selecting employee benefit plans
  - Incorporate priorities into corporate giving (if applicable)
- **Educators**
  - Understand health issues that affect our community
  - Recognize that many healthy habits can be established in childhood
  - Develop or review school wellness program
- **Faith-Based and Community-Based Organizations**
  - Understand health issues that affect our community
  - Incorporate priorities into service activities (if applicable)
  - Talk with members about health, including Social Determinants of Health (SDOH) and root causes
  - Invite CHIP staff or stakeholders to speak to members
- **Healthcare Affiliates**
  - Consider adding your organization to the plan
  - Offer patients resources to address not only health care needs, but also behavioral health and SDOH needs
- **Government Officials**
  - Talk to people about health and the community when the opportunity arises
  - Understand health issues, including SDOH and root causes, that affect our community
  - Review the policy-related approaches
  - Invite steering committee members to speak with you about this plan

We invite participation from people and sectors across the entire Capital Area. Please share this plan, and any actions that are being taken to achieve the goals within the plan, with core staff and others in the community. New partners are welcome, and the report is updated every 6 months.

Conclusion

Many people think of health as solely a product of personal responsibility or health care, while in truth the environments in which people live, work, play, and the opportunities they have within those environments, build the foundation for health. Community health is broad and is affected by many facets of everyday life like the Social Determinants of Health. The COVID-19 pandemic underscored the impact these factors have upon overall health and are reflected in two new priority areas selected by the community this cycle— “Safe & Affordable Housing” and “Community Safety.” These priorities are joined by “Health Care Access and Quality” and “Behavioral Health,” which were priorities in the previous two cycles. The mix of new and old priorities allowed the CHIP to build upon established relationships while creating new ones. Advances in all four priority areas, which encompasses 105 activities, 16 objectives and 19 community partners, are anticipated over the next three years across the region with this new, region-centered CHIP.

We invite participation from people and sectors across the entire Capital Area. Please share this plan, and any actions that are being taken to achieve the goals within the plan, with core staff and others in the community. Join us and stay informed by signing up for our email list via MailChimp.



Community Stakeholders

Ikram Adawe
Julie Anderson, Greater Lansing Food Bank
Angela Austin, One Love Global
Leslie Bachelor, Sparrow Health System
Kellie Banko, PHPMM
Malea Belton, Eaton RESA
Jason Blanks, Capital Area Health Alliance
Roxanne Case, Ingham County Land Bank
Alesha Cavanaugh
Emily Daubert, Eaton Rapids Medical Center
Kalli Dempsey, Eaton County Housing Services
Jennifer Duncan, Eaton Rapids Medical Center
Pam Elise, Capital Area Community Services
Misty Fogg, Capital Area Community Services
Mary Anne Ford, Capital Area Health Alliance
Stacy Fox-Elster, CEICMH
Amanda Gerding, CASA for Kids
Heidi Glew
Ken Hall, Tri-County Regional Planning Committee
Joan Illardo, MSU-CHM
Shirin Kambin, Immigrant & Refugee Resource Collaborative
Jane Kramer, NorthWest Initiative
Amy Krautkramer, McLaren Greater Lansing
Holly Makimaa, Eaton Rapids Health Alliance
Sheri Mandeville, Clinton/Eaton MDHHS Community Resource Coordinator
Tanya Marsh, Eaton Rapids Medical Center
LeAnne Mattox, Ingham & Potterville Housing Commissions
Rod McNeil, Ingham County Health Department
Lori Noyer, Ingham County Health Plan Corp.
Denise Paquette, Allen Neighborhood Center
Jeanne Pearl-Wright, Eaton County Commissioner
Lindsay Peters, Eaton Rapids Medical Center
Grey Pierce, Queering Medicine
Robin Ross, United Way of South Central Michigan
Nikki Selleck, Eaton RESA
Karen Smith, Tri-County Office on Aging
Aleea Swinford, Ingham Health Plan
Sara Thelen, Mid-Michigan District Health Department
Linda Toomey, McLaren Greater Lansing
Charisse Tuell, Eaton RESA
Misti Vankampen, Capital Area Community Services
Peggy Vaughn-Payne, Northwest Initiative
Claudine Williams, Eaton Continuum of Care
Jessica Yorko, Ingham County Health Department
Angie Zell, MSU Extension

CHIP Core Staff

Anne Barna, Ingham County Health Department
Nicole Baumer, Tri-County Regional Planning Commission
Liz Braddock, Mid-Michigan District Health Department
Amanda Darche, Ingham County Health Department
Joel Hoepfner, Community Mental Health Authority of Clinton, Eaton, and Ingham Counties
Rex Hoyt, Mid-Michigan District Health Department
Chris Chesla-Hughes, Barry-Eaton District Health Department
Cristin Larder, Ingham County Health Department
Nick Miller, Ingham County Health Department
Brittany Moore, Ingham County Health Department
Susan Paulson, Ingham County Health Department
Aurelia Peña, Barry-Eaton District Health Department
Colette Scrimger, Barry-Eaton District Health Department
Janine Sinno Janoudi, Ingham County Health Department
Emily Smale, Barry-Eaton District Health Department
Paige Swem, Ingham County Health Department
Sara Thelen, Mid-Michigan District Health Department
Kara Trimbach, Mid-Michigan District Health Department
Linda Vail, Ingham County Health Department
Dana Watson, Ingham County Health Department