CLINTON * EATON * INGHAM

Healthy! Capital Counties

a community approach to better health

2012 Community Health Profile & Health Needs Assessment

Acknowledgements

A project such as this, conducted at such scope and swiftness, could not have been possible without the support and meaningful participation of many people and organizations across Clinton, Eaton, and Ingham counties. Sincere thanks go to the members of the Community Advisory Committee — representing diverse sectors across the three counties. Your continued support is welcomed as we transition from the assessment to the planning stage of this endeavor. Additional thanks go to those who served on the Steering Committee, a workgroup comprised of partners from each hospital system, each health department, and Michigan State University.

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Support for this project was provided by:

HOSPITALS

- Eaton Rapids Medical Center
- Hayes Green Beach Memorial Hospital
- McLaren Greater Lansing
- Sparrow Health System

ACADEMIC PARTNER

- Michigan State University

HEALTH PLANS

- Ingham Health Plan Corporation
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- Physician's Health Plan of Mid-Michigan

LOCAL HEALTH DEPARTMENTS

- Barry-Eaton District Health Department
- Ingham County Health Department
- Mid-Michigan District Health Department

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Project Guidance and Community Engagement:

- **Members of the Community Advisory Committee**

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Vision

The vision of the Healthy! Capital Counties Community Health Improvement Process 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

About The Project

PURPOSE

The purpose of this Community Health Profile is to describe the health status of the population, key health behaviors, describe determinants of health outcomes and behaviors, and examine root causes of ill health and health inequalities. A community health assessment and improvement plan is a collaborative, systemic process of collecting and analyzing data and information, mobilizing communities, developing priorities, garnering resources, and planning actions to improve the population's health.

DEFINITIONS*

Community Health Improvement Process: A comprehensive approach to assessing community health and developing and implementing action plans to improve community health through substantive community member and local public health system partner engagement. The community health improvement process yields two distinct yet connected deliverables: a community health assessment presented in the form of a **community health profile** and a **community health improvement plan**.

Community Health Assessment (CHA): A process that engages with community members and partners to systematically collect and analyze qualitative and quantitative health-related data from a variety of sources within a specific community. The findings of the CHA are presented in the form of a **community health profile** and inform community decision-making, the prioritization of health problems and the development and implementation of community health improvement plans.

Community Health Improvement Plan (CHIP): An **action-oriented plan** outlining the priority community health issues (based on the community health assessment findings and community member and partner input) and how these issues will be addressed, including strategies and measures, to ultimately improve the health of a community. The CHIP is developed through the community health improvement process.

*from the NACCHO Demonstration Site Project Requirements, Required CHA/CHIP Characteristics

PROCESS

The Healthy! Capital Counties project began as a partnership between the four hospital systems and the three localhealth departments serving Ingham, Eaton, and Clinton counties in December of 2010. The 2010 Patient Protection and Affordable Care Act requires non-profit hospitals to conduct or participate in a "community health needs assessment", partner with public health and the com- munity, and to develop an action plan to address health needs identified in the assessment.

The public health departments, while accredited at the State level in Michigan, must conduct a high-quality Community Health Assessment and Community Health Improvement Plan as a prerequisites to apply for voluntary national accreditation through the Public Health Accreditation Board. Building on a regional history of cross-hospital system and cross-health department collaboration, the entities decided to partner collaboratively on this project to conserve and enhance the local capacity to do this work.

In July of 2011, the Barry-Eaton District Health Department, with co-applicants Ingham County Health Department and Mid- Michigan District Health Department, was one of twelve sites awarded a small Community Health Assessment/Community Health Improvement Planning Demonstration Site grant from the National Association of County and City Health Officials, through funds from the Robert Wood Johnson Foundation. This grant provided primarily technical assistance, extensive training for the lead staff members, and access to nationally-recognized experts at Community Health Assessment and Improvement Planning. In addition to the NACCHO demonstration grant, funding contributed by each partnering health system, provided the financial underpinning of this collaborative health assessment initiative, referred to as the Healthy! Capital Counties Project.

COMMUNITY ENGAGEMENT

The Healthy! Capital Counties project is unique in its multi-agency, collaborative structure and it philosophical promise to integrate and apply a health equity perspective to its processes and data interpretations. Health equity is defined as the economic and social conditions that influence the health of individuals, communities, and jurisdictions as a whole. [1]

The project includes two main workgroups — one of which is the Steering Committee, made of hospital, health department, and university representatives to provide guidance to the staff as well as to assist with project design, promotion, communications, and media. The other, larger group is the Community Advisory Committee, which provides a community voice for the project and assists with community engagement and ownership.

In October of 2011, the first Community Advisory Committee meeting was convened. It consisting of numerous representatives, such as: community members, elected officials, cross-sector agency representatives, and leaders from each of the three counties, in addition to members of the steering committee meeting. The Community Advisory Committee has provided leadership and community engagement on key aspects of the project, including: project visioning, indicator selection, identification of key focus group populations, promotion and recruitment of focus group participants, and report structure and design. Current and future tasks will include promotion and participation in seven community dialogues and development of the Community Health Improvement Plan.

1 Dennis Raphael, Social Determinants of Health; Toronto: Scholars Press, 2004

JURISDICTION

Many persons 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 need to establish a process that would simultaneously look broadly at the region as a whole and at the county level while also viewing smaller communities more closely was essential. The jurisdiction covered by this Community Health Profile includes all of the residents living in Clinton, Eaton, and Ingham counties.

MODEL

We used the Association for Community Health Improvement's model for our Community Health Assessment and Improvement Planning project. Constructed by a team of professionals working in both hospital and public health settings, this model fit both the nature of our project as well as the timeframe. The website for the model is www.assesstoolkit.org.

Steps in this model were modified in order to meet the NACCHO grant CHA/CHIP specifications, to meet PHAB accreditation standards, and to enhance community engagement.

Health equity principles were also applied in the framing of the project. Utilizing specific expertise garnered through NACCHO, the Steering and Advisory Committees and staff outlined a plan that would allow for:

- the inclusion of social determinants of health - defined as the physical, economic, and social environment in which people live;
- the participation of communities that are traditionally marginalized; and
- the application of facilitated dialogue to bring equity and balance to the community engagement process.

The Association for Community Health Improvement Model

DATA COLLECTION

The data presented in this report was compiled from a variety of sources and include both primary (collected for local health assessment purposes) and secondary data sources (collected for another purpose, usually by another organization/institution). All of the data collected for the Healthy Capital Counties project were quantitative (information are described in terms of quantity of an item), except for the focus group data, which was qualitative (information is described in terms of attributes, characteristics, properties).

Primary Data Sources

Two primary data sources were used in the development of this report: the Healthy! Capital Counties focus groups and the Capital Area Behavioral Risk Factor and Social Capital survey.

Healthy! Capital Counties Focus Groups In order to gather information from traditionally hard to survey populations and to document the experiences, thoughts, beliefs, and stories of the community, a series of focus groups were conducted for the project. Eight focus groups were held in February and March of 2012 and took place in various locations throughout the three-county area. Groups that were actively solicited for input were:

- Persons with disabilities
- Persons recovering from substance addiction
- Persons who are uninsured
- Persons who have low incomes
- Persons who identify as Hispanic or Latino (including those who speak Spanish and those who speak English)
- Persons who identify as Black or African American
- Persons who are unemployed

Capital Area Behavioral Risk Factor & Social Capital Survey Since 2000, the Capital Area United Way, Barry-Eaton District Health Department, Ingham County Health Department, and Mid-Michigan Health Department have conducted a telephone health survey of the adult population in their jurisdictions (Barry, Eaton, Ingham, Clinton, Gratiot, and Montcalm counties) on various behaviors, medical conditions, and preventive health care practices. The survey was conducted using the Capital Area Behavioral Risk Factor & Social Capital survey instrument, which uses questions from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System questionnaire, as well as questions developed by the health departments to collect information of interest to the local community. A total of 2,431 adults in Clinton, Eaton, and Ingham counties responded to the telephone survey and the overall survey response rate was 48%.

Secondary Data Sources

In addition to primary data sources, secondary sources were also used. These included:

American Community Survey (ACS), U.S. Census Bureau In 1992, the House Commerce Oversight Subcommittee asked the Census Bureau to create an annual snapshot of demographic information so Congress can react to current trends instead of 10-year-old data. The American Community Survey (ACS) is the response to that request. It is an ongoing statistical survey conducted by the U.S. Census Bureau, sent to approximately 250,000 addresses monthly (or 3 million per year) that gathers information about: demographics, family and relationships, income and benefits, and health insurance. In 2010 it replaced the long form of the decennial census.

Michigan Department of Community Health (MDCH) The Michigan Department of Community Health is responsible for the collection of information on a range of health related issues in order to: monitor the general health and well-being, health program development, targeting and evaluation of program progress, identify emerging health issues and trends.

Michigan State Police Uniform Crime Report Statistical reports including crime statistics, financial information, traffic crash statistics, and traffic safety research reports are kept by the Michigan State Police from participating law enforcement agencies throughout the state.

Wellogic System, Michigan Department of Environmental Quality (Michigan DEQ) Well water chemistry information was obtained from the Michigan DEQ's Wellogic system. Wellogic is the Internet-based data entry program developed by the state of Michigan in 2000 to provide an easy method for water well drilling and pump installation contractors to submit water well records. DEQ is mandated to: assess water quality, provide regulatory oversight for all public water supplies, issue permits to regulate the discharge of industrial and municipal wastewaters, monitor State Water resources for water quality, the quantity and quality of aquatic habitat, the health of aquatic communities, and compliance with state laws.

Michigan Profile for Healthy Youth Survey (MiPHY): Michigan Department of Education and MDCH The Michigan Profile for Healthy Youth is an online student health survey. It provides student results on health risk behaviors including substance use, violence, physical activity, nutrition, sexual behavior, and emotional health in grades 7, 9, and 11. The survey also measures risk and protective factors most predictive of alcohol, tobacco, and other drug use and violence.

Food Desert Locator, United States Department of Agriculture The online Food Desert Locator is an Internet-based mapping tool that pinpoints the location of "food deserts" around the country and provides data on population characteristics of census tracts where residents have limited access to affordable and nutritious foods.

Area Resource File, Health Resources and Services Administration Health Resources and Services Administration's Area Resource File (HRSA ARF) contains information on health facilities, health professions, measures of resource scarcity, health status, economic activity, health training programs, and socioeconomic and environmental characteristics. In addition, the basic file contains geographic codes and descriptors, which enable it to be linked to many other files and to aggregate counties into various geographic groupings. Data from this file was used by the County Health Rankings.

GEOGRAPHIC AREA GROUPS METHODOLOGY

Counties are typically not homogenous areas. One part of a county maybe very urban, meanwhile another part can be very rural. Nevertheless, the lowest geography for which health data is usually reported is at the county level. While accurate, this way of presenting the data mask variations that maybe present at the sub-county level. To the extent possible, this project sought to give a more nuanced view of health in the capital area.

What usually prevents health professionals from reporting sub-county statistics is population size. A city/township with a population of 150,000 has sufficient persons experiencing health events (births, deaths, diabetes, heart attacks, etc.) to calculate statistics that are both stable and maintain confidentiality — but a city or township with a population of 15,000 does not. To overcome this problem, we divided the tri-county area into small geographic units and then assembled similar geographic units together into groups with sufficient population sizes for reporting health statistics. For the purposes of this project, sub-county geographic areas were grouped using either:

population density and median home value, or

median home value

Both these characteristics were calculated using data from the U.S. Census Bureau. While not the only characteristics of sub-county geographic areas, we feel they are accurate risk markers that describe the lived experience of the majority of the population.

URBAN GROUPS (median home value)

The City of Lansing, the City of East Lansing, and Lansing Charter Township, were divided into individual census tracts. The median home value was determined for each tract and then the census tracts were sorted and grouped. There are three of these urban groups —

Urban Low Price, meaning those census tracts where the median home value is less than $120,900

Urban Mid Price, where the census tracts have median home values ranging from $120,900 to less than $183,600

Urban Upscale, where median home value ranges from $183,600 to $296,400.

GROUP NAME	Median Home Value
Urban Low Price	< $120,900
Urban Mid Price	$120,900 to $183,600
Urban Upscale	>$183,600

SUBURBAN and RURAL GROUPS (median home value and population density)

The remaining areas of the capital area were divided into their individual cities and townships. Using the population density of each municipality (calculated as person per square mile) and its median home value, the cities and township were sorted and grouped into four groups:

Farms & Fields, townships with a population density less than 419 people per square mile, and median home values less than or equal to $167,000

Countryside Suburbs, townships with a population density less than 419 people per square mile, and median home values of more than $167,000

GROUP NAME	POPULATION DENSITY	Median Home Value
Farms & Fields	< 419 persons/square mile	< $167,000
Countryside Suburbs	< 419 persons/ square mile	> $167,000
Small Cities	1000-2500 persons/ square mile	
Inner Suburbs	419-999 persons/ square mile	

Small Cities, which are exurban cities (and one township) with high population density of 1,000-2,500 people per square mile

Inner Suburbs, townships that are immediately adjacent to the urban areas, with population density of 419-999 people per square mile

UNDERSTANDING the MAPS

The maps displayed in this report are visual representations of the rates across each of the geographic area groups, and are not interpretable as "the rate" for a particular location. For example, the rate of Child Poverty in the "Small Cities" area is 4.7%. This means that across the group of municipalities that make up the Small Cities group, the overall rate is 4.7%. Does this mean that the rate of child poverty in Charlotte, or Mason, or St. Johns is 4.7%? Absolutely not. The rate in the municipalities making up the groups may vary — and **the specific rate for a specific location cannot be found by consulting the map**. Data is available by municipality for the American Community Survey — however, most data are not reportable to the municipal or census tract level, which is why the data are grouped by the geographic areas when possible.

CITATIONS

Throughout the report, specific books and journal reports are cited with publication information. Websites are cited with web addresses. However, we also often consulted sources such as the County Health Rankings or the Michigan Department of Community Health to explain background information about an indicator. These are noted with [CHR] and [MDCH], respectively.

How does health happen?

Health can seem like a very fragile thing — one minute you have it, the next minute it is gone. Some people look to their genetics to explain their ill health, others think of their bad behaviors. Some feel that their very neighborhood makes it hard to be healthy. On an individual level, most people work very hard to stay healthy, or get healthy again.

This report is concerned with the *changeable* aspects of health, and therefore does not address genetics or heritable diseases. While personal responsibility plays a role in each person's individual health, it's important to also consider other factors of social and collective responsibility to improve health. **This report is designed to tell us the patterns of ill health across populations or groups of people, rather than examining health at an individual level.** In this report, we examine **health outcomes** to determine patterns of disease and death across populations.

Some of what influences health outcomes are **health behaviors**, or ways of living which protect from or contribute to health problems. These behaviors are what people usually think of as causing ill health, things like smoking, drinking, not having a primary care doctor. Also included are things that reflect someone's **physical or mental condition**, such as obesity or poor mental health — these are often linked to poor health outcomes.

Over the past 30 years, researchers have found that **social, economic, and environmental factors** (the social determinants of health), predict which groups are more likely to have poor health outcomes and poor health behaviors. These can be thought of as characteristics that can either constrain (hurt) or support (help) healthy living. These factors examine concepts like lack of access to healthy foods, educational achievement, and exposure to childhood poverty. These disadvantages often pile up on each other to make healthy living more challenging for some populations than for others.

The final level are those things which affect how different groups are exposed to the social, economic, and environmental factors. These **opportunity measures** are those which examine evidence of structural power and wealth inequities — factors which predict which groups will be challenged with poor social, economic, and environmental conditions. Understanding opportunity measures is a key aspect of a **health equity** perspective. The opportunity measures presented in this report are those that have been shown to result in poor health outcomes. To put it bluntly, there is increasing evidence that income inequality and housing segregation is making us sick.

Healthy! Capital Counties Model for How Health Happens

Adapted from D. Bloss and R. Canady, Ingham County Social Justice and Health Equity Project, and R. Hofrichter, *Tackling Health Inequities Through Public Health Practice, 2010*

2012 Indicators

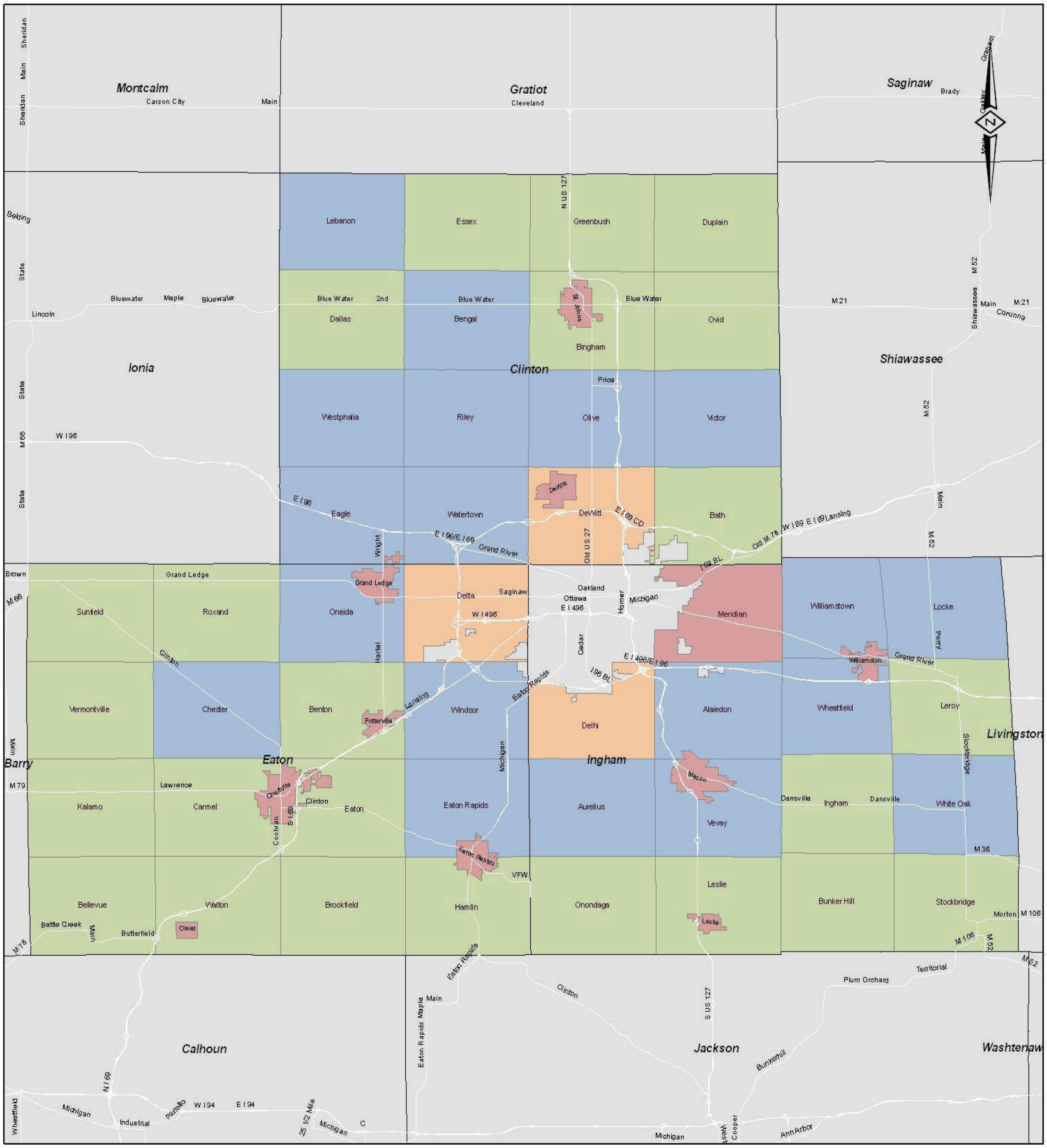
DOMAIN	INDICATOR GROUP	INDICATOR	MEASURES	SOURCE	Year (or Group of Years)	***Smallest* Final** Geographic Level of Analysis[1]
Opportunity Measures	**Income**	Income Distribution	Gini coefficient of income inequality	ACS	2006-2010	HCC geo groups
	Segregation	Housing Segregation	Gini coefficient of minority-headed households	ACS	2006-2010	HCC geo groups
Social, Economic, and Environ-mental Factors	**Social and Economic Factors**	Income	% children in poverty	ACS	2006-2010	HCC geo groups
		Education	Education distribution in adults older than 25	ACS	2006-2010	HCC geo groups
		Social Connection & Support	Social Capital	BRFS	2008-2010	County
		Community Safety	Rate of violent crimes per person	MSP	2010 (+prior)	HCC geo groups
		Affordable Housing	Households who spend more than 30% of income on housing	ACS	2008-2010	HCC geo groups
		Quality of Primary Care	Rate of Ambulatory-Care Sensitive Hospitalizations (Preventable)	MDCH Vital Statistics	2010 (+ prior)	HCC geo groups
	Environmen tal Factors	Environmental Quality	% water wells w/evidence of significant nitrate contamination	MDEQ	2011 (+prior)	HCC geo groups
		Built Environment	Food Desert Status	USDA	2006/2010 ACS	HCC geo groups
Behaviors, Stress, and Physical Condition	**Health Behaviors and Physical Condition**	Obesity	Adult Weight Distribution (BMI Categories)	BRFS	2008-2010	County
			Adolescent Weight Distribution (BMI Categories)	MiPHY	2010	County
		Tobacco Use	Current Smoking in adults	BRFS	2008-2010	County
			Current Smoking in adolescents	MiPHY	2010	County
		Alcohol Use	Binge Drinking in adults	BRFS	2008-2010	County
			Binge Drinking in adolescents	MiPHY	2010	County
	Clinical Care	Access to Care	Persons with a primary medical provider	BRFS	2008-2010	County
			Ratio of population to the number of primary care physicians	County Health Rankings	2008	County
		Communicable Disease Prevention	% children 19-35 months who receive recommended immunizations	MCIR	2011	County
	Stress	Mental Health	Poor mental health days in adults	BRFS	2008-2010	County
			Adolescents with symptoms of depression in past year	MiPHY	2010	County
Health Outcomes	**Illness (Morbidity)**	Child Health	Preventable Asthma Hospitalization Rate in children 0-18	MDCH Vital Records	2010 (+ prior)	HCC geo groups
		Quality of Life	Perceived health status (good vs. poor)	BRFS	2008-2010	County
		Adult Health	Preventable Diabetes-related Hospitalization Rate in adults 18+	MDCH	2011 (+prior)	
	Deaths (Mortality)	Premature Death	% deaths before age 75	MDCH Vital Records	2009 (+ prior)	HCC geo groups
		Maternal & Child Health	Infant Mortality Rate	MDCH Vital Records	2009 (+ prior)	HCC geo groups
		Chronic Disease	Deaths due to cardiovascular disease	MDCH Vital Records	2009 (+ prior)	HCC geo groups
		Safety Policies and Practices	Deaths due to accidental Injury	MDCH Vital Records	2009 (+ prior)	HCC geo groups

[1] HCC Geo Groups = 7 groups of census tracts, cities, and/or townships grouped by median home value and population density in Clinton, Eaton, and Ingham Counties.
*subject to reportable data availability; some areas may have too few responses/incidents to report, or reliable data are not available at sub-county level

ACS = American Community Survey, conducted by the U.S. Census Bureau
BRFS = Behavioral Risk Factor Survey, conducted by local health departments
MCIR = Michigan Care Improvement Registry
MDCH = Michigan Department of Community Health
MDEQ = Michigan Department of Environmental Quality
MiPHY = Michigan Profile for Healthy Youth Survey
MSP = Michigan State Police
USDA = United States Department of Agriculture

Municipality Grouping for Healthy! Capital Counties

Non-Urban Areas



0 2.5 5 10 15 20 Miles

LEGEND

Tri-county geographic groups

- Farms & Fields
- Countryside Suburbs
- Small Cities
- Inner Suburbs

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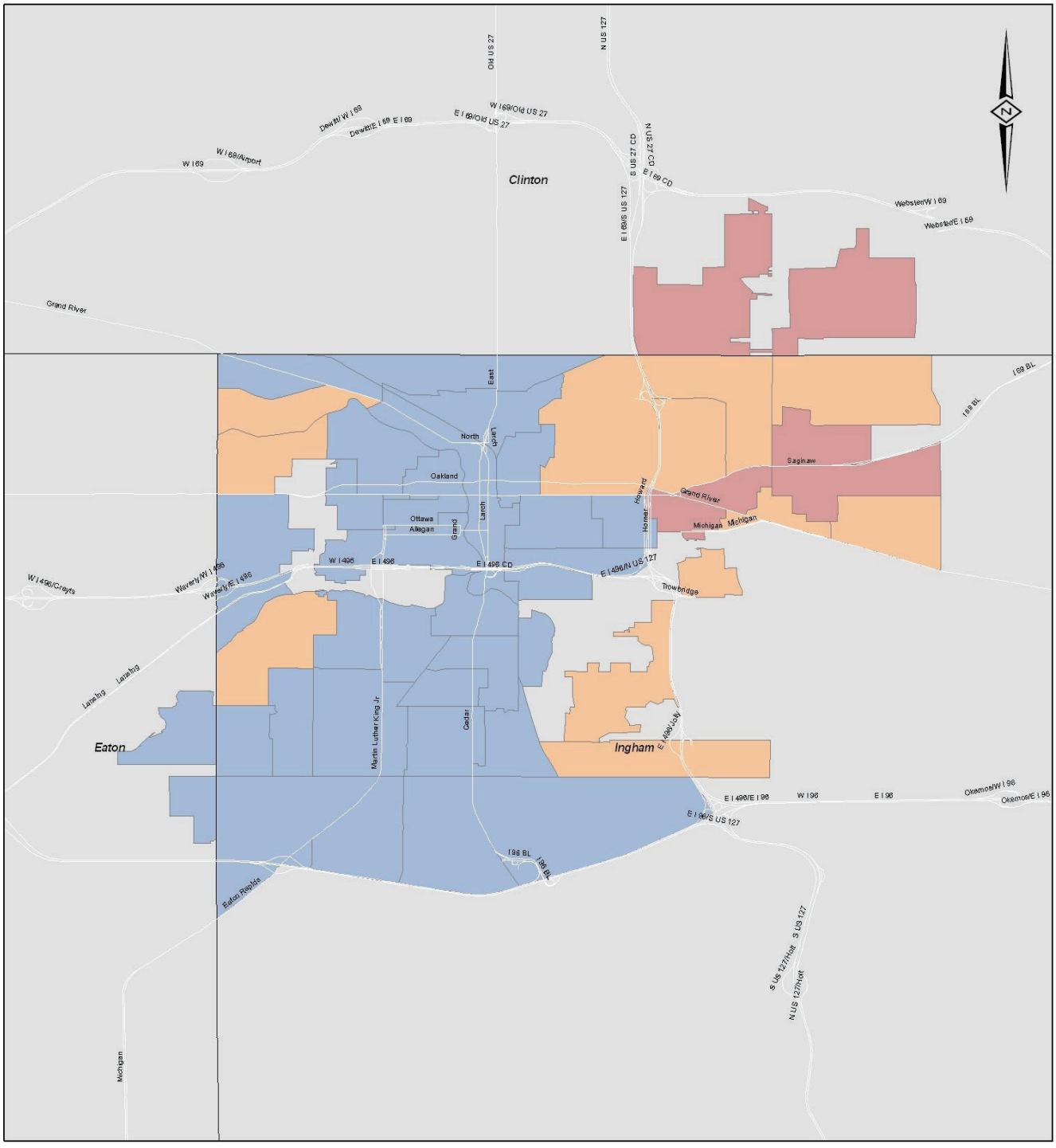
Urban Groupings for Healthy! Capital Counties

(includes Lansing, East Lansing, and Lansing Charter Township)



0 0.5 1 2 3 4 Miles

LEGEND

Urban geographic groups

- Urban low price (MHV ≤ $120,900)
- Urban mid-price ($120,900 < MHV < $183,600)
- Urban high price (MHV ≥ $183,600)

MHV = median home value

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Indicator Section

This section presents data indicator-by-indicator, with all of the available data for a given topic presented together.

Income Inequality

MEASURE:
Gini coefficent for income inequality. This measure ranges from 0.0 to 1.0. When the index is at 0, total income is shared equally between all families; when it is at 1.0, all income is owned by one family and all others have none. Here income is defined as new revenues and economic resources received by individuals and families during the course of a year.

DATA SOURCE:
American Community Survey, www.census.gov

YEAR: 2006-2010

REASON FOR MEASURE:
In general, this measure is used to examine the extent of inequality, and the number itself does not imply value — neither 0 or 1 would be "ideal". However, places with **high** income inequality (Gini coefficients ranging from 0.5 and above) such as countries in southern Africa and many South American countries, have generally **poorer health** outcomes than places with relatively low income inequality (Gini coefficients less than 0.35), such as Europe, Australia, Canada, and Scandinavia.

At the neighborhood level, spatial income inequality is neither intrinsically bad nor good. There is not much income inequality in neighborhoods consisting of new high-priced houses; nor is there much in neighborhoods consisting of low-rent private or public housing. However, across a region or community, high levels of income inequality may affect health outcomes.

Income inequality may have negative consequences for the poor. The movement of high-income earners away from the low income earners, for example, may leave low income earners with relatively few jobs or reduce the extent to which the middle class and the rich confer positive effects on the poor, such as tax revenue, charitable and cultural investment, and business investment. Diversity in incomes among neighbors can enhance the social environment by improving distribution of role models, and providing positive social networking opportunities.

speaking of health

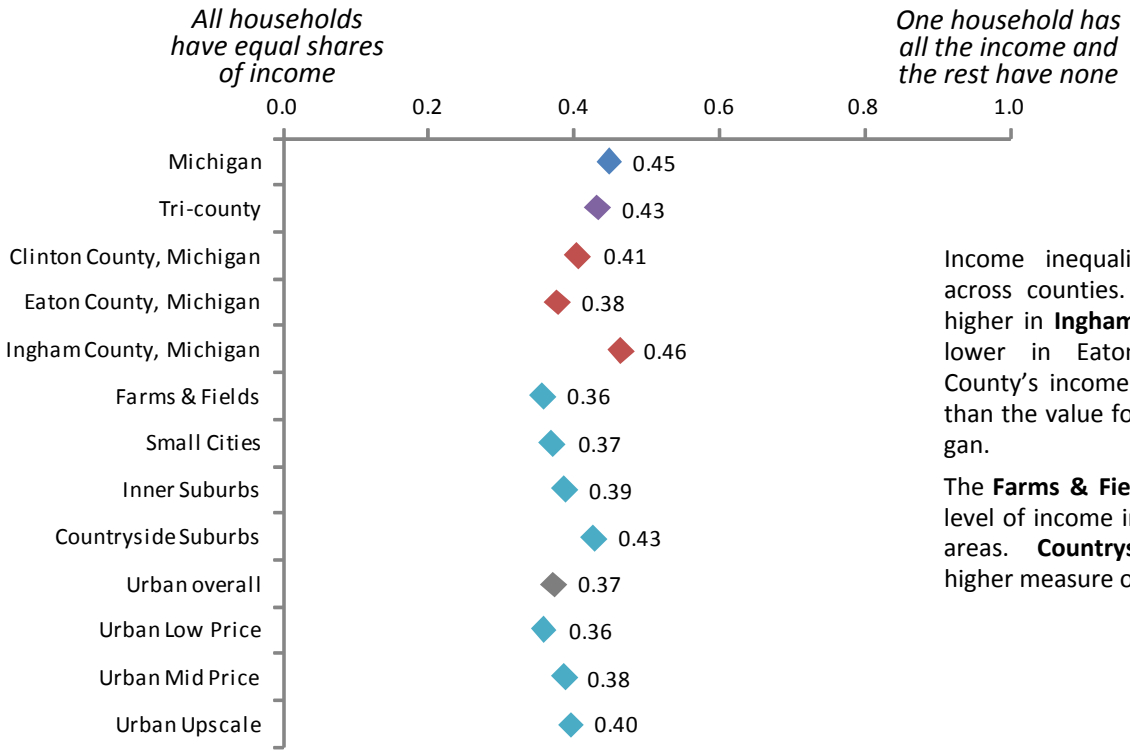
Focus Group Participants:

"The way we are with this economy, there are more people joining together, there is much more contact with neighbors, they are sharing different things."

"When I moved up here I thought I would be able to find a job quickly because I have always had a job but there are none here that pay decent wages."

"We need more jobs for people in our community."

Gini coefficient of Income Inequality

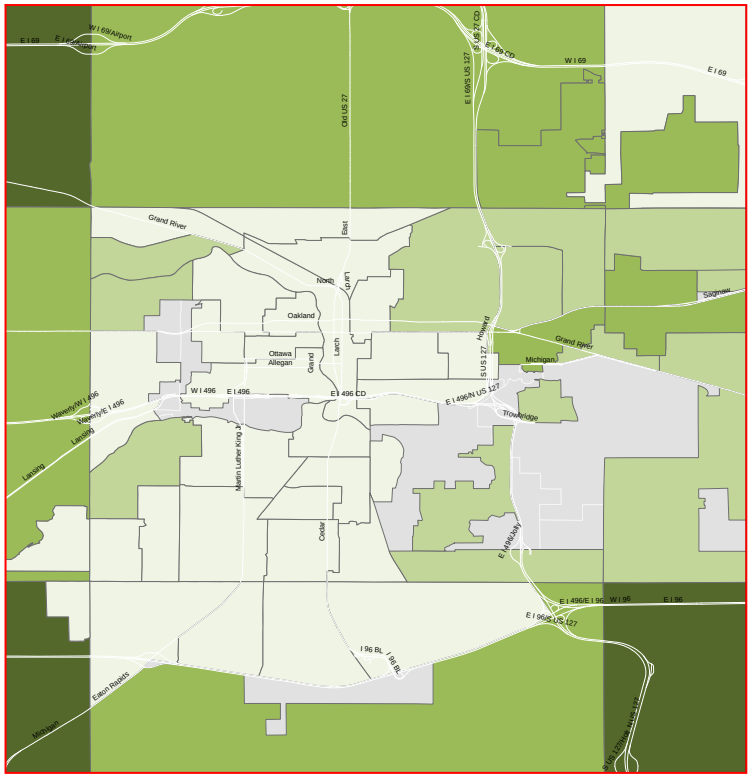


Income inequality is not uniform across counties. Income inequity is higher in **Ingham County** and is the lower in Eaton County. Ingham County's income inequality is higher than the value for the state of Michigan.

The **Farms & Fields** area has a lower level of income inequality than other areas. **Countryside Suburbs** has a higher measure of income inequality.

Income Inequality

Maps showing the Gini income inequality index by Geographic Area Groups



Legend

Gini index for income inequality

0 = most equal and 1 = completely unequal

- < 0.37
- 0.37 - 0.39
- 0.39 - 0.41
- > 0.41

Farms & Fields and Urban Low Price areas have the lowest rates of income inequality, followed by the Small Cities and Urban Mid Price areas.

Moderate rates of income inequality is found in the Inner Suburbs and Urban Upscale areas, with the highest level of income inequality in the Countryside Suburbs area.

Housing Segregation

MEASURE:

Housing segregation is measured using the Gini coefficient for the minority-headed (non-White) households in a population.

Here, a Gini coefficient of "0" would mean an area is fully integrated — whites and minorities are equally distributed throughout the area. A value of "1" would mean the opposite; an area is fully segregated; in other words, complete apartheid.

DATA SOURCE:

American Community Survey, www.census.gov

YEAR: 2006-2010

REASON FOR MEASURE:

Neighborhoods and community environments play an important role in health. Racial (housing) segregation can affect health through several ways. Such health effects can include reduced access to resources that encourage healthy habits including healthier food options and walkable neighborhoods. Segregation of this kind can create unequal access to important resources as well as exposures to potentially hazardous materials. Racial housing segregation has also been found to be associated with increases in very pre-term births in minorities.

Historically, housing segregation was enforced through policies such as "redlining", literally, red lines drawn on maps to indicate where persons of color could rent or purchase homes. While this practice became illegal nationally in 1968 with the Fair Housing Act, previous decades of legal segregation are still apparent today. Over the past 40 years, demographers have noted an increase in Whites settling in areas outside the urban core.

Just as communities with greater diversity in income can offer more opportunities for the poor to achieve well-being, more-integrated communities can offer increased opportunities for social interaction and mutual benefit.

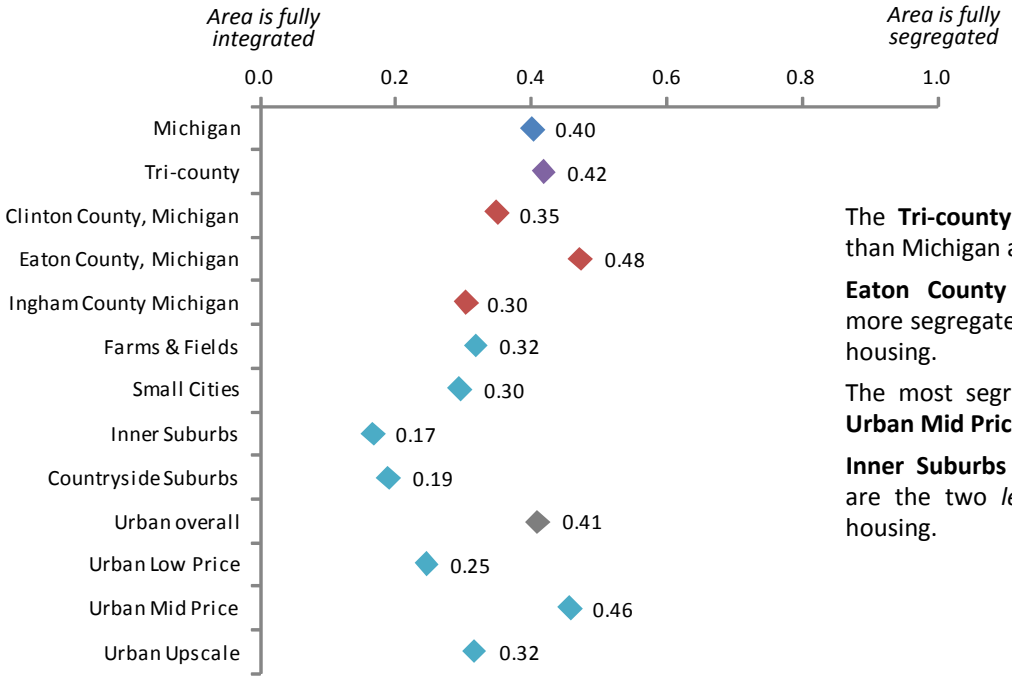
speaking of health

"Researchers postulate that racial segregation is a fundamental cause of disease differences between black and white people because it shapes social conditions for black people at the individual and community levels."

"Institutional racism and mortgage discrimination may be a major factor influencing neighborhood structure, composition, development and wealth attainment."

Mendez DD, Hogan VK, Culhane J. Institutional racism and pregnancy health: using Home Mortgage Disclosure act data to develop an index for Mortgage discrimination at the community level. ***Public Health Rep. 2011 Sep-Oct;126 Suppl 3:102-14.***

Gini coefficient of Housing Segregation of Minority-headed Households



The **Tri-county** area is more segregated than Michigan as a whole.

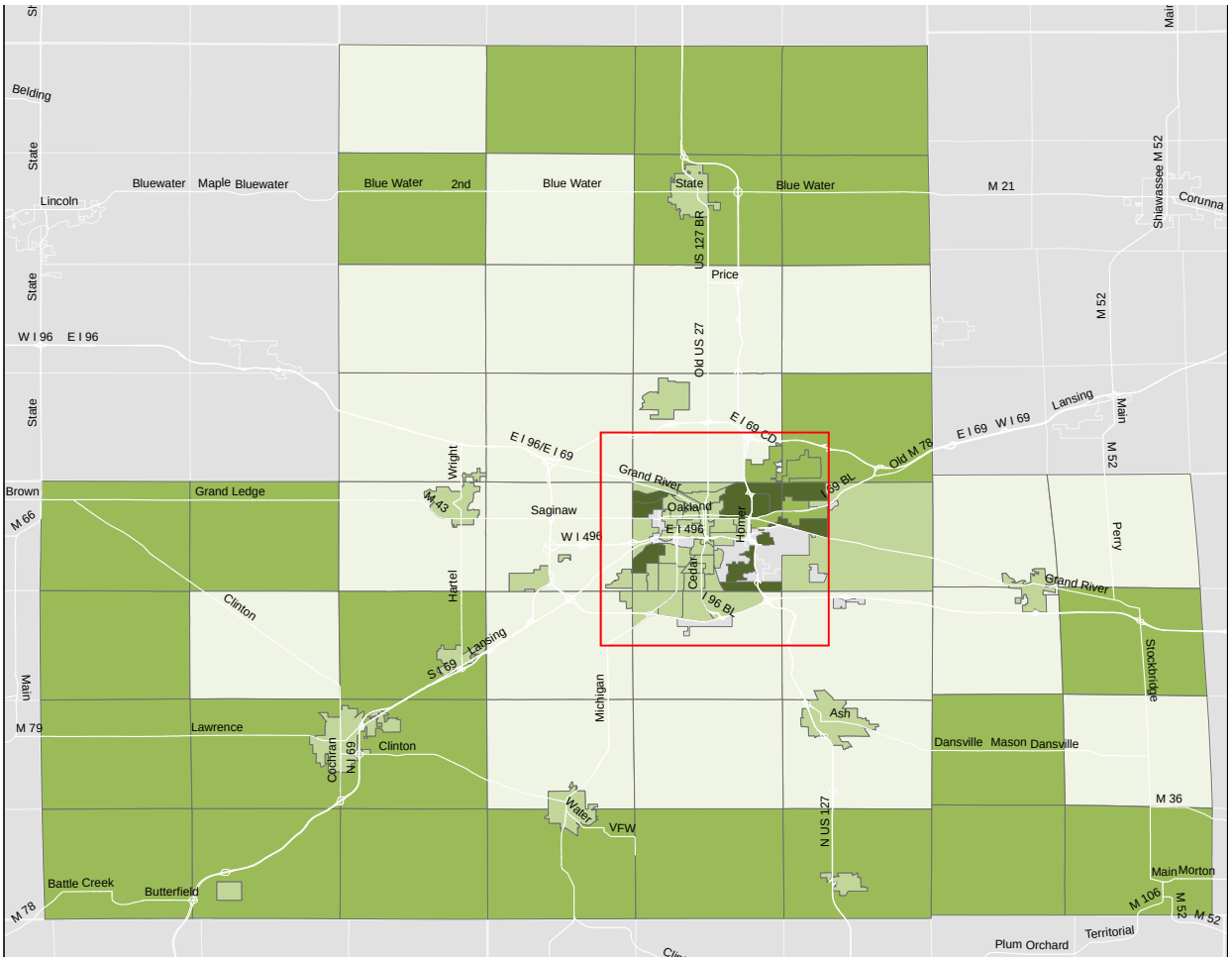
Eaton County and **Clinton County** are more segregated than Ingham County for housing.

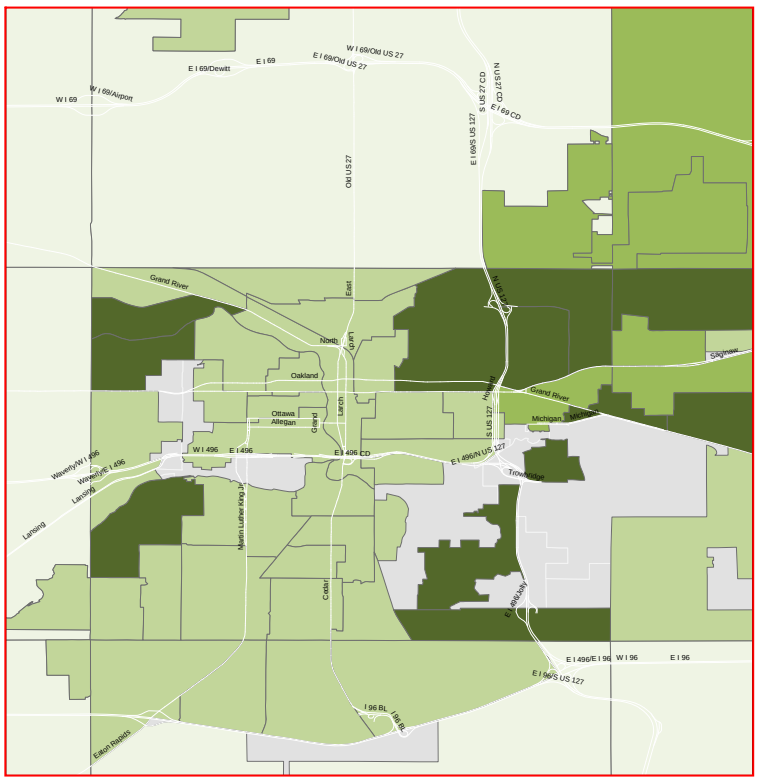
The most segregated Urban area is the **Urban Mid Price** area.

Inner Suburbs and **Countryside Suburbs** are the two *least* segregated areas for housing.

Housing Segregation

Maps showing the Gini housing segregation index by Geographic Area Groups





Legend

Gini index for segregation of minority-headed households

0 = integration to 1 = complete segregation

- < 0.25
- 0.35 - 0.32
- 0.32 - 0.39
- > 0.39

The Inner Suburbs and Countryside Suburbs areas have the lowest rates of housing segregation, followed by the Urban Low Price and the Small Cities areas.

Moderate rates of housing segregation are found in the Farms & Fields and Urban Upscale areas, with the highest level of housing segregation in the Urban Mid Price area.

Child Poverty

MEASURE:

The percent of children living in families with incomes below the Federal Poverty Level for their family size. In 2010, the Federal Poverty Level was $18,310 per year for a family of three, $22,050 for a family of four, and $25,790 for a family of five.

DATA SOURCE:

American Community Survey, www.census.gov

YEAR: 2006-2010

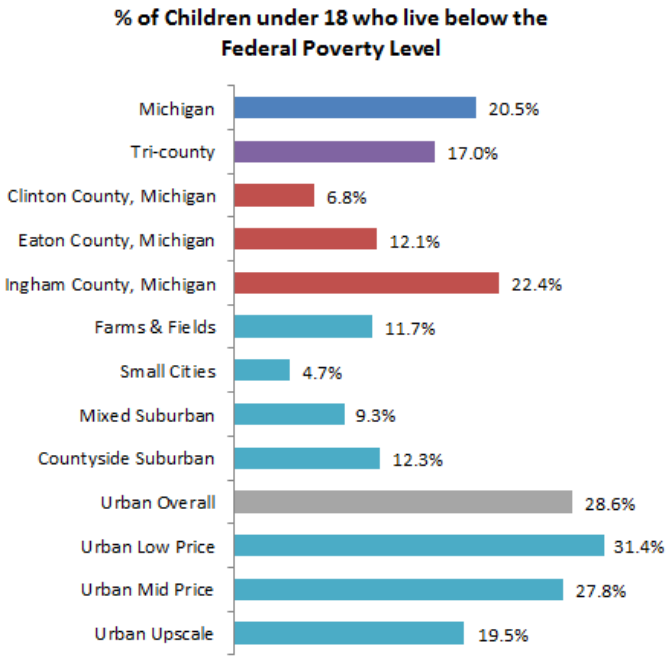
REASON FOR MEASURE:

Poverty can result in negative health consequences, such as increased risk of mortality, increased prevalence of medical conditions and disease incidence, depression, intimate partner violence, and poor health behaviors. While negative health effects resulting from poverty are present at all ages, children in poverty have greater morbidity and mortality due to an increased risk of accidental injury and lack of health care access. Children's risk of poor health and premature mortality may also be increased due to the poor educational achievement associated with poverty. The children in poverty measure is highly correlated with overall poverty rates. [CHR]

speaking of health

"Children raised in poverty have fewer chances to grow up in good health. In fact, research has shown that growing up in poverty is actually toxic to the developing brain. While people may later overcome these disadvantages of growing up in poverty, we as a community miss the opportunity to develop the potential of all children when we don't work to address childhood poverty."

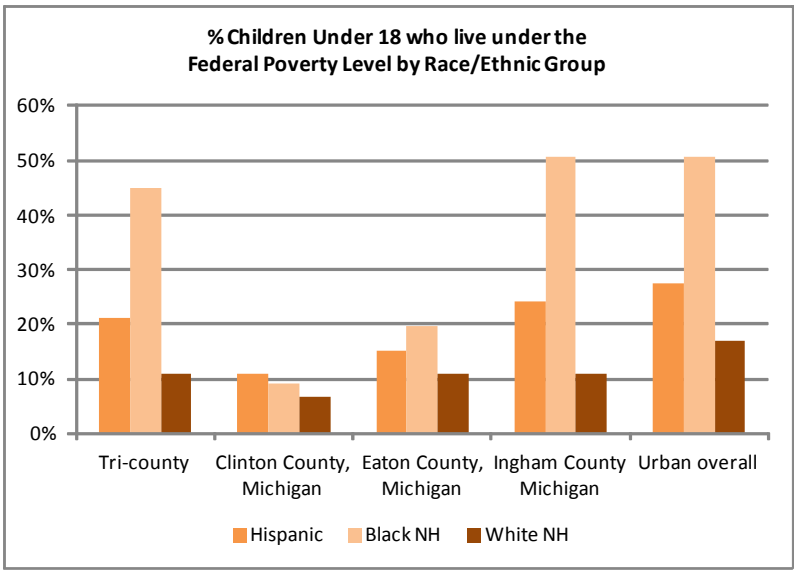
— Karen Black, Clinton County Great Start Director



Child poverty is not equally distributed throughout the capital area, but is highest in the ***Urban*** areas and lowest in the ***Small Cities*** area.

Because of the high percentage of the ***Urban*** area that is located in Ingham County, the county has a higher rate of child poverty than Clinton or Eaton County.

While over 1 in 4 children live in poverty in the Urban area, there are over 1 in 10 children living in poverty in the rural ***Farms & Fields*** area as well.



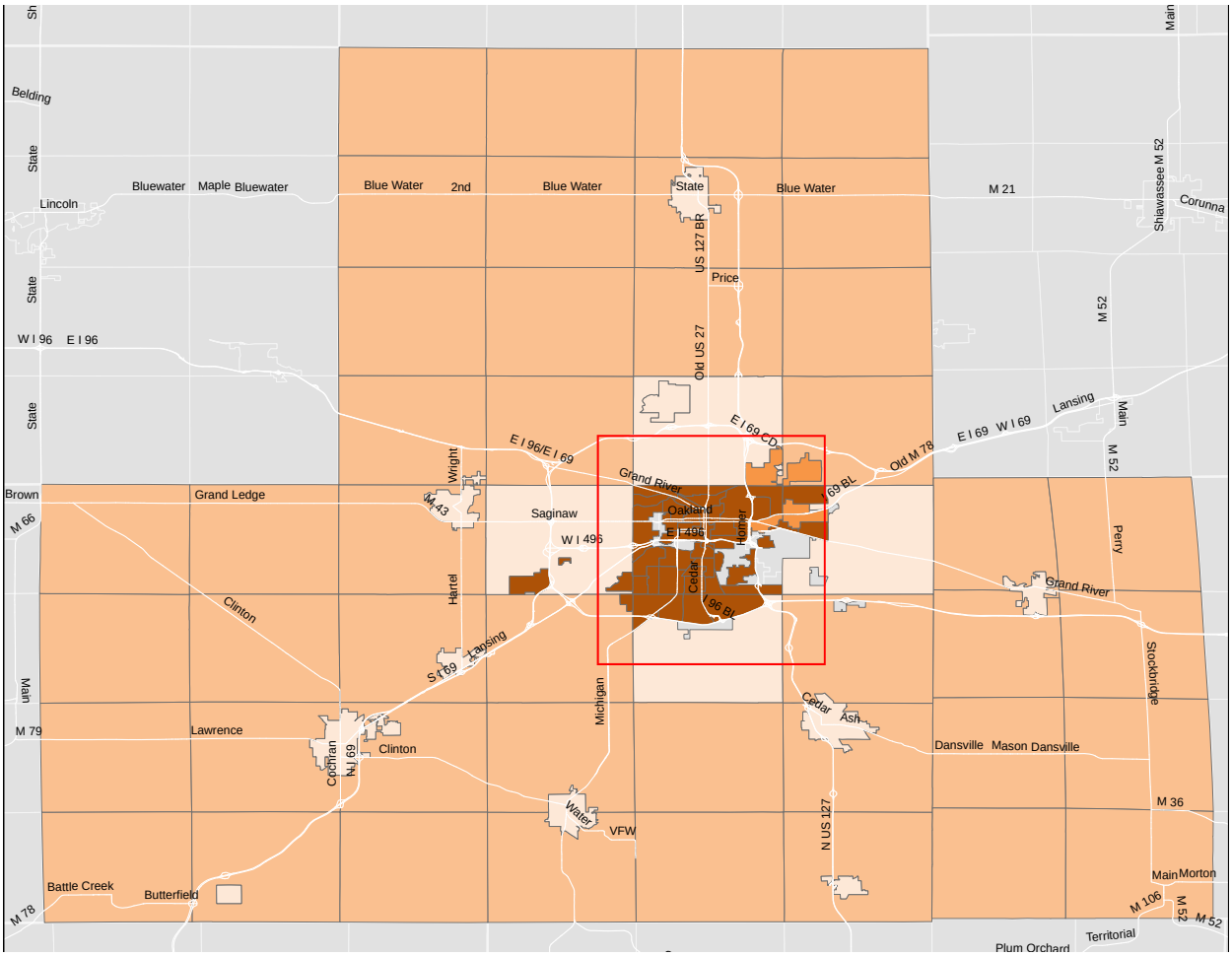
The rates of children in poverty vary significantly by racial/ethnic group.

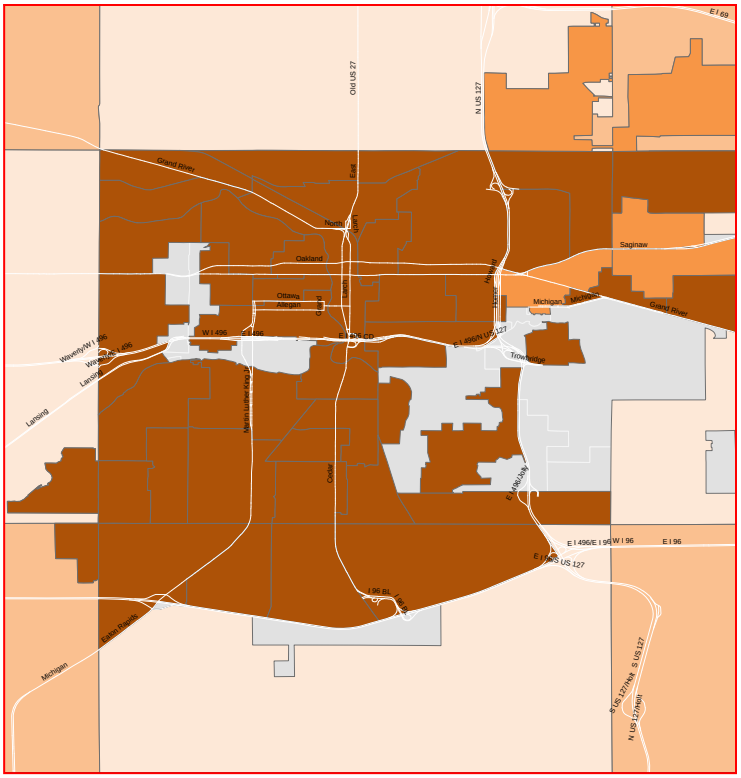
45 of every 100 Black children live under the poverty level in the tri-county region. 20 of every 100 Hispanic children live under the poverty level, and 10 of every 100 White children live under the poverty level.

This disparity significantly disadvantages children of color who are more likely to grow up with fewer opportunities to achieve good health.

Child Poverty

Maps showing the % of children in poverty by Geographic Area Groups





Legend

Percentage of children in poverty

- < 10.4%
- 10.4% - 17.4%
- 17.4% - 24.4%
- > 24.4%

The Small Cities and Inner Suburbs areas have the lowest rates of child poverty, followed by the Farms & Fields and Countryside Suburbs areas.

A moderate rate of child poverty is found in the Urban Upscale area, with the highest level of child poverty in the Urban Low Price and Urban Mid Price areas.

Education

MEASURE:

The percent of adults who are 25 years or older who have a Bachelor's degree or higher.

DATA SOURCE:

American Community Survey, www.census.gov

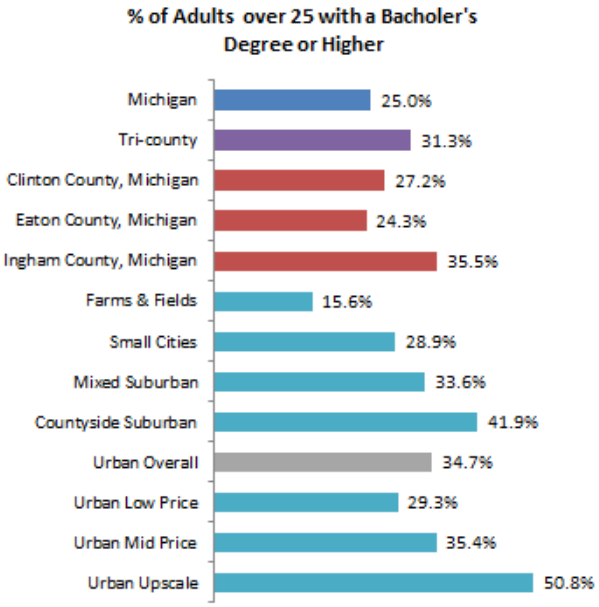
YEAR:

2006-2010

REASON FOR MEASURE:

The relationship between higher education and improved health outcomes is well known, with years of formal education correlating strongly with improved work and economic opportunities, reduced psychosocial stress, and healthier lifestyles. [CHR]

In other words, persons with more education have healthier lives than those with less education.



Compared to the state, the Tri-county area has a higher rate of adults with college degrees. Ingham County has the highest rate of college degrees among the counties.

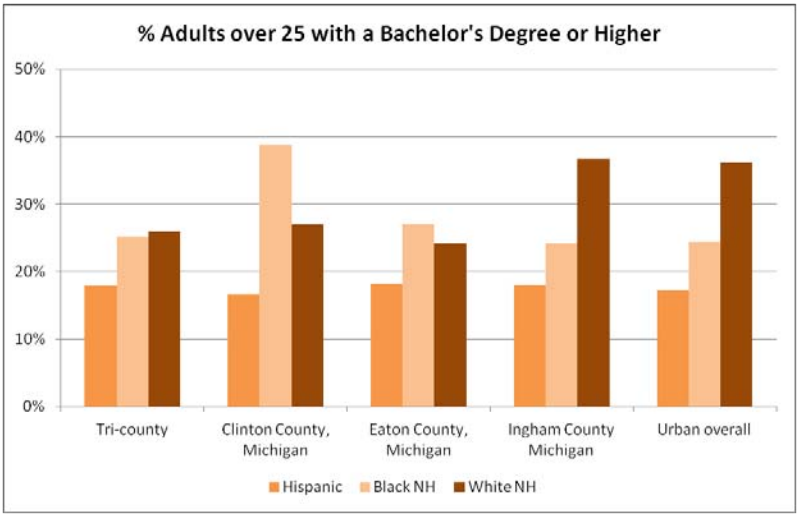
The lowest rate of educational achievement in adults is in the **Farms & Fields** area, where **fewer than 1 in 6** adults have at least a bachelor's degree. The highest rate of educational achievement is in the **Urban Upscale** area, where **more than half** of all adults over 25 have a bachelor's degree or higher.

speaking of health

Focus Group Participants:

"What would have prevented me from being in chronic pain? Education and a better job that was less physical. My problem was caused by wear and tear on my body. I know a lot of other construction workers in the same condition."

"The less educated you are... you don't live as long or have as healthy a life"

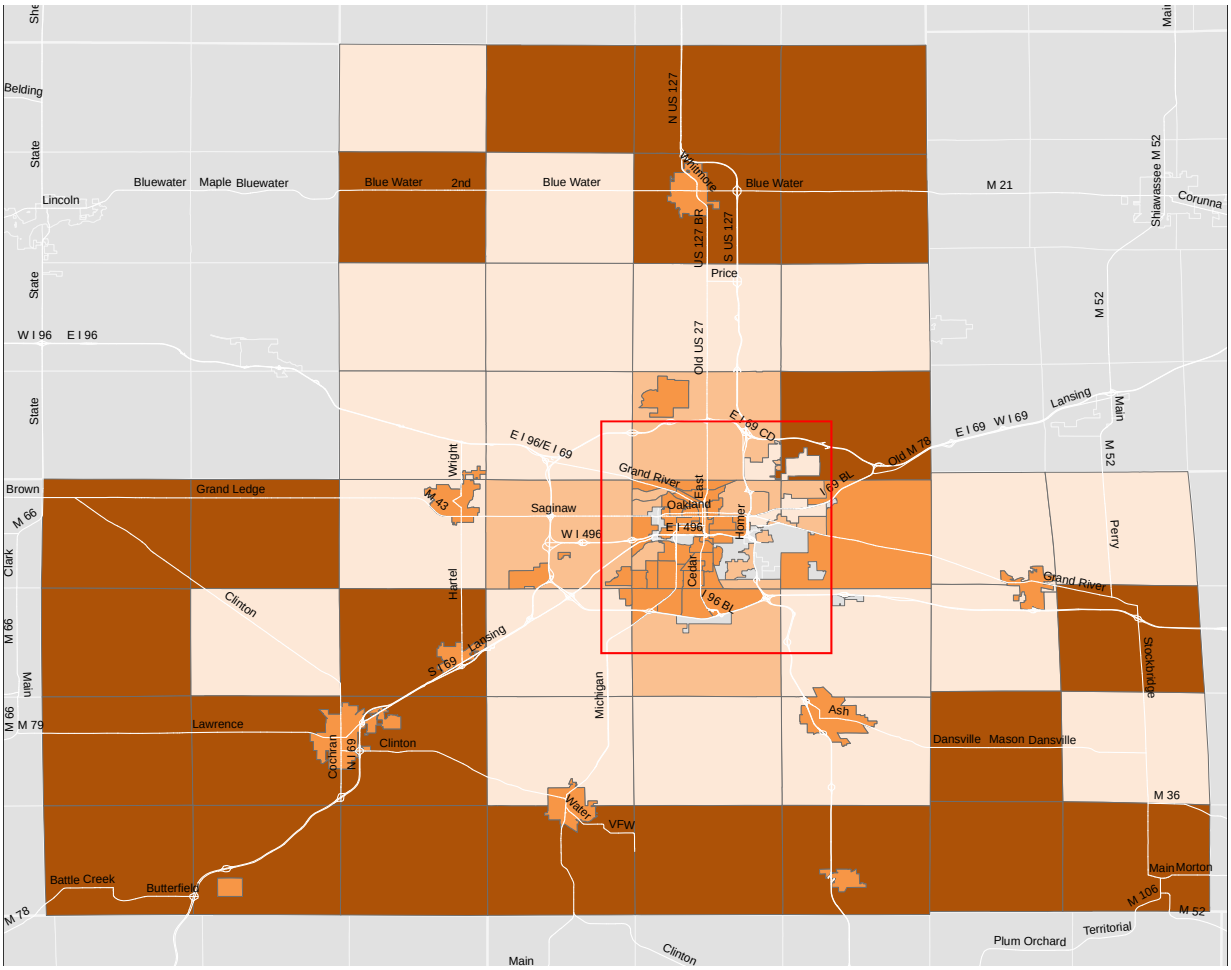


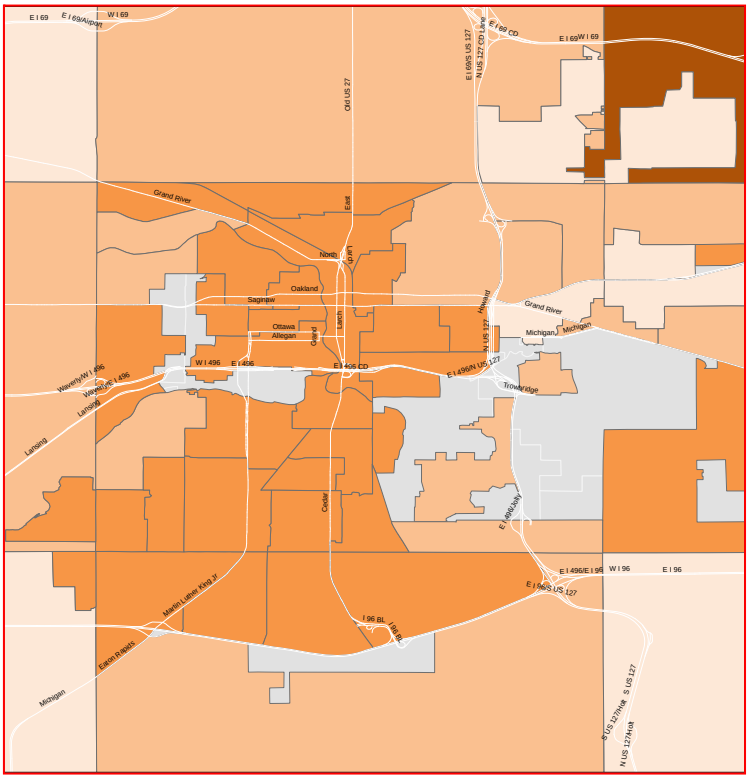
There are differences in educational achievement across racial and ethnic groups as well. In the Tri-county area, the percent of adults over 25 with a bachelor's degree or higher is lowest in Hispanics, with fewer than 1 in 5 adults with this level of education, and is highest in Whites.

In Ingham County and in the Urban area, **Whites are more likely** to have high educational achievement than Blacks or Hispanics. In Clinton County, and to a lesser extent in Eaton County, **Blacks are more likely than whites** to have high educational achievement — however, in all counties, **Hispanics are less likely than other groups** to have a bachelor's degree or higher.

Education

Maps showing the % of adults 25 and older with a 4-year degree or higher, by Geographic Area Groups





Legend

Percentage of adults 25yrs old or older with at least a 4yr college degree

- < 25.8%
- 25.8% - 32.8%
- 32.8% - 41.8%
- > 41.8%

The Farms & Fields area has the lowest rate of adults with a four year degree, followed by the Small Cities, Urban Low Price, and Urban Mid Price areas.

The highest rates of adults with a four year degree are in the Urban Upscale and the Countryside Suburbs areas.

Social Capital

MEASURE:

The percent of adults with one or more instances of civic participation sometime in the previous month. This participation could be any of the following: working on a **community project**, attended a **public meeting** discussing town or school affairs, attending a **political meeting** or rally, attending any **club or organizational meeting** (not including meetings for work), or **volunteering**.

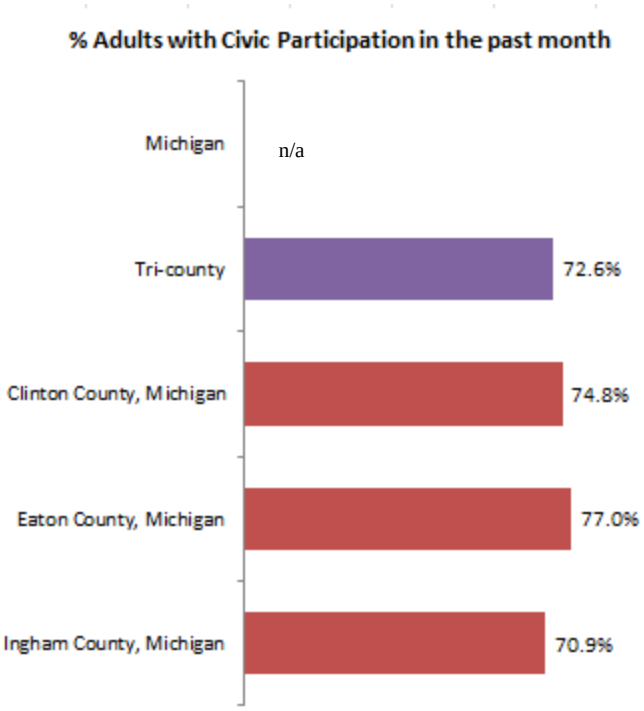
DATA SOURCE:

Capital Area Behavioral Risk Factor and Social Capital Survey

YEAR: 2008-2010

REASON FOR MEASURE:

Research has demonstrated a link between social capital (which includes the concepts of 'reciprocity', 'trust', and 'civic participation') and mortality rates. The more social capital a population has, the more likely they are to have good health outcomes. The measure of 'civic participation' was selected because it illustrates the most tangible element of social capital.



Generally, about 3 in 4 adults in the tri-county area participated civically sometime in the past month. Rates in the three counties are not statistically significantly different from each other.

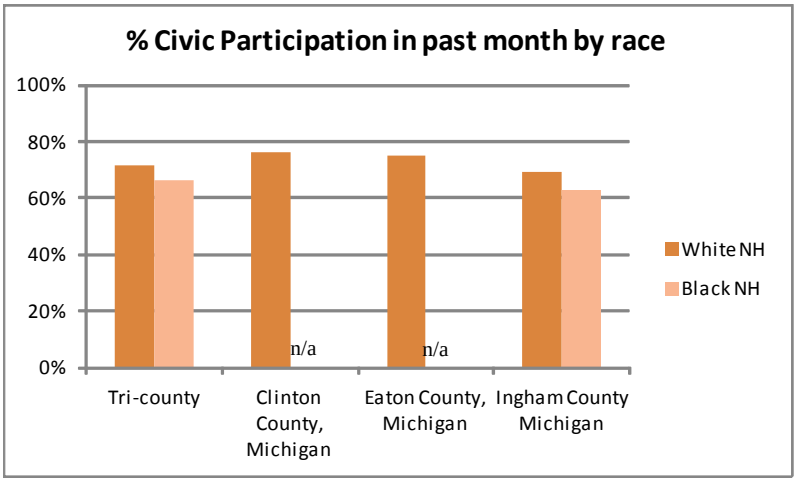
This rate is not available at the state level. Sub-county level geographic area group breakouts are not available for this indicator.

speaking of health

Focus Group Participants:

"Please find ways to get people involved in making these changes within the community!"

"The way we are today with this economy, there are more people joining together, there is much more contact with neighbors, they are sharing different things. Because they find that sharing more is sort of a relief and it improves your mental health when you have contact with other people, and in the neighborhood. I love where I am."



Persons identifying as Black or African-American are slightly less likely to report having participated civically in the past month across the tri-county area. Whites living in Ingham County are less likely to report civic participation than are Whites living in Eaton or Clinton counties.

Community Safety

MEASURE:

The number of violent crimes per 100,000 people. Violent crimes are defined as offenses that involve face-to-face confrontation between the victim and the perpetrator, including homicide, forcible rape, robbery, and aggravated assault.

DATA SOURCE:

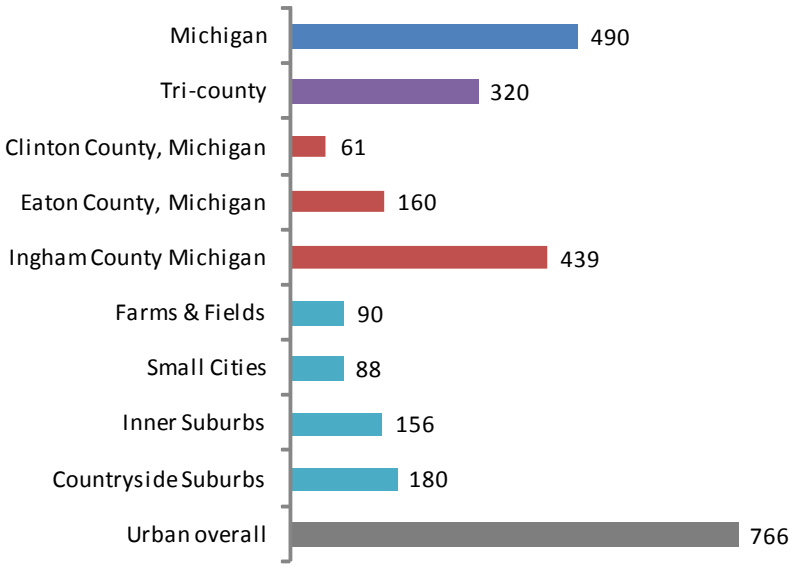
Michigan Uniform Crime Report

YEAR: 2010

REASON FOR MEASURE:

High levels of violent crime compromise physical safety and psychological well-being. Crime rates can also deter residents from pursuing healthy behaviors such as exercising out-of-doors. Additionally, some evidence indicates that increased stress levels may contribute to obesity prevalence, even after controlling for diet and physical activity levels.[CHR]

Rate of violent crimes per 100,000 persons



The violent crime rate is highest in the **Urban** areas, with a rate nearly twice as high as Ingham County as a whole, and more than twice as high as the Tri-County as a whole.

Clinton County enjoys the lowest violent crime rate — with a rate of only 61 crimes per 100,000 people. **Farms & Fields** and **Small Cities** areas also have very low rates of violent crime.

Areas located around the urban areas (Inner Suburbs and Countryside Suburbs experience higher rates than areas farther away from the Urban areas. Breakouts of the different urban areas were not reportable.

speaking of health

Focus Group Participants:

"In Lansing someone is getting shot everyday and they need to teach these kids other ways to solve their problems."

"I have 2 big dogs that I go walking with to feel safe. I carry a knife day or night in my purse."

"I feel safe in my neighborhood because we all look after one another."

"The children can't be left alone. Before you could let them go out and play outside, and you could watch them from the window — but not now. You have to go outside with the child, because you don't know who's going to walk by your house."

"This is way too much like a storm."

speaking of health

"I come from Eaton Rapids. I lived there almost my whole life and we basically left our doors open. Here, on the East side of Lansing, they have drive-by shootings, and we're not used to so much violence."

"Clinton County is really a blessing. I moved to St. Johns from Lansing...I live in the busiest area of St. Johns, and still feel safe."

"Everyone seems pretty well off, safe, and comfortable in Fowler. It's unheard of to hear of anything bad happening in such a small town -- if something bad happens everyone is shocked."

Affordable Housing

MEASURE:

The percent of households that pay 30 percent or more of their household income on housing costs.

DATA SOURCE:

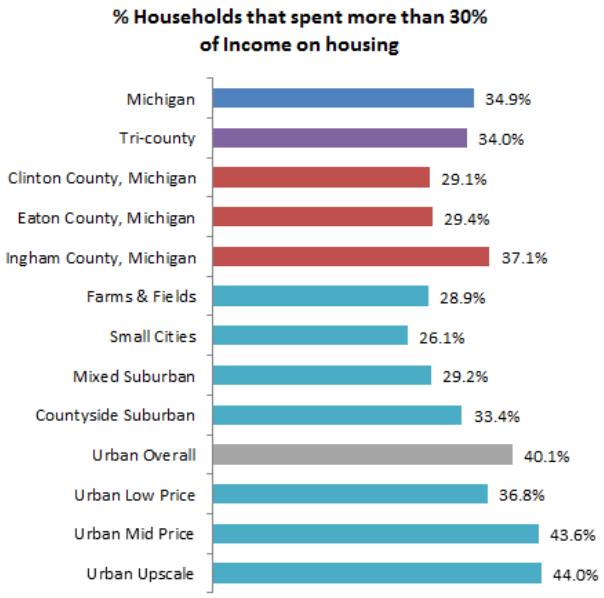
American Community Survey, www.census.gov

YEAR: 2006-2010

REASON FOR MEASURE:

Affordable housing may improve health outcomes by freeing up family resources for nutritious food and health care expenditures. Quality housing can reduce exposure to mental health stressors, infectious disease, allergens, neurotoxins, and other dangers. Families who can only find affordable housing in very high-poverty areas may be prone to greater psychological distress and exposure to violent or traumatic events. Stable, affordable housing may improve health outcomes for individuals with chronic illnesses and disabilities and seniors by providing a stable and efficient platform for the ongoing delivery of health care and other necessary services.

http://www.nhc.org/media/documents/HousingandHealth1.pdf



The areas with the highest portion of residents who spend more than 30% of their income on housing is the **Urban Mid Price** area and the **Urban Upscale** area — where 44 in 100 households live in unaffordable housing.

Households in the **Small Cities** area are the least likely to spend more than 30% of their income on housing, with only about 26 in 100 families living in unaffordable housing.

A greater share of households in Ingham County live in unaffordable housing than in Eaton or Clinton counties — this is likely because the majority of the urban areas lie in Ingham County.

speaking of health

Focus Group Participants:

"A lot of people have left their community to find jobs or affordable housing due to these economic times."

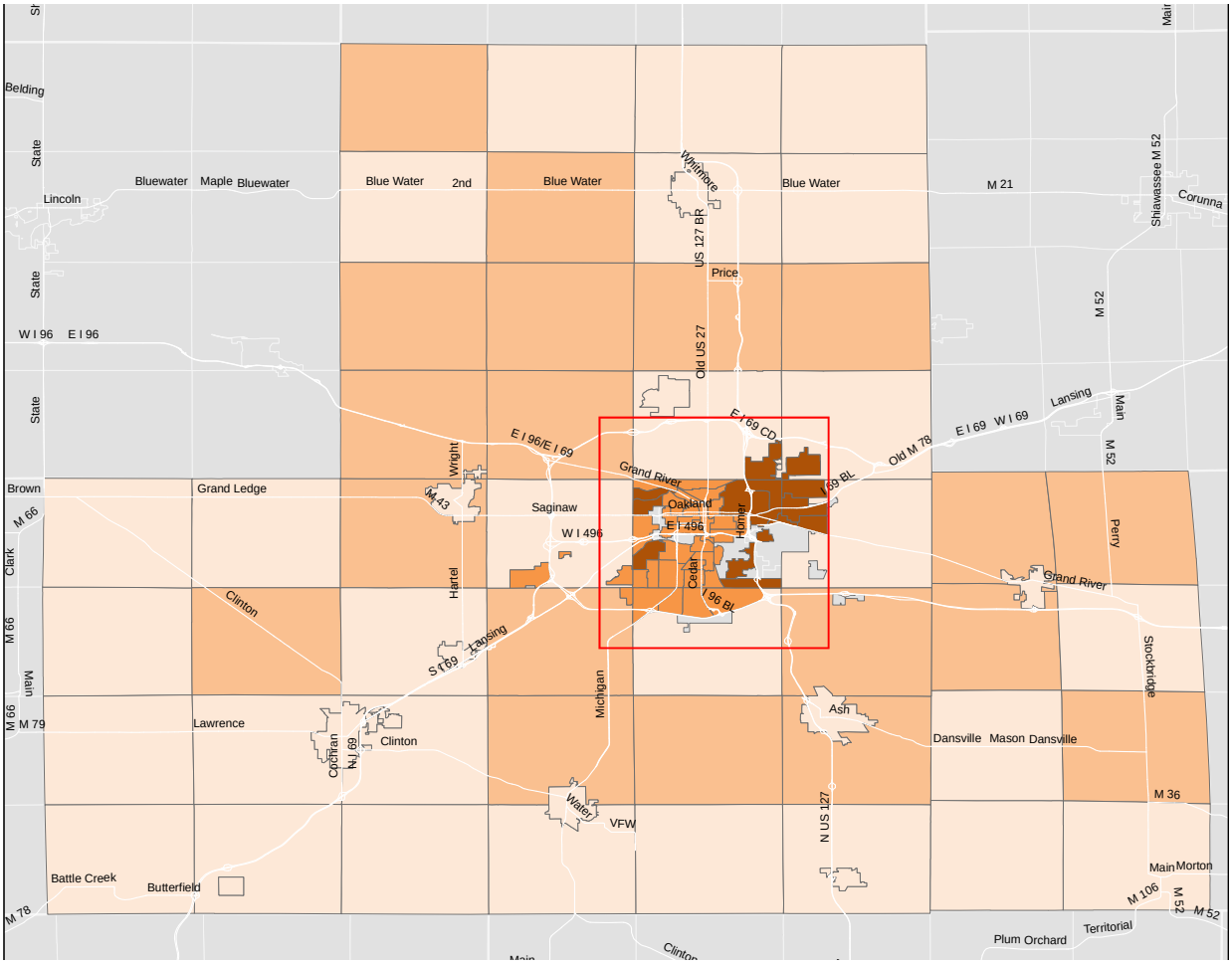
"The way the economy is right now you have to choose between your health and paying your living expenses."

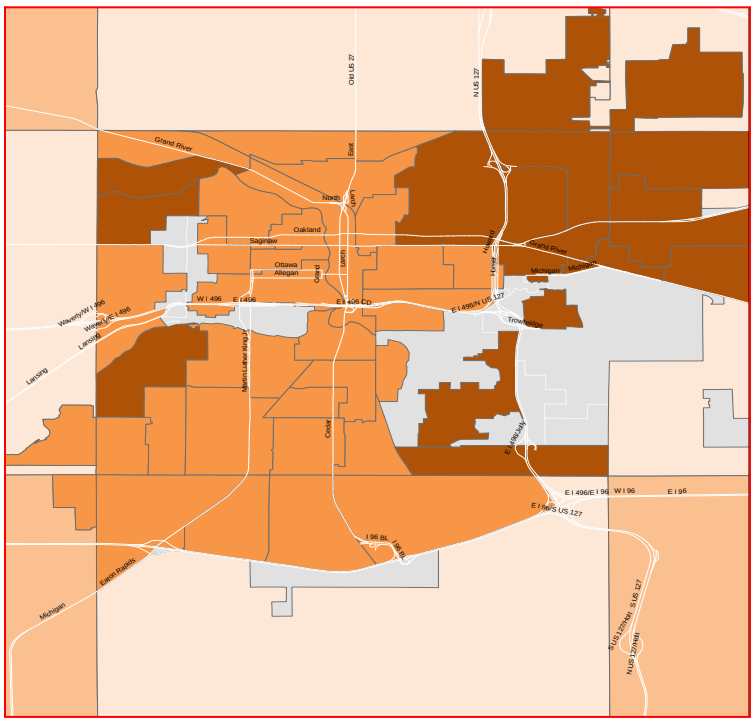
"A lot of people lost their house because they can't cover the expensive hospital bills."

"Six years ago, I had congestive heart failure, heart problems, and I had to quit my job. I left my house and went to live with my daughter. For me, this was a big change because I was used to being independent, to have my own things."

Affordable Housing

Maps showing the % of households that spend more than 30% of income on housing by Geographic Area Groups





Legend

Percentage of households who spend more than 30% of income towards housing

- < 30.5%
- 30.5% - 35.4%
- 35.4% - 39.5%
- > 39.5%

The Small Cities, Farms & Fields, and Inner Suburbs areas have the lowest percentage of households with unaffordable housing, followed by the Countryside Suburbs area.

A moderate rate of unaffordable housing is found in the Urban Low Price area, with the highest level of unaffordable housing in the Urban Mid Price and the Urban Upscale areas.

Quality of Primary Care

MEASURE:

The number of Ambulatory Care Sensitive hospitalizations per 10,000 people per year.

Ambulatory Care Sensitive hospitalizations such as asthma, diabetes or dehydration are hospitalizations for conditions where timely and effective ambulatory care can decrease hospitalizations by preventing the onset of an illness or condition, controlling an acute episode of an illness, or managing a chronic disease or condition. Ambulatory care is care provided in a primary care setting, such as a doctor's office, rather than a hospital.

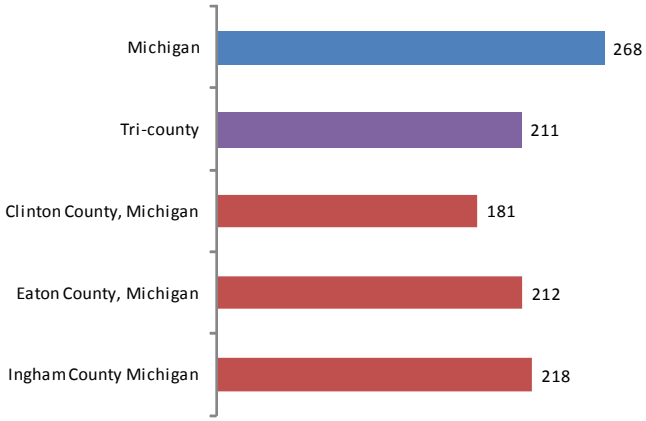
DATA SOURCE: Michigan Department of Community Health

YEAR: 2010

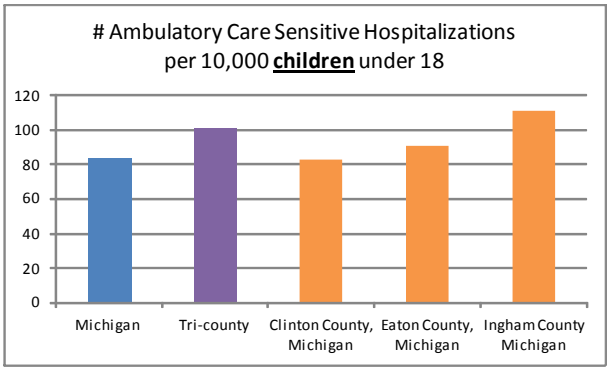
REASON FOR MEASURE:

High rates of Ambulatory Care Sensitive hospitalizations in a community are an indicator of a lack of (or failure of) prevention efforts, a primary care resource shortage, poor performance of primary health care delivery systems, or other factors that create barriers to obtaining timely and effective ambulatory care. [MDCH]

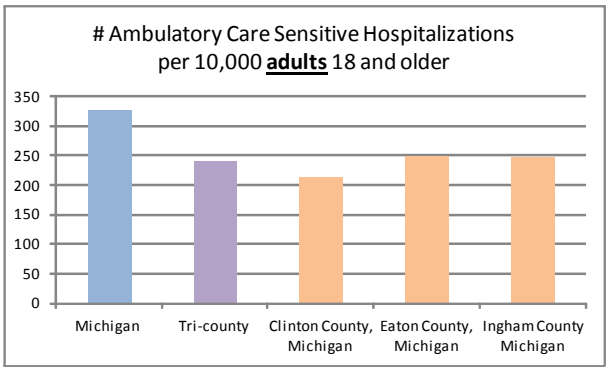
Rate of ACS hospitalizations per 10,000



While Ambulatory Care Sensitive Hospitalization rates were not available at the sub-county level for our geographic groups, there are some significant differences between the counties. **Clinton County has the lowest rate** of Ambulatory Care Sensitive hospitalizations. Eaton and Ingham counties have higher rates of Ambulatory Care Sensitive hospitalization — their rates are not statistically significantly different from each other.



Ingham County and **Eaton County** have higher rates of ambulatory care sensitive hospitalizations in children than children across Michigan. Clinton County's rate is comparable to the state. This indicates that the primary care and prevention system for children is not ideal in these communities.



All three counties have lower rates of ambulatory care sensitive hospitalizations in adults than across Michigan. Clinton County is the lowest of the three counties.

speaking of health

Focus Group Participants:

"Before — I could go for my annual [visits], because I was working, I had my work insurance. Now — I'm retired, and I went recently for the same thing to get my tests done, and my routine exam. I received the bill and I said 'Oh, wow'."

"I have Ingham Health Plan and now I can actually go see a doctor and that wasn't available to me before I joined the plan."

"We take advantage of free screenings when they are available. These need to be made more available to low-income persons."

Environmental Quality

MEASURE:

The percent of water wells with nitrate levels above the maximum contaminant level of 10.0 parts per million.

DATA SOURCE:

Michigan Department of Environmental Quality

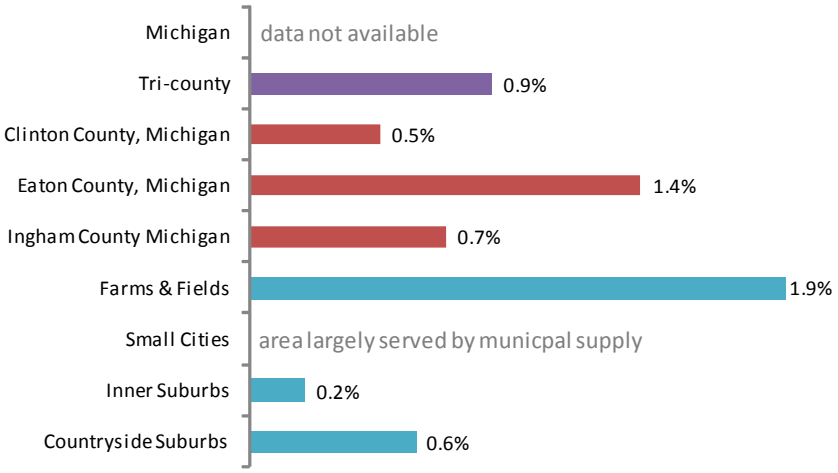
YEAR: 1988-2011

NOTE: data is included for such a long time span because nitrate levels are slow to change, and private wells are not usually tested every year.

REASON FOR MEASURE:

Nitrate (NO3) is a form of nitrogen combined with oxygen. It can be converted in the body to nitrite (NO2).Elevated nitrate in drinking water can cause a disease called *methemoglobinemia*, a blood disorder primarily affecting infants under six months of age. Also, because nitrate contamination can be related to human, animal, or industrial waste practices or products, excessive levels of nitrate in drinking water may indicate potential for the presence of other types of contaminants.

Percent of Water Wells with Nitrate levels above the maximum contaminant level



About 2 in every 100 water wells located in the **Farms & Fields** area have been contaminated by nitrates. **Eaton County** also has a significant proportion of water wells that have been contaminated by nitrates — about 1.5 per 100 wells.

Data for the Small Cities group and the Urban groups were not included in this analysis because these areas are served by municipal water supplies which are frequently tested for nitrates and other contaminants. If a municipal well has a high level of nitrates, that well water is typically mixed with water from other non-contaminated wells to assure a safe level of nitrates.

speaking of health

"We are concerned about nitrate contamination because it can signify that an entire aquifer is compromised, possibly putting a whole area at risk of contaminated water.

Water chemistry is very slow to change, which is why monitoring for and limiting sources of contamination now is important.

Nitrates are mostly an individual health concern for those who operate their own private wells — those with municipal water (city water) drink water that is routinely tested for nitrates. Homes with private water wells should test for nitrates and other contaminants regularly."

— Eric Pessell
Environmental Health Director
Barry-Eaton District Health Department

How Does Contamination Occur?

Nitrate, one of the most widespread contaminants, can get into water if a well is improperly constructed or located where it is subject to contamination sources. Typical sources of nitrate include

- wastes from livestock operations
- septic tank/ drainfield effluent
- crop and lawn fertilizers
- municipal wastewater sludge application
- natural geologic nitrogen

Shallow water wells in sandy unconfined aquifers are more vulnerable to nitrate contamination than deeper wells protected by overlying clay strata.

Once an aquifer is contaminated, wells must be drilled even deeper into a non-contaminated aquifer.

Built Environment

MEASURE:

The percent of the population that lives in a USDA-defined 'food desert.'

A USDA 'food desert' is a census tract that is ***low-income*** (poverty > 20% or median income < 80 percent of statewide median income) and where a substantial number or share of people have ***low access***, defined as living more than 1 mile (urban) or more than 10 miles (rural) away from a grocery store or supermarket.

DATA SOURCE: USDA (United States Department of Agriculture)

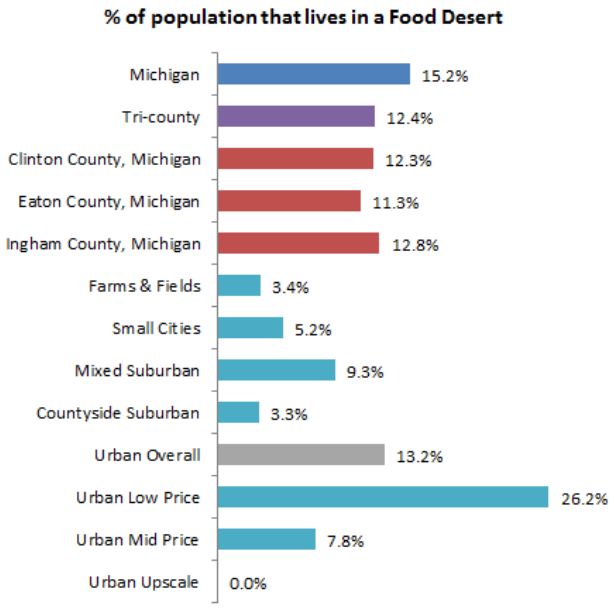
YEAR: 2006 (most recent year available)

REASON FOR MEASURE:

The majority of studies that have examined the relationship between store access and dietary intake find that better access to a supermarket or large grocery store is associated with eating healthier food. Better access to a supermarket is associated with reduced risk of obesity and better access to convenience stores is associated with increased risk of obesity.

Recent research suggests that lack of access to specific nutritious foods may be less important than relatively easy access to all other foods. "Food swamps" may better explain increases in BMI and obesity than "food deserts." Increasing access to specific foods like fruits and vegetables, whole grains, and low-fat milk alone may not make a dent in the obesity problem. Any of the stores that carry these nutritious foods at low prices also carry all the less healthy foods and beverages as well.

http://www.ers.usda.gov/Publications/AP/AP036/AP036d.pdf

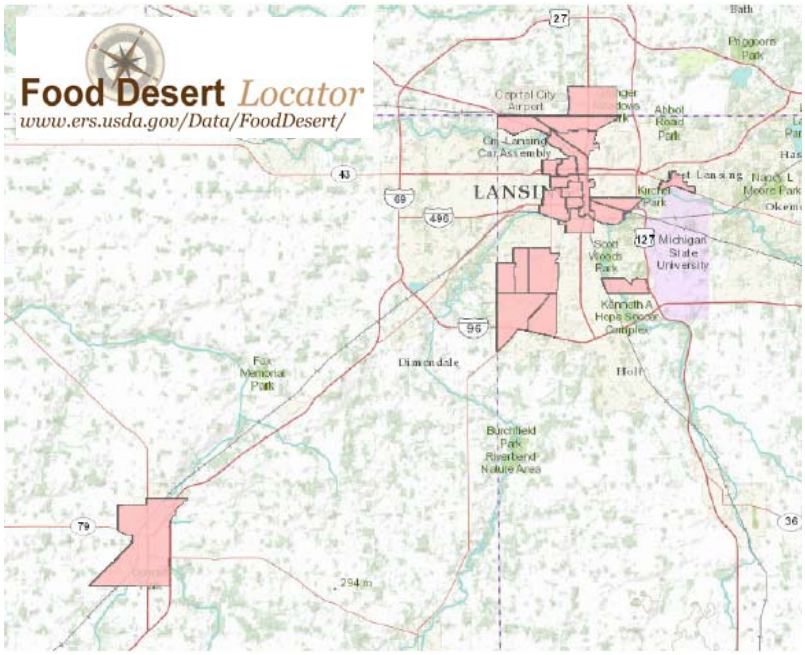


Distribution of 'food deserts' are not random across the three county area. They are concentrated in the **Urban** areas — but particularly in the **Urban Low Price** area, where median home value is lowest.

While there are no persons living in a food desert in the **Urban Upscale** area, nearly 1 in 10 people living in the **Inner Suburbs** area live in a food desert.

Roughly equal percentages of persons live in food deserts in each of the three counties.

Census Tracts which meet the definition of a USDA Food Desert area in Clinton, Eaton, and Ingham Counties.
Food Desert census tracts are colored pink.



speaking of health

Focus Group Participants:

"It'd be nice if there was a grocery store downtown by the capital. I have to walk to the Kroger in Frandor, but it's closer than all the way out to Meijer's."

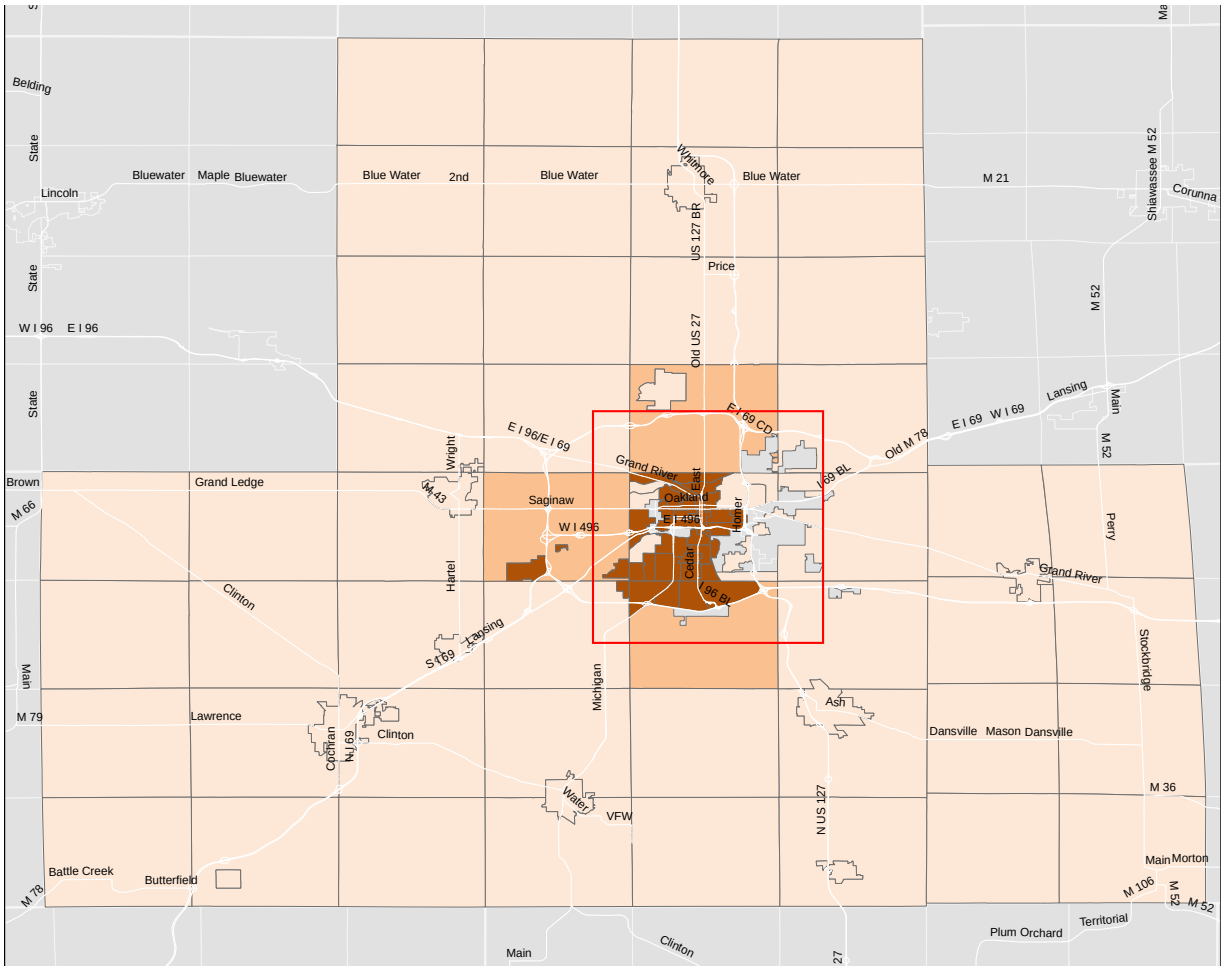
"Food stamps doesn't cover enough to buy food, it doesn't cover fresh vegetables."

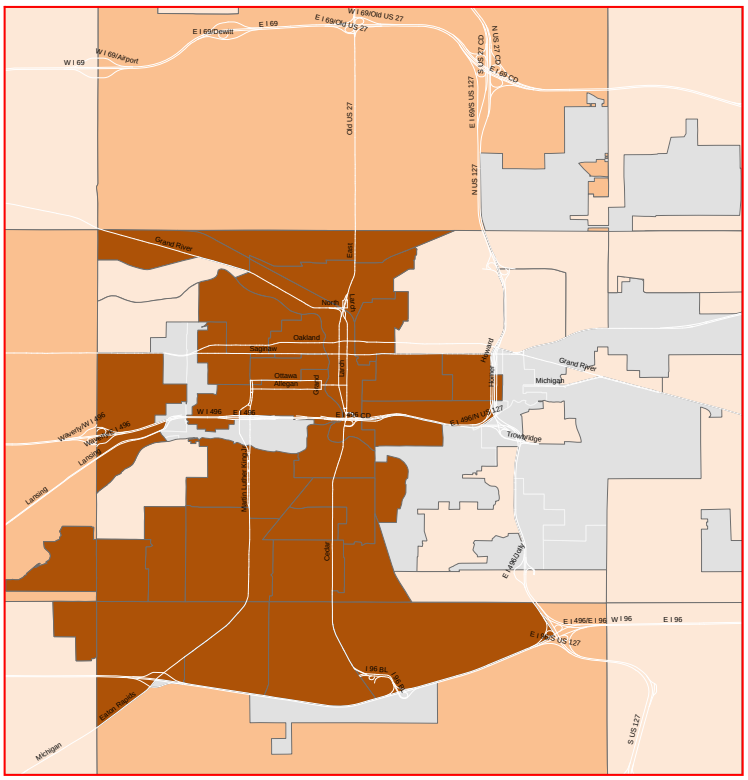
"I went with the cheaper food options instead of the healthier options."

"Dollar menus make it cheap and affordable to be unhealthy."

Built Environment

Maps showing the % of households that live in a food desert by Geographic Area Groups





Legend

Percentage of population living in an area designated as a food desert

- < 8.2%
- 8.2% - 14.2%
- 14.2% - 20.2%
- > 20.2%

The Urban Upscale, Farms & Fields, Small Cities, Urban Mid Price, and Countryside Suburbs areas have the lowest percentage of population living in a food desert, followed by the Inner Suburbs area.

The highest rates of persons living in a food desert is found in the Urban Low Price area.

Obesity (adults)

MEASURE:

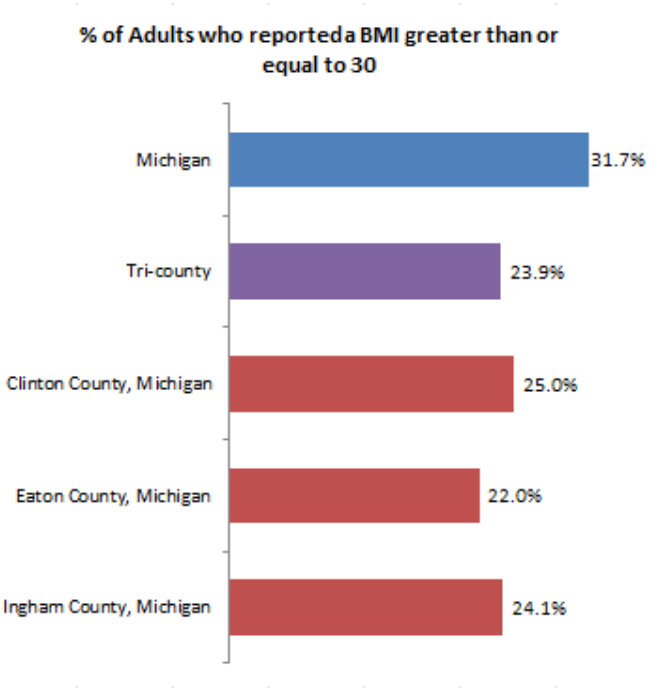
Adult obesity prevalence represents the percentage of the adult population (age 18 and older) with a body mass index (BMI) greater than or equal to 30 kg/m2. BMI is calculated from the individual's self-reported height and weight. BMI is defined as weight in kg divided by height in meters, squared.

DATA SOURCE: Behavioral Risk Factor Survey (adults)

YEAR: 2008-2010

REASON FOR MEASURE:

Obesity is often the end result of an overall energy imbalance due to poor diet and limited physical activity. Obesity increases the risk for health conditions such as coronary heart disease, type 2 diabetes, cancer, hypertension, dyslipidemia, stroke, liver and gallbladder disease, sleep apnea and respiratory problems, and osteoarthritis. [CHR]



The tri-county region has a lower prevalence of adult obesity than Michigan, as is true for each of the Capital area counties. Across nearly every geographic area, about 1 in every 4 adults are obese, which increases risks for poor health outcomes.

Sub-county level geographic area group breakouts are not available for this indicator.

speaking of health

Focus Group Participants:

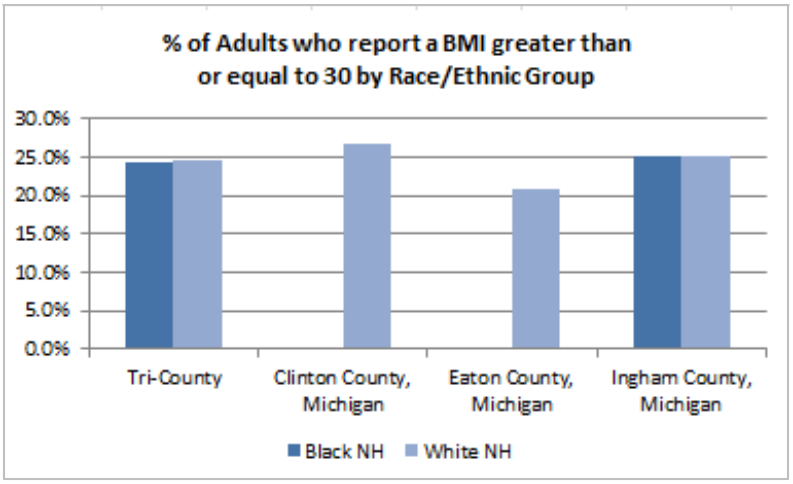
"I have a hard time with my weight."

"I feel like I am starting to get better but still struggle with my weight; I am improving my nutrition and getting off some of my prescriptions."

"I have arthritis and back problems that limit my activity and have gained a lot of weight."

"I don't think people have enough time so they go with the easier, quicker, less healthy food options instead of preparing healthier food."

"I think obesity is a personal choice and it should not listed as a disease."



Although the available data is limited, obesity prevalence among the most populous racial groups in the tri-county region does not vary considerably.

Due to low reportable survey results of African-Americans for Clinton and Eaton counties, obesity prevalence could not be accurately determined for Black (Not Hispanic) residents of these counties.

Obesity (adolescents)

MEASURE:

Adolescent obesity prevalence represents the percentage of 7th, 9th, and 11th grade students who are obese (at or above the 95th percentile for BMI by age and sex).

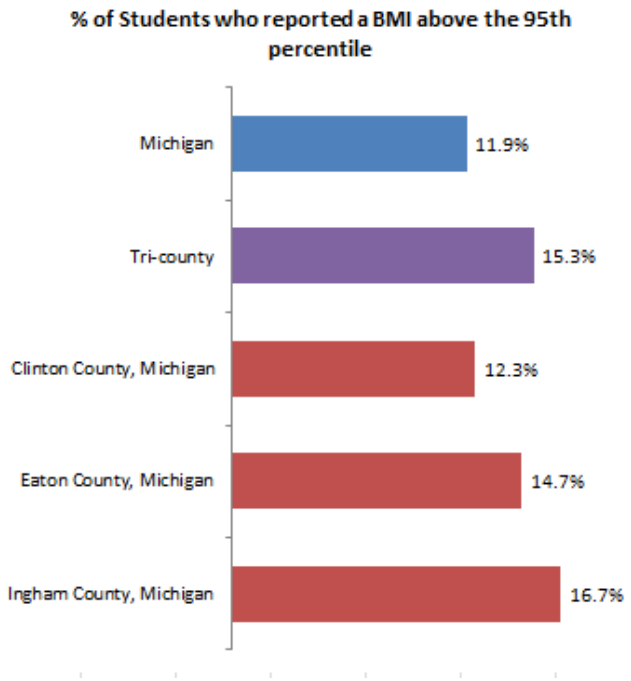
DATA SOURCE: Michigan Profile for Healthy Youth Survey (youth)

YEAR: 2010

REASON FOR MEASURE:

Some of the immediate health effects of obese youth are that they are more likely to have risk factors for cardiovascular disease, such as high cholesterol or high blood pressure. In a population-based sample of 5- to 17-year-olds, 70% of obese youth had at least one risk factor for cardiovascular disease. Obese adolescents are more likely to have prediabetes, a condition in which blood glucose levels indicate a high risk for development of diabetes. Children and adolescents who are obese are at greater risk for bone and joint problems, sleep apnea, and social and psychological problems such as stigmatization and poor self-esteem.

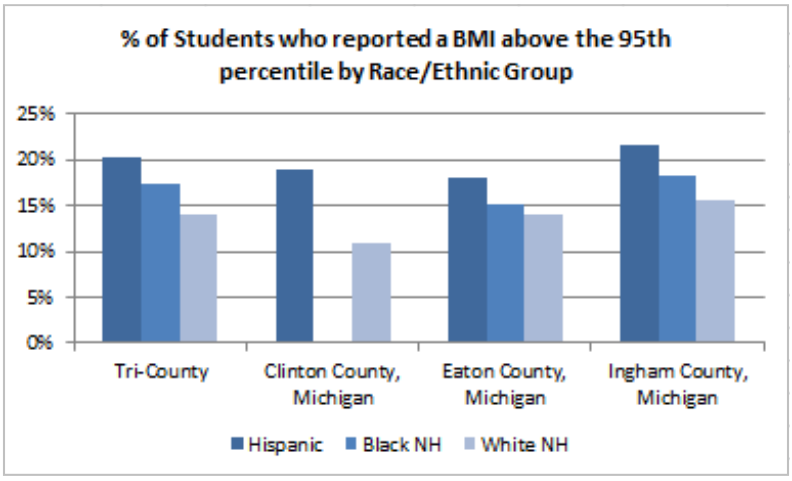
Some of the long-term health effects are children and adolescents who are obese are likely to be obese as adults and are therefore more at risk for adult health problems such as heart disease, type 2 diabetes, stroke, several types of cancer, and osteoarthritis. One study showed that children who became obese as early as age 2 were more likely to be obese as adults. Overweight and obesity are associated with increased risk for many types of cancer, including cancer of the breast, colon, endometrium, esophagus, kidney, pancreas, gall bladder, thyroid, ovary, cervix, and prostate, as well as multiple myeloma and Hodgkin's lymphoma. [CDC]



The tri-county region has a higher prevalence of adolescent obesity than Michigan, as is true for each of the Capital area counties.

Clinton County fared better at 12.3% than either Eaton or Ingham counties, but was still above the 11.9% obesity rate that the State of Michigan currently holds.

Across nearly every geographic area in the Capital Area, about 1 in every 7 adolescents are obese, which increases risks for poor health outcomes.



Although the available data is limited, obesity prevalence among the most populous racial groups in the tri-county region does consistently vary.

Throughout all three counties Hispanic adolescents were more likely to be obese followed by Black and White adolescents respectively. Ingham County had slightly higher rates for all three racial/ethnic groups as compared to Clinton and Eaton counties.

Due to low reportable survey results of African-Americans for Clinton County, obesity prevalence could not be accurately determined for Black (Not Hispanic) residents of this county.

Tobacco Use (adults)

MEASURE:

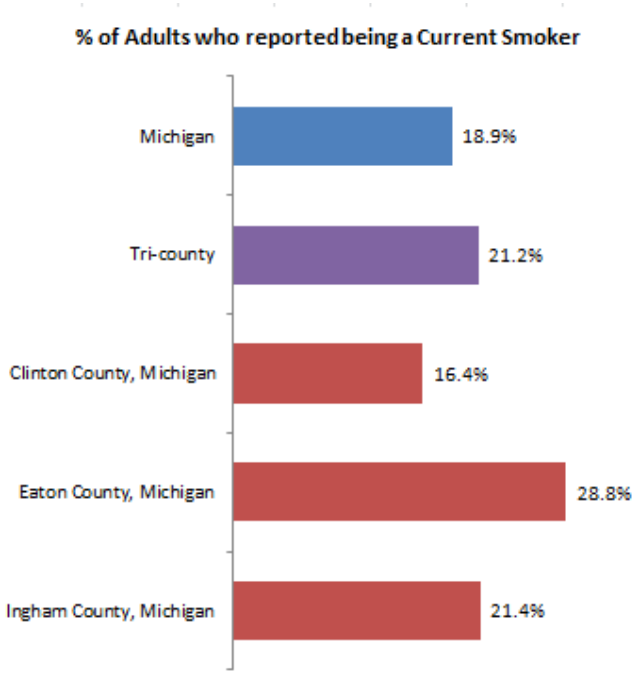
Adult smoking prevalence represents the estimated percentage of the adult population that currently smokes every day or "most days" and has smoked at least 100 cigarettes in their lifetime.

DATA SOURCE: Behavioral Risk Factor Survey (adults)

YEAR: 2008-2010

REASON FOR MEASURE:

Each year approximately 443,000 premature deaths occur in the United States primarily due to smoking. Cigarette smoking is identified as a cause in multiple diseases including various cancers, cardiovascular disease, respiratory conditions, low birth weight, and other adverse health outcomes. Measuring the prevalence of tobacco use in the population can alert communities to potential adverse health outcomes and can be valuable for assessing the need for cessation programs or the effectiveness of existing programs. [CHR]



The tri-county region has a higher self-reported adult smoking prevalence than the state of Michigan. Within the tri-county region, adult smoking rates vary considerably, from a low of 16.4% for Clinton County to a high of 28.8% for Eaton County.

Sub-county level geographic area group breakouts are not available for this indicator.

speaking of health

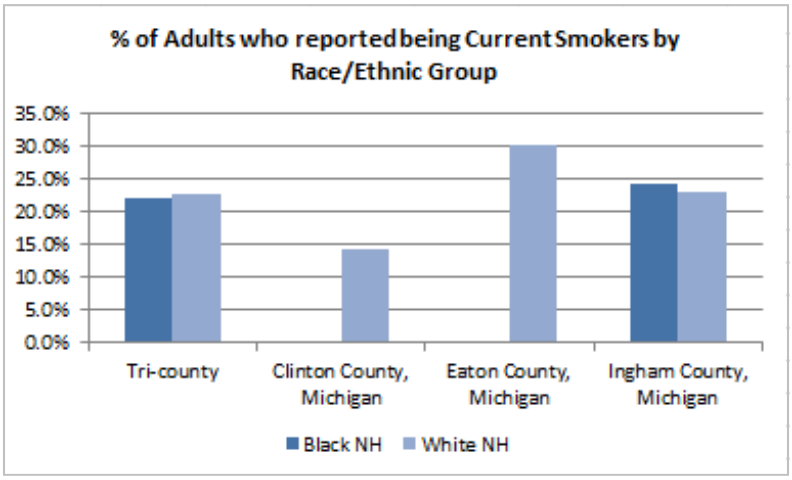
Focus Group Participants:

"Both my parents smoked and I have not and will not take up the habit because I hated being around it when I was a kid."

"I started [to smoke] when I was 13, haven't been able to quit yet. My mom's on oxygen now – she's still smoking with oxygen."

""I try to hide it from my child but he tries to imitate me smoking. He has had 15 ear infections related to my smoking habit. I was unaware that this was due to my smoking until I saw a specialist."

"My brother worked in an environment where there was a lot of smoke and he has COPD now, even though he never smoked."



The adult smoking prevalence does not vary significantly between the most populous racial groups in the tri-county region.

Due to low reportable survey results of African-Americans for Clinton and Eaton counties, smoking status could not be accurately determined for Black (Not Hispanic) residents of these counties.

Tobacco Use (adolescents)

MEASURE:

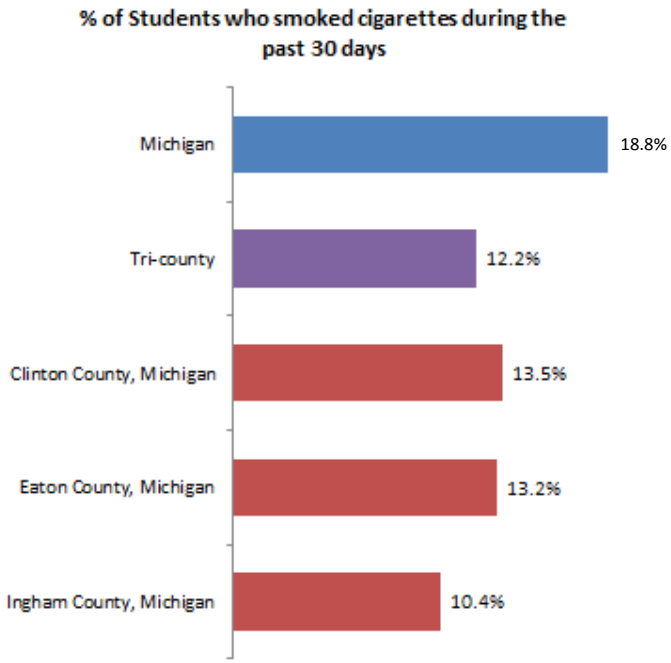
Adolescent smoking prevalence represents the percentage of students who smoked cigarettes on one or more of the past 30 days (recent).

DATA SOURCE: Michigan Profile for Healthy Youth Survey (youth)

YEAR: 2010

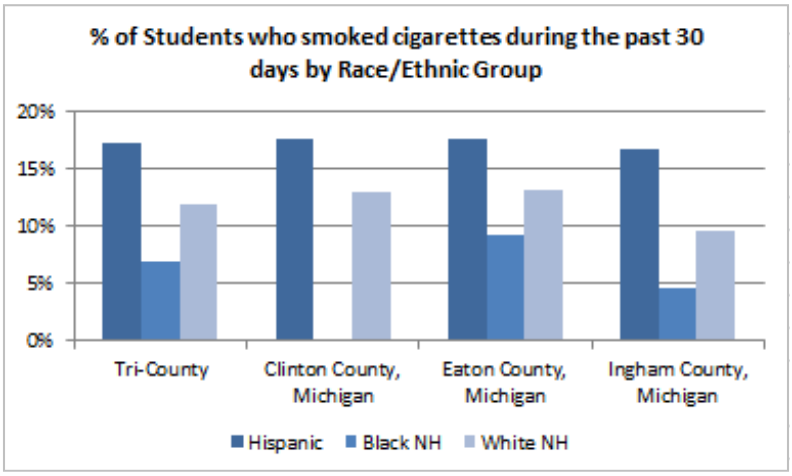
REASON FOR MEASURE:

Each year approximately 443,000 premature deaths occur in the United States primarily due to smoking. Cigarette smoking is identified as a cause in multiple diseases including various cancers, cardiovascular disease, respiratory conditions, low birth weight, and other adverse health outcomes. Measuring the prevalence of tobacco use in the population can alert communities to potential adverse health outcomes and can be valuable for assessing the need for cessation programs or the effectiveness of existing programs. [CHR]



The tri-county region has a lower self-reported adolescent smoking prevalence than the state of Michigan. Within the tri-county region, adolescent smoking rates vary slightly, from a low of 10.4% for Ingham County to a high of 13.5% for Clinton County.

Sub-county level geographic area group breakouts are not available for this indicator.



The adolescent smoking prevalence does vary significantly between the most populous racial groups in the tri-county region.

Hispanic adolescent's smoking rates are significantly higher than that of Black or White adolescents within the tri-county area, and that still holds true for each individual county where data is available.

Due to low reportable survey results of African-Americans for Clinton County, smoking status could not be accurately determined for Black (Not Hispanic) residents of this county.

Alcohol Use (adults)

MEASURE:

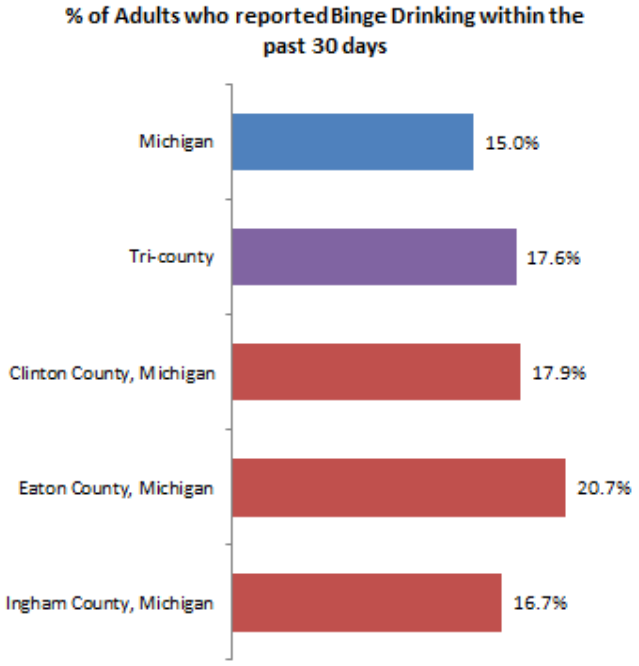
Binge drinking is defined as consuming more than 4 (women) or 5 (men) alcoholic beverages on a single occasion within the past 30 days. Heavy drinking is defined as drinking more than 1 (women) or 2 (men) drinks per day on average.

DATA SOURCE: Behavioral Risk Factor Survey

YEAR: 2008-2010

REASON FOR MEASURE:

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. [CHR]



speaking of health

Focus Group Participants:

"I am recovering from alcohol addiction, and every day I don't drink, my heart gets lighter and lighter."

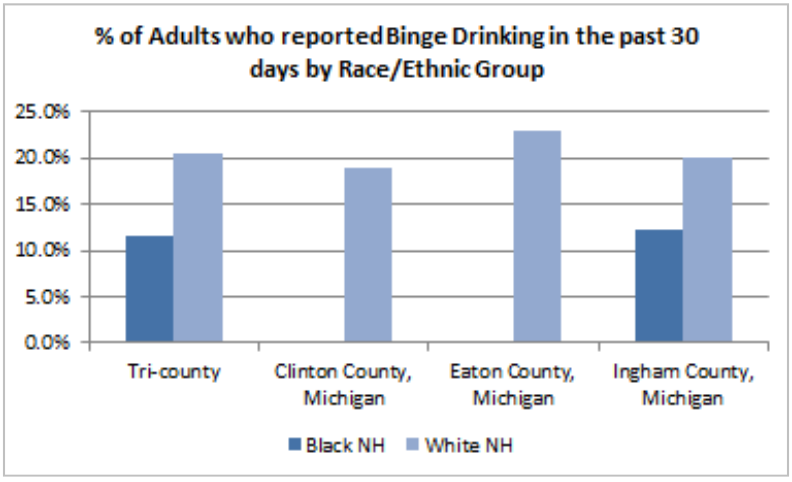
"There are liquor stores on almost every corner."

"My kids' father tried to detox [suddenly stop drinking alcohol] on his own. We were having an open house for my son. His father stayed the night and the next morning he was dead of acute alcohol withdrawal."

A higher proportion of tri-county region adults reported at least one incidence of recent binge drinking than adults representing all of Michigan. Within the tri-county region, binge drinking rates varied from a low of 16.7% (Ingham County) to 20.7% (Eaton County).

As a whole, nearly 1 in 5 adults in the tri-county area have reported binge drinking in the past 30 days.

Sub-county level geographic area group breakouts are not available for this indicator.



The rates of adult binge drinking vary considerably by racial group.

The rate of binge drinking is twice as high in White residents of the Capital Area compared to the rate among Black residents.

Due to low reportable survey results of African-Americans for Clinton and Eaton counties, binge drinking rates could not be accurately determined for Black (Not Hispanic) residents of these counties.

Alcohol Use (adolescents)

MEASURE:

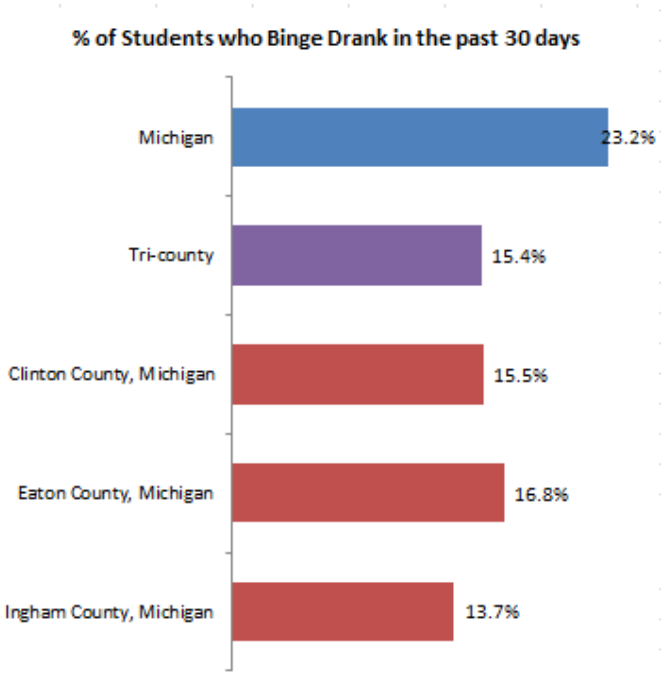
Adolescent binge drinking prevalence represents the percentage of 7th, 9th, and 11th grade students who had five or more drinks of alcohol in a row, that is, within a couple of hours, during the past 30 days (binge).

DATA SOURCE: Michigan Profile for Healthy Youth Survey (youth)

YEAR: 2008-2010

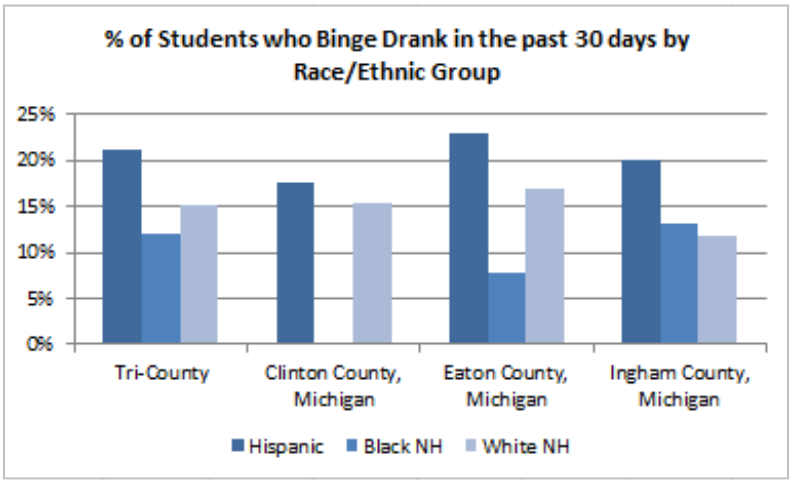
REASON FOR MEASURE:

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. [CHR]



A significantly lower proportion of tri-county region adolescents reported at least one incidence of recent binge drinking than adolescents representing all of Michigan. Within the tri-county region, binge drinking rates varied from a low of 13.7% (Ingham County) to 16.8% (Eaton County).

As a whole, nearly 1 in 7 adolescents in the tri-county area have reported binge drinking in the past 30 days.



The rates of adolescent binge drinking vary considerably by racial group.

The rate of binge drinking was consistently higher for Hispanic adolescents per county, but varied for Black and White adolescents in the three counties. Blacks in Ingham County were nearly two times more likely to have binge drank than Blacks in Eaton County.

Due to low reportable survey results of African-Americans for Clinton County, binge drinking rates could not be accurately determined for Black (Not Hispanic) residents.

Access to Care

MEASURE:

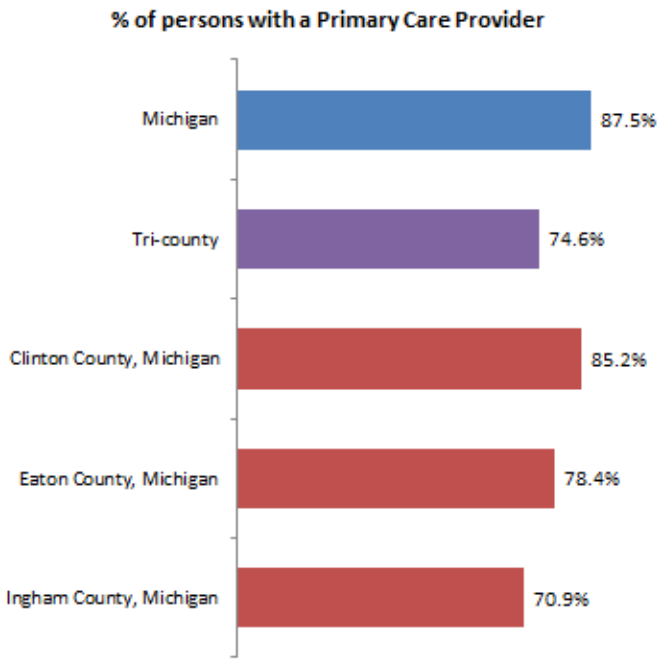
Access to a Personal Health Care Provider represents the percentage of adults who report they have regular access to someone they consider to be their personal doctor or primary care provider. This would generally be a physician practicing in a primary care specialty such as general medicine, family medicine, internal medicine, pediatrics or gynecology.

DATA SOURCE: Behavioral Risk Factor Survey

YEAR: 2008-2010

REASON FOR MEASURE:

Having access to care requires not only having financial coverage but also access to providers. While high rates of specialist physicians has been shown to be associated with higher, and perhaps unnecessary, utilization, having sufficient availability of primary care physicians is essential so that people can get preventive and primary care, and when needed, referrals to appropriate specialty care. [CHR]



A lower proportion of tri-county area adults have regular access to a health care provider than Michigan adults (74.6% vs. 87.5%). Access to a health care provider varies considerably at the county level, with ***Clinton County*** faring better than the both Eaton and Ingham counties.

Access to a health care provider is strongly influenced by other factors, such as income, employment, and health insurance status.

This implies that many residents within the tri-county do have access to a primary care provider; however they may be traveling outside the three-county region to access these services.

speaking of health

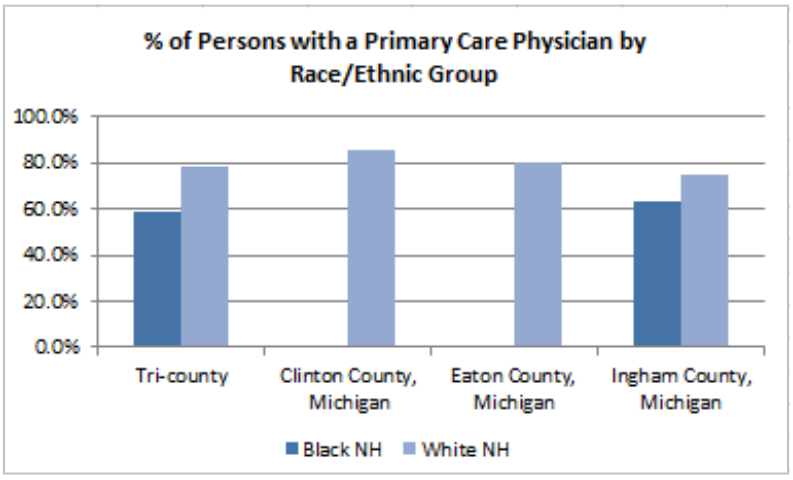
Focus Group Participants:

"I have to drive an hour and a half to get the services I need at a cost I can afford because I don't have insurance and don't qualify for Medicaid."

This year I don't know [if I'll go to my annual visit] because I don't have insurance, I don't have a family doctor."

"With the doctor, there's so little face time."

"Finding a doctor who is accepting new Medicaid patients is very difficult to do"



The rate at which a person has a primary care physicians varies greatly by racial/ethnic group.

6 of every 10 African-Americans have a primary care provider in the tri-county area, while 8 out of every 10 white adults have a primary care provider in the tri-county area.

Due to low reportable survey results of African-Americans for Clinton and Eaton counties, primary care provider rates could not be accurately determined for Black (Not Hispanic) residents of these counties.

Access to Care

MEASURE:

Access to a Personal Health Care Provider represents the ratio of the population per one provider. This would generally be a physician practicing in a primary care specialty such as general medicine, family medicine, internal medicine, pediatrics or gynecology.

DATA SOURCE: County Health Rankings

YEAR: 2006

REASON FOR MEASURE:

Evidence suggests that access to effective and timely primary care has the potential to improve the overall quality of care and help reduce costs. One analysis found that primary care physician supply was associated with improved health outcomes ranging from reduced all-cause, cancer, heart disease, stroke, and infant mortality; a lower prevalence of low birth weight; greater life expectancy; and improved self-rated health. The same analysis also found that each increase of one primary care physician per 10,000 population is associated with a reduction in the average mortality by 5.3%. Another study found that states with a higher ratio of primary care physicians compared to specialists had improved quality and effectiveness of care, as well as lower health care spending than states with a higher ratio of specialists. [CHR]

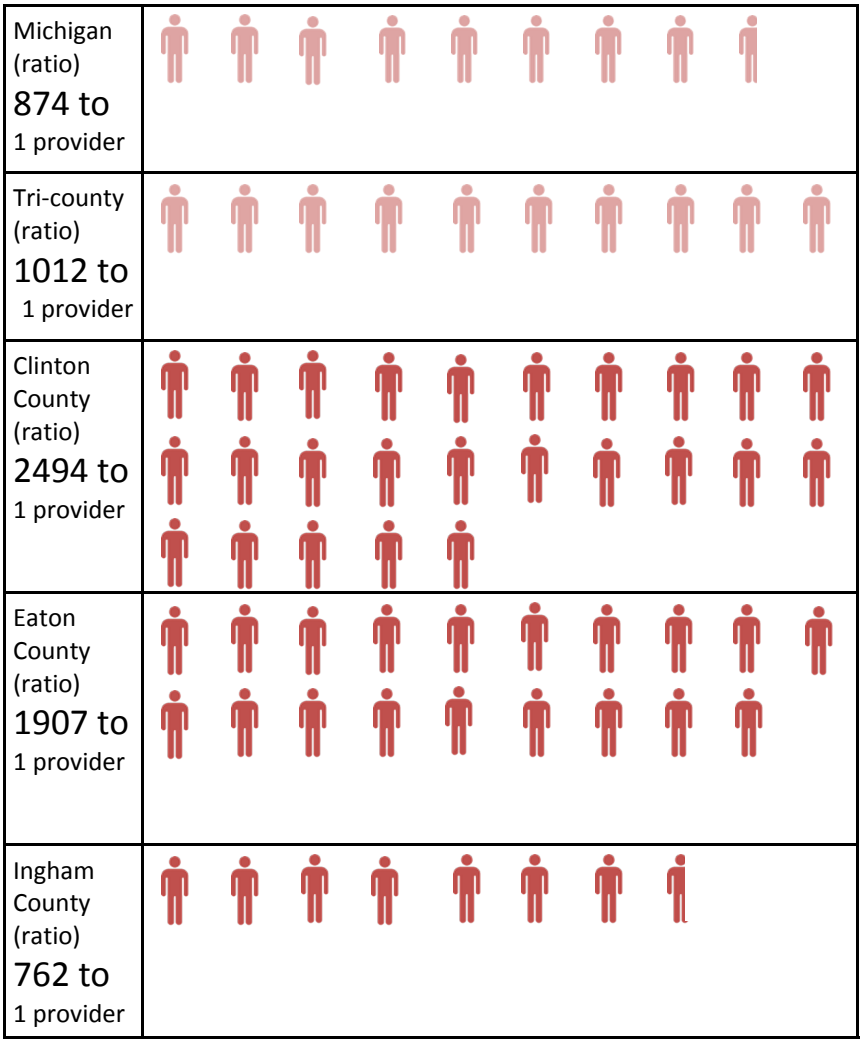
speaking of health

Focus Group Participants:

"I still can't get in to see a doctor. [It's been] almost four months that I've had insurance and yet I don't have a doctor that can treat me."

"I go back to my former town to go to the doctor cause I couldn't get a doctor here."

Ratio of population to the number of Primary Care Physicians



The ***Tri-county area*** has a worse ratio of population to the number of primary care physicians, with approximately 140 more residents per primary care provider than that of Michigan.

Clinton County fared the worst and ***Ingham County*** the best within the Tri-county area. Clinton County had approximately 3 times more people per health care provider than that of Ingham County. Ingham County was the only county within the tri-county area that fared better than Michigan. This is likely because many physicians are based in Lansing (Ingham County) and also serve people from the surrounding counties.

Communicable Disease

MEASURE:

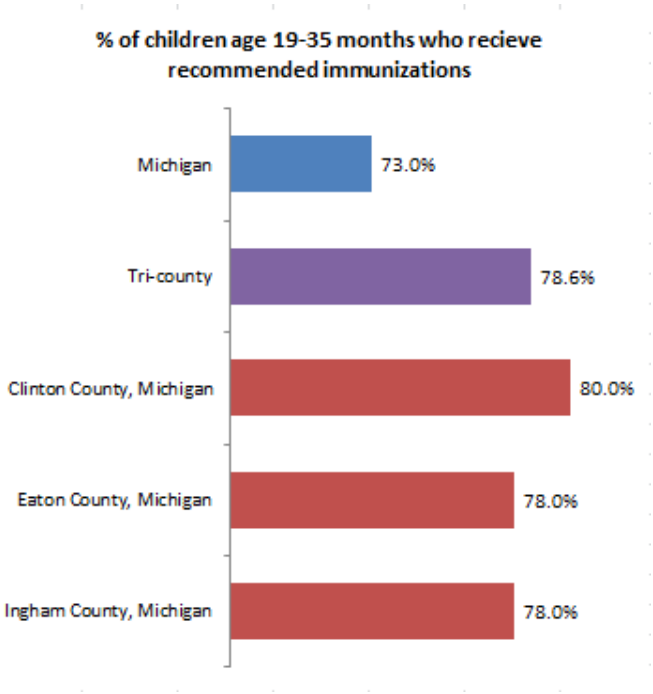
Adequate immunization coverage represents the percentage of children age 19-35 months who have received the recommended immunizations (4:3:1:3:3:1 series). The completion of this series means that these children have received 4 doses of diphtheria/tetanus/pertussis vaccine (DTaP), 3 doses of inactivated poliovirus vaccine (IPV), 1 dose of measles/mumps/rubella vaccine (MMR), 3 doses of Haemophilus influenzae type b vaccine (Hib), 3 doses of hepatitis B vaccine (HepB), and 1 dose of varicella vaccine (VAR).

DATA SOURCE: Michigan Care Improvement Registry

YEAR: 2011

REASON FOR MEASURE:

Most of the vaccinations a child receives in the first few years of life provide lifelong protection (immunity) against deadly childhood diseases. This measure highlights one of the preventative aspects of healthcare that markedly reduces morbidity and improves long-term health for the individual and the community. High rates of immunization are important across the community in order to protect individuals who are not able to be vaccinated, such as immune-compromised persons.



Immunization rates are only available at the county level, so there is no information for the additional geographic subgroups or a breakdown by racial/ethnic group.

As the chart illustrates, all three counties have higher immunization rates as compared to the state of Michigan, with Clinton County having a slightly higher rate than Eaton or Ingham counties.

Healthy People 2020 has set a goal to achieve a 90% immunization rate for children in this age group. As a region, the Capital area has yet to achieve this target rate. It is also important to reach this goal in high-risk populations who are more susceptible to infectious diseases.

Sub-county level geographic area group breakouts are not available for this indicator.

speaking of health

Focus Group Participants:

"My kids receive the immunizations and WIC benefits through the health department."

"People are not getting their children vaccinated now because they believe it leads to other health issues and I think it will be a major problem in the future with people not being vaccinated"

Mental Health (adults)

MEASURE:

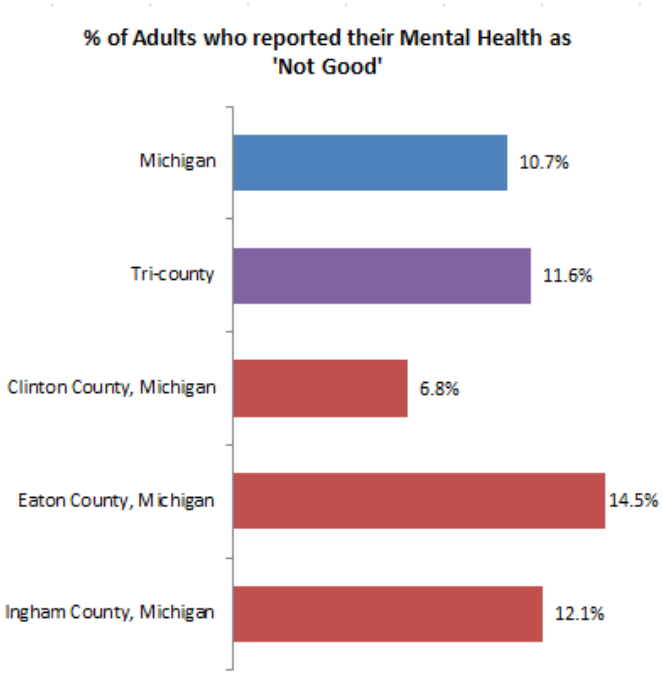
This indicator represents the percentage of adults who reported 14 or more days of poor mental health in the past 30 days. Adults who report this frequency of poor mental health days are categorized as having a mental health status that is "not good." The term mental health in this context includes, but is not limited to, stress, depression, and problems with emotions.

DATA SOURCE: Behavioral Risk Factor Survey (adults)

YEAR: 2008-2010

REASON FOR MEASURE:

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. [CHR]



A higher proportion of tri-county adults reported a mental health status that was "not good" as compared to Michigan adults.

The proportion of adults whose mental health was not good varied between counties within the Capital area, most notably Clinton County (6.8%) and Eaton county (14.5%). Clinton County was the only county in the tri-county area to fare better than Michigan for mental health.

Sub-county level geographic area group breakouts are not available for this indicator.

speaking of health

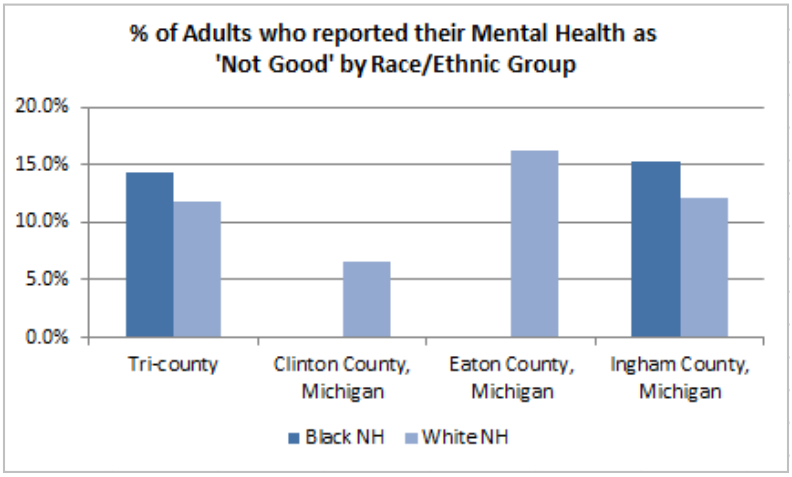
Focus Group Participants:

"Dealing with pain all the time, every day it's a struggle, I'm sure if I went in they'd diagnose me with at least mild depression. There's days when it's tough for me to want to get up and face the day. Enjoy good days."

"I think that health starts out first emotionally, mentally."

"My daughter is now 19, there just wasn't enough preventative mental health services [when she was a teen-ager]. I had her when I was 16."

"I feel I am affected equally by my physical and mental health . I think they go hand in hand."



The rate of adults who reported their mental health as 'not good' varies by racial group.

The African-American or Black population had higher rates in both the Ingham County and tri-county region of poor mental health in the past 30 days when compared to Whites.

Whites in Eaton County are 3 times more likely to have worse mental health then are Whites in Clinton County, and Whites in Ingham County are two times more likely to have worse mental health than Whites in Clinton County.

Mental Health (adolescents)

MEASURE:

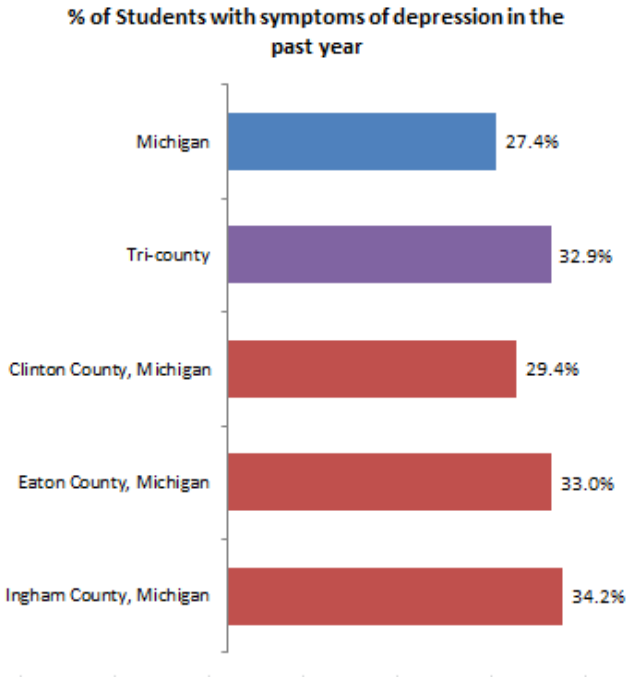
This indicator represents the percentage of 7th, 9th, and 11th grade students who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months. The term mental health in this context includes, but is not limited to, stress, depression, and problems with emotions.

DATA SOURCE: Michigan Profile for Healthy Youth Survey (youth)

YEAR: 2010

REASON FOR MEASURE:

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. [CHR]

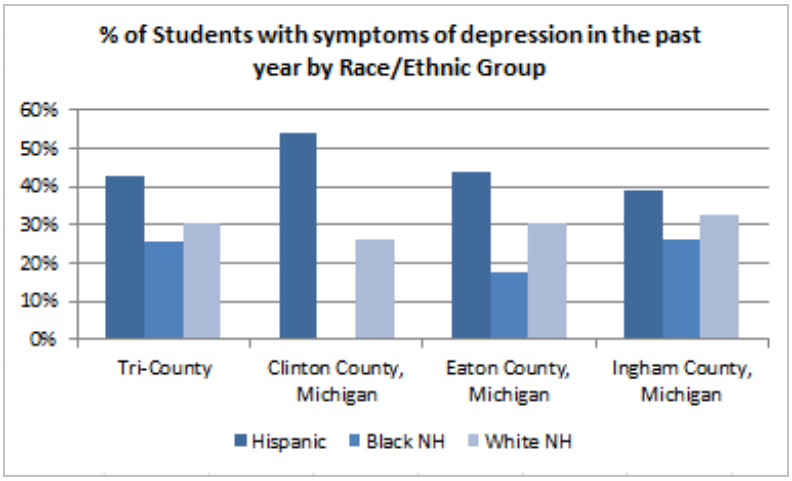


A higher proportion of tri-county adolescents reported "symptoms of depression" as compared to Michigan adolescents.

The proportion of adolescents who reported "symptoms of depression" varied between counties within the Capital area, most notably Clinton County (29.4%) and Ingham County (34.2%).

Clinton County fared better than both Eaton and Ingham Counties, but all three counties fared worse than Michigan.

Sub-county level geographic area group breakouts are not available for this indicator.



The rate of adolescents who reported "symptoms of depression" varies by racial group.

The Black or African-American population had lower rates in each county in the region of "symptoms of depression" in the past year when compared to Hispanics and Whites.

Hispanics in Clinton County are 2 times more likely to have "symptoms of depression" than Whites in Clinton County, and Blacks in Ingham County are 1 1/2 times more likely to have "symptoms of depression" than Blacks in Eaton County. White rates were fairly consistent across all three counties.

Asthma

MEASURE:

The number of ambulatory care sensitive hospitalizations related to asthma among children younger than 18, per 10,000 children. Ambulatory Care Sensitive hospitalizations are sometimes called "preventable" hospitalizations, as they could have been prevented through adequate ambulatory, or primary care treatment.

DATA SOURCE:

Michigan Department of Community Health

YEAR: 2010

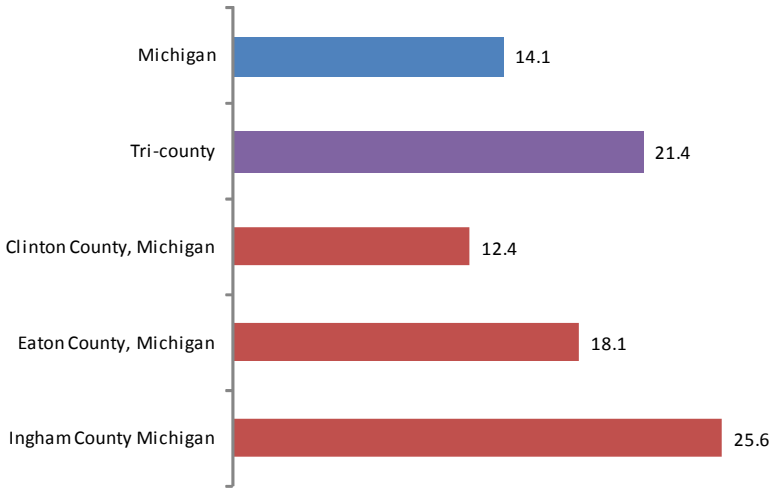
REASON FOR MEASURE:

Asthma is an inflammation of the airways. The inflammation of asthma is chronic, which means it is always present and never goes away.

Many factors can influence the prevalence of asthma and lead to asthma attacks. A majority of these factors are due to the environment such as: dust, pollen and proximity to highways.

Asthma attacks can include wheezing, breathlessness, chest tightness and coughing. [MDCH]

 # Preventable Hospitalizations Due to Asthma per 10,000 children under 18



The preventable child asthma hospitalization rate in the Tri-county area is **higher** than the rate for the state of Michigan.

Ingham County has the highest preventable hospitalization rate for asthma among children. This rate is much higher than the rate for **Michigan** and is more than double the rate for **Clinton County.**

Eaton County also has a higher preventable asthma hospitalization rate than the state as a whole**.**

Asthma hospitalizations can be prevented by decreasing the overall prevalence of asthma in the population — through improvements to air quality and home environments — and through assuring that children who already have asthma have appropriate comprehensive treatment plans with adequate medication, trained care providers, and supportive environments.

speaking of health

"I have a four and a half year old child [with asthma]..it has been a sort of partnership between the doctor and an asthma program that I heard about...it has been like some sort of team, including we, as parents, we have tried to improve and try to avoid giving him so much medicine"

"He had to use three inhalers in the morning, for a boy who only weighed 20 pounds, and was a year old. And the asthma program has taught us how to manage the house, and how to talk to the doctor and try different doses of medications so that he can succeed. He always walks around with his inhaler all the time."

Perceived Health Status

MEASURE:

The percent of adults who rate their health as 'fair' or 'poor' when asked, "Would you say that in general your health is excellent, very good, good, fair, or poor?". Self-reported health status is a general measure of health-related quality of life in a population.

DATA SOURCE:

Capital Area Behavioral Risk Factor Survey

YEAR: 2008-2010

REASON FOR MEASURE:

Self-reported health status is a widely used measure of people's health-related quality of life. In addition to measuring how long people live, it is important to also include measures of how healthy people are while alive – self-reported health status has been shown to be a very reliable measure of current health. [CHR]

Perceived Health represents ***quality of life*** — the physical, emotional, and social aspects of health and well-being. This indicator complements the **Premature Death** indicator, which puts more emphasis on the *quantity*, rather than *quality*, of life.

speaking of health

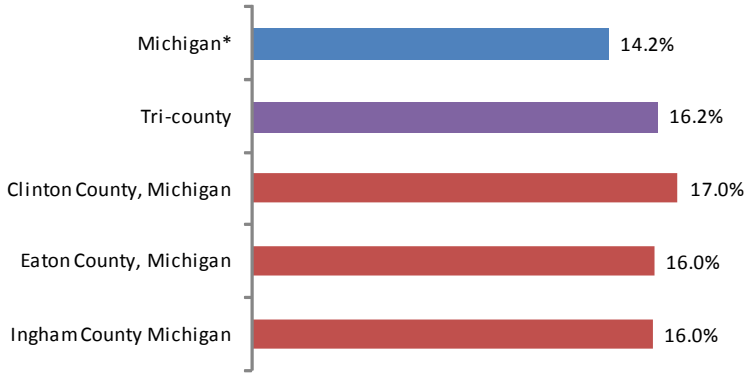
Is this measure too subjective?

Some researchers suggest a person's judgment about his or her health is too subjective. Others note that cultural differences will influence how people evaluate their health. Still, people's perceptions of their own health have been found to be a good predictor of future health-care use and of mortality rates. Self-reported health status may also reflect aspects of health—such as disease severity and undiagnosed disease—that are not captured in the more objective measures of health status. Good-to-excellent self-reported health status correlates with lower risk of mortality.(1) Poor self-reported health status can be a good predictor of subsequent illness and premature death.(2) Self-reported health status is also linked to age, with older people more likely to report poor health than younger people.

1 E.L. Idler and Y. Benyamini, "Self-Rated Health and Mortality: A Review of Twenty-Seven Community Studies," Journal of Health and Social Behavior, 38, 1 (March 1997), 21–37.

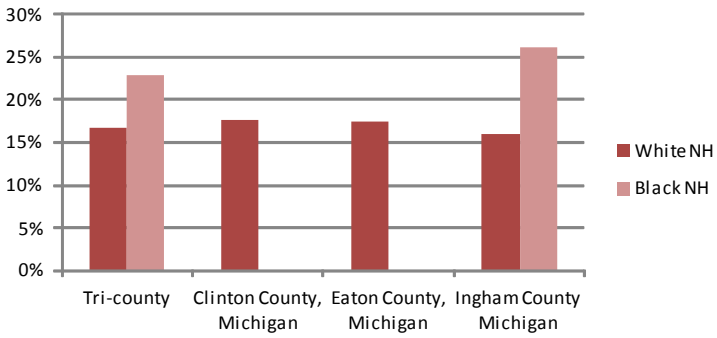
2 J. McCallum et al., "Self-reported Health and Survival: A 7-year Follow-up Study of Australian Elderly," American Journal of Public Health, 84, 7 (July 1994), 1100–1105.

% Adults with Fair or Poor perceived health



All three counties report higher rates of fair or poor perceived health than Michigan as a whole. The differences between the county rates are not statistically significant.

% Adults with Fair or Poor perceived heath, by racial group



Black or African American residents of the tri-county area report higher rates of fair or poor perceived health than do Whites. In Ingham County, more than 1 in 4 Black or African American residents report fair or poor perceived health, whereas the rate is about 1 in 7 for White residents. This indicates that the Black or African American population is experiencing much poorer health -related quality of life than the White population.

Most adults have excellent or very good perceived health status in the Tri-county area

Diabetes

MEASURE:

Age-specific preventable hospitalization rate per 10,000 persons related to diabetes among adults.

DATA SOURCE:

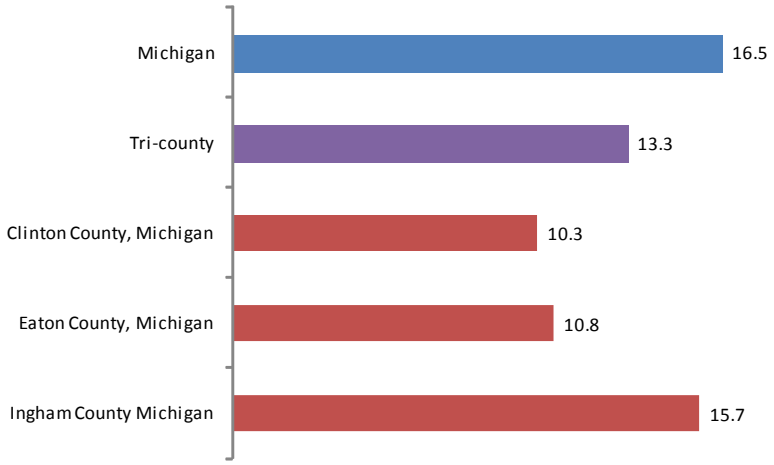
Michigan Department of Community Health

YEAR: 2007-2009

REASON FOR MEASURE:

As rates of overweight and obese individuals increase, diabetes also continues to become more prevalent in the U.S. Diabetes presents as one of three types: Type 1, Type 2 and gestational diabetes. Diabetes is a chronic disease and is a large cause of morbidity and mortality in the U.S. Complications from diabetes can include stroke, kidney failure, nerve damage, blindness and lower limb amputations.

 # Preventable Hospitalizations due to Diabetes per 10,000 adults



The rate of preventable diabetes hospitalizations in the Tri-county area is lower than the rate across the state as a whole.

While all three counties have rates lower than Michigan, Ingham County has a much higher rate than Eaton or Clinton County.

speaking of health

Focus Group Participants:

"I have diabetes and manage it through medications but also diet and exercise and have lost 30 lbs since I began doing that."

"My mom just has diabetes cause she's older, but I have seven sisters, but all but two of us have diabetes. One passed away from complications of diabetes."

"As a diabetic on social security it is very hard to eat the proper kinds of food due to your budget."

Premature Death

MEASURE:

The percent of deaths that occur before the age of 75, out of all deaths.

DATA SOURCE:

Michigan Department of Community Health

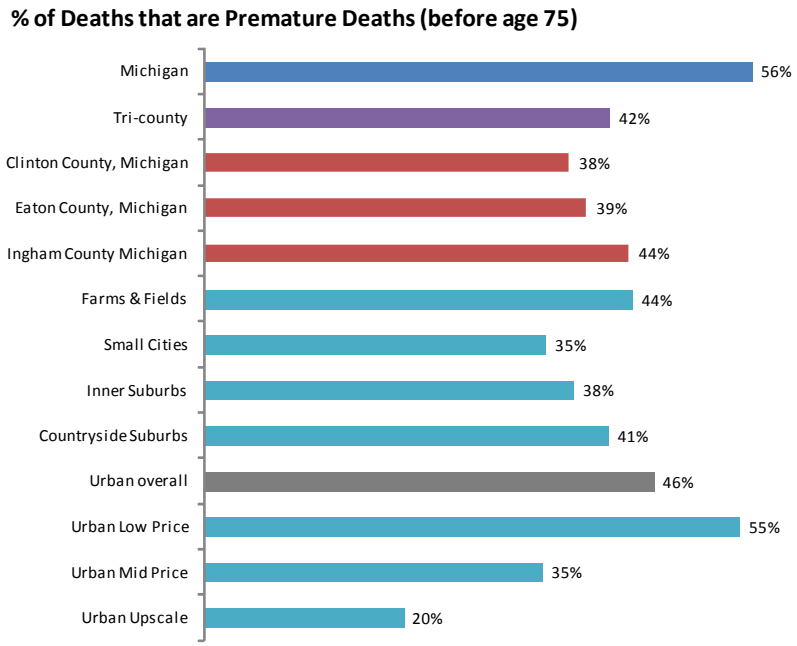
YEAR:

2007-2009

REASON FOR MEASURE:

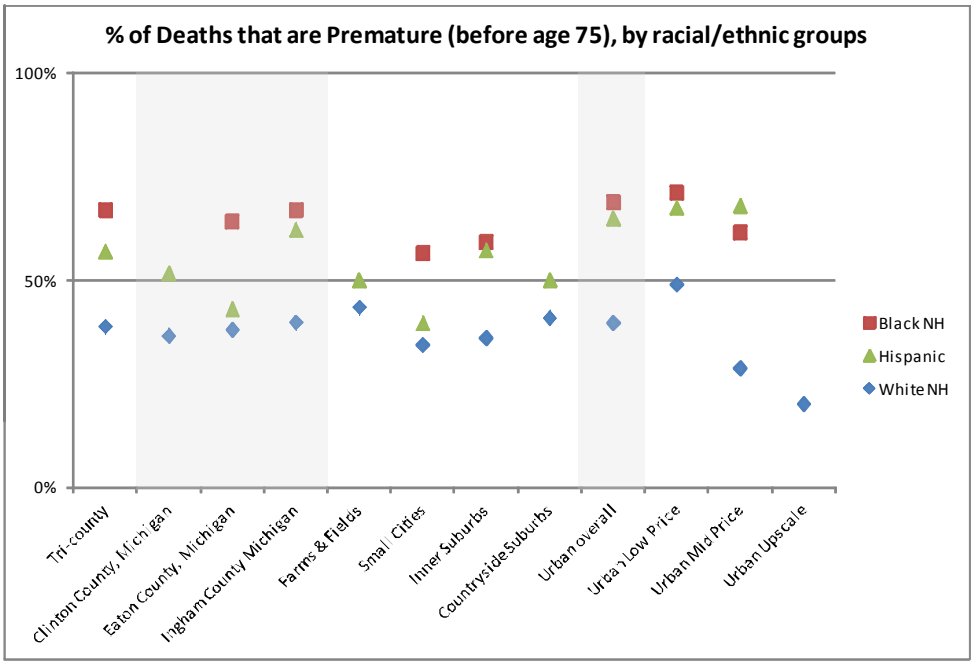
One way to examine health outcomes across populations is to examine the likelihood that a person will lead a long life, reaching the age of 75 years. **If a person dies before reaching 75, they are counted as a "premature death".**

Measuring premature mortality, rather than overall mortality, focuses attention on deaths that could have been prevented. By examining premature mortality rates across communities and investigating the underlying causes of high rates of premature death, resources can be targeted toward strategies that will extend years of life.



While all of the areas in the Tri-county region have lower rates of premature death than Michigan, there are wide variations in premature death rates.

The **Urban Low Price** area has the highest rate of premature deaths — **more than half** of all deaths occur before the age of 75 in this area. In contrast, the **Farms & Fields** area has the second-highest rate of premature deaths — 44 of every 100 deaths occur before the age of 75.



These data show some of the most striking evidence of health disparities across the Capital region.

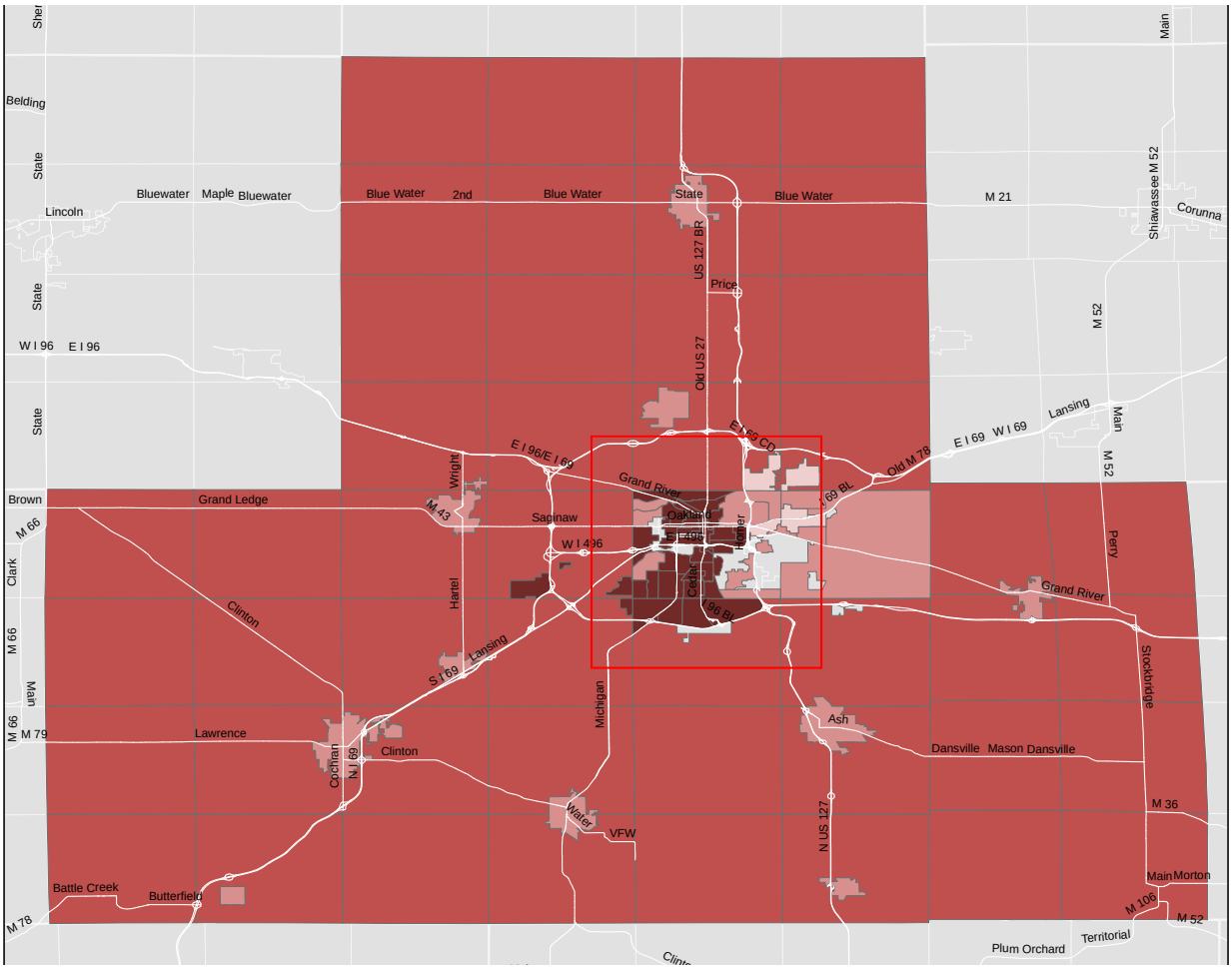
More than 50% of all Black or African-American deaths are premature, **across all of the geographic areas** examined in the Tri-county region. *Some areas do not have a reportable figure for Black premature deaths (Clinton, Farms & Fields, Urban Upscale, Countryside Suburbs).*

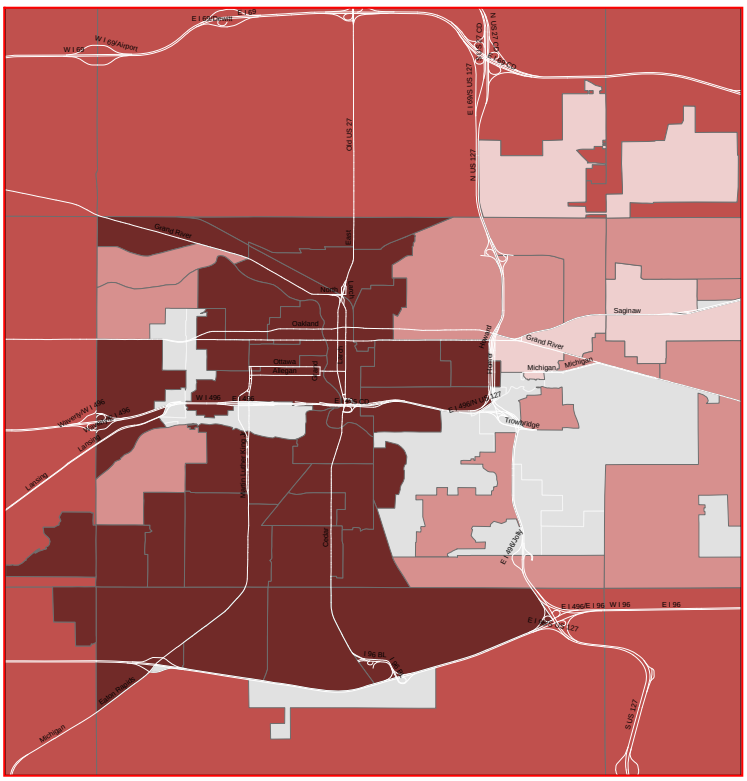
Similarly, the rates of premature deaths for Hispanics are higher than the rates for Whites in all of the geographic areas. *The Urban Upscale area did not have reportable figures for Hispanic premature deaths.*

"NH" means "not Hispanic"

Premature Death

Maps showing the % of deaths that are premature by Geographic Area Groups





Legend

Percentage of premature deaths* among all deaths

- < 28.0%
- 28.0% - 37.0%
- 37.0% - 46.0%
- > 46.0%

* Premature death is defined as death before age 75 years.

Premature Death is lowest in the Urban Upscale area, followed by the Small Cities area.

The Urban Low Price area has the highest percentage of deaths that are premature, or before age 75 years.

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Infant Mortality

MEASURE:

The number of infants who are born alive but die before age one, per every 1000 live births.

DATA SOURCE:

Michigan Department of Community Health

YEAR: 2007-2009

REASON FOR MEASURE:

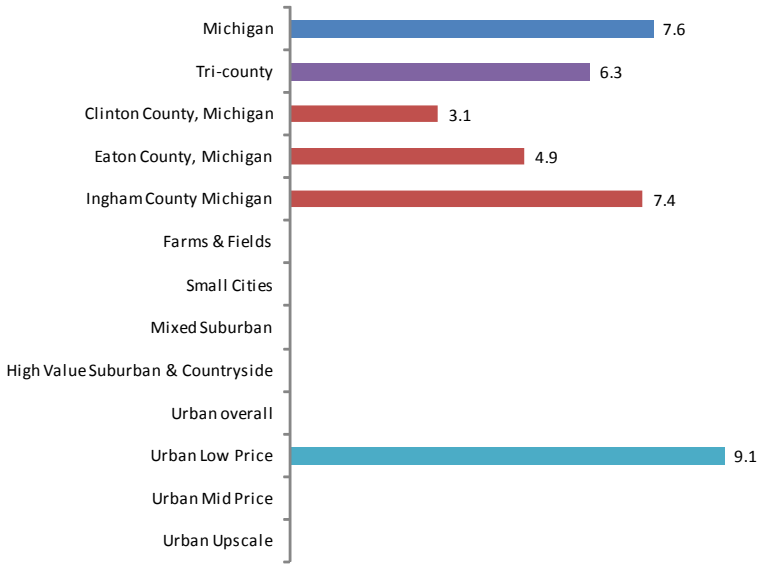
Infant mortality rates are an important indicator of health of a community because they are associated with maternal health, quality of and access to medical care, socioeconomic conditions, public health practices, and power and wealth inequities. Black infants consistently fare worse than White infants, even when comparing mothers with similar income and educational levels. Prevention of preterm birth is critical to lowering the overall infant mortality rate and reducing racial/ethnic disparities in infant mortality. Infant mortality rates are highest among infants born to mothers who are adolescents, unmarried, smokers, have lower educational levels, had a fourth or higher order birth, and those who did not obtain adequate prenatal care. Substantial racial/ethnic disparities in income and access to health care may also contribute to differences in infant mortality.

speaking of health

"Infant mortality is a critical indicator of the overall health and welfare of Michigan and the quality and accessibility of prenatal care for women. While the rate of infant mortality generally has been decreasing in the United States, it has increased in Michigan over the past three years."

— Governor Rick Snyder

 # Infant Deaths per 1000 live births

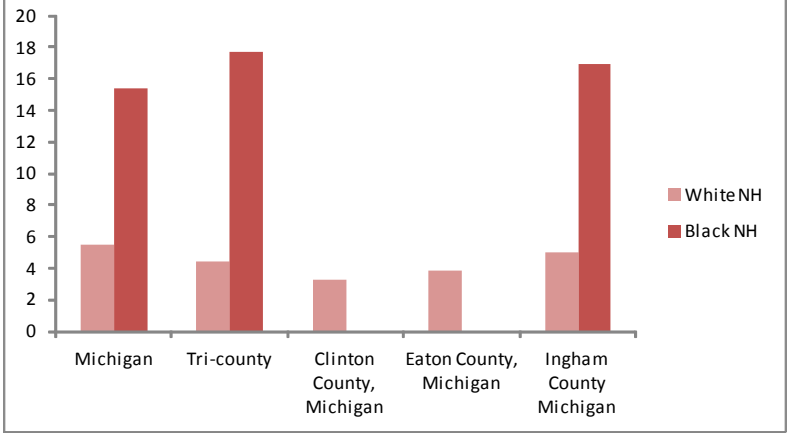


NOTE: the infant mortality rate is not reportable at many of the sub-county group levels as there are too few events to report reliable rates.

Given the higher proportion of Black, or African-American persons living in the **Urban Low Price** area, it's not surprising that the rate for that area is higher than the rate in the tri-county area, and the state as a whole.

The rate of Black or African-American infant mortality is nearly ***four times*** the rate of White infant mortality in the Tri-county area. The rate for Ingham County White infants is similar to the rate for Eaton and Clinton County White infants.

 # Infant Deaths per 1000 live births, by racial group



Cardiovascular Disease

MEASURE:

The age-adjusted death rate due to Cardiovascular Disease per 10,000 residents.

DATA SOURCE:

Michigan Department of Community Health

YEAR: 2010

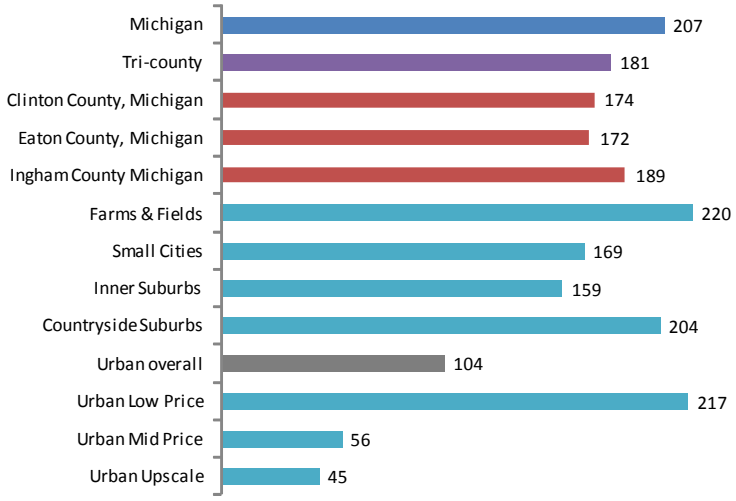
REASON FOR MEASURE:

Cardiovascular disease is the largest cause of death in Michigan. Cardiovascular disease includes diseases of the heart and blood vessels in the body. Examples of such diseases are: coronary heart disease, heart failure, sudden cardiac death and hypertensive heart disease.

Cardiovascular disease is an important indicator to track due to the risk of chronic morbidity and mortality that accompany it.

Cardiovascular disease is often linked to other factors that can influence health. Low education, low income and low SES have all been associated with increased cardiovascular disease and cardiac arrests. [MDCH]

 # Cardiovascular Disease Deaths per 10,000 people



The **Farms & Fields** area and the **Urban Low Price** area have the highest death rates due to cardiovascular disease.

The **Urban Mid Price** and the **Urban Upscale** areas have the lowest rates of cardiovascular disease deaths in the capital area.

speaking of health

Focus Group Participants:

"I didn't care about my health my whole life and I know I am paying the price for that. I have high blood pressure and diabetes now."

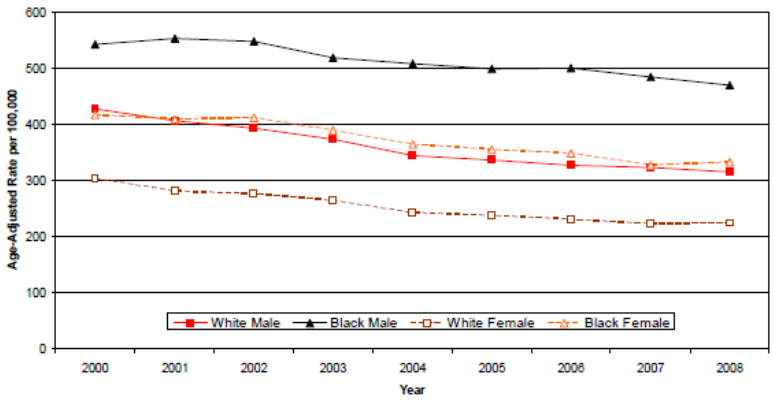
"I'm concerned for my children because of our family history of heart attacks in men and cancer in women in our family."

While ***local*** cardiovascular disease death data are not available by racial or ethnic groups, significant disparities exist across the state.

Across Michigan, Black Men have the highest rates of cardiovascular disease deaths, followed by Black Women. White Males have a higher rate of mortality from cardiovascular disease than White Women.

Heart Disease and Stroke in Michigan: 2010 Surveillance Update

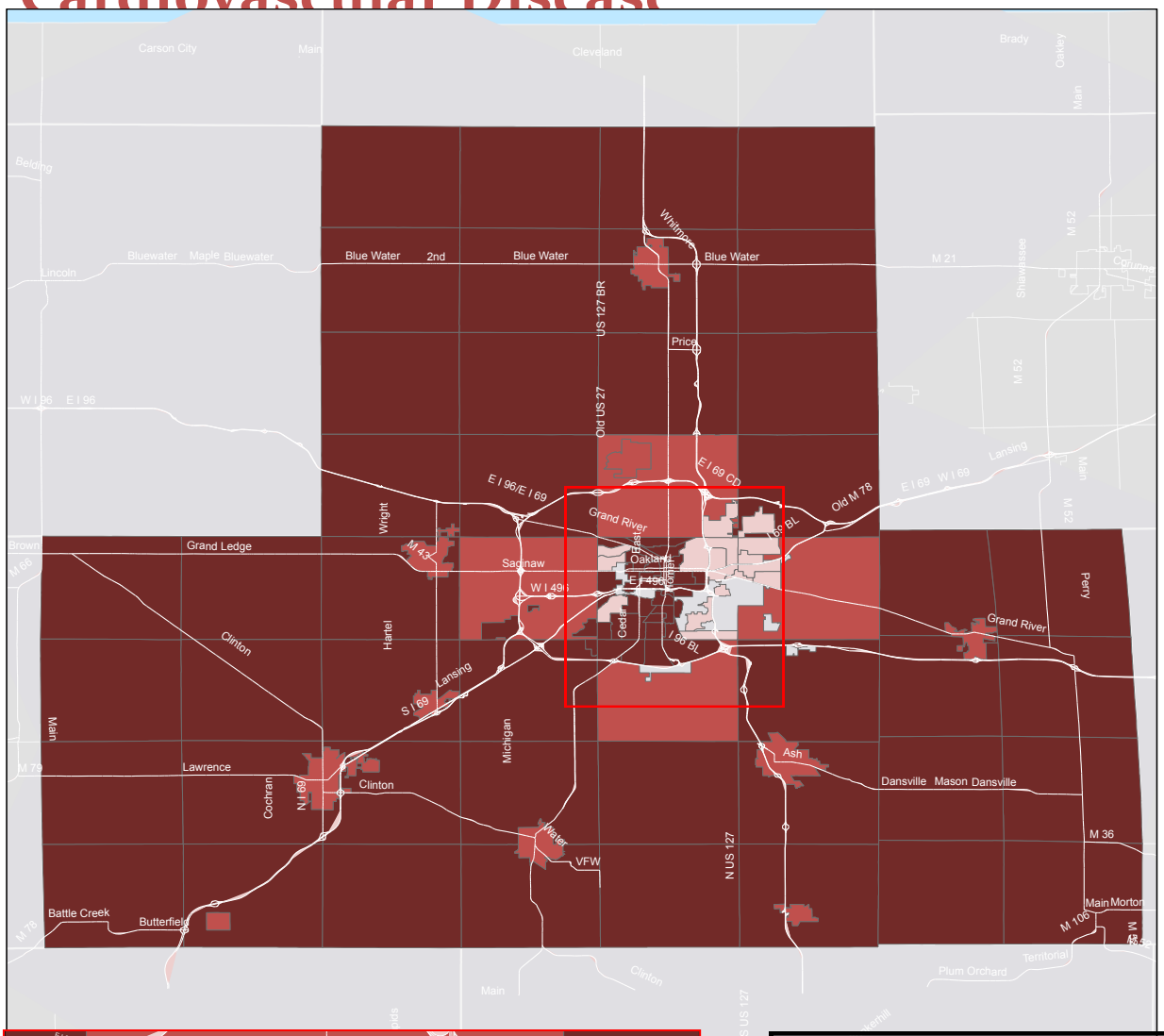
Age-Adjusted Mortality Rates by Race and Gender for Cardiovascular Disease for Michigan, 2000-2008

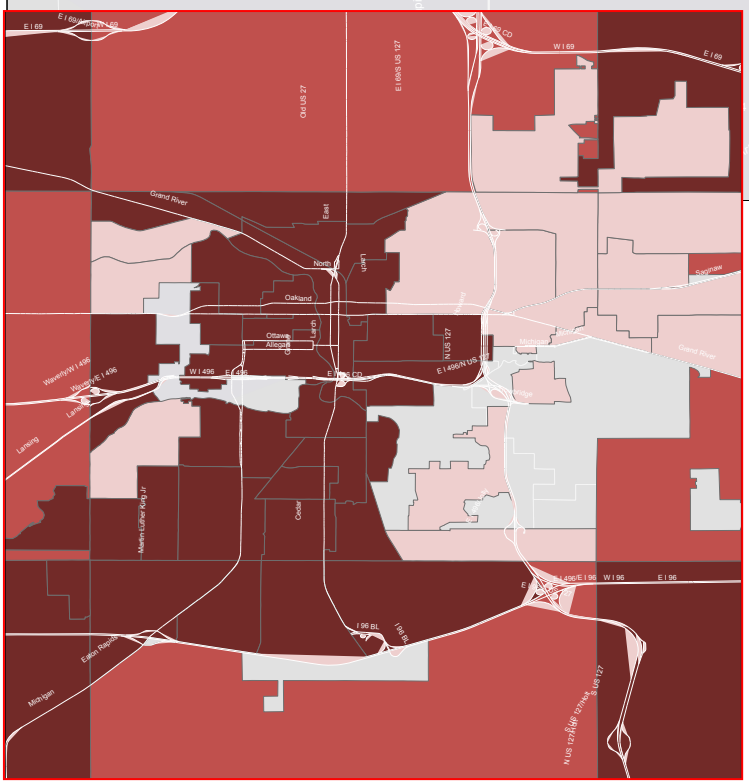


Source: MDCH Vital Statistics

Age-adjusted to the 2000 U.S. standard population

Cardiovascular Disease





Legend

Age-adjusted rate of death due to Cardiovascular disease per 10,000 residents

- < 87.8
- 87.8 - 131.8
- 131.8 - 175.8
- > 175.8

The Urban Upscale and Urban Mid Price areas have the lowest rates of cardiovascular disease deaths, followed by the Small Cities and Inner Suburbs areas.

The highest rates of cardiovascular disease deaths are in the Urban Low Price, Countryside Suburbs, and the Farms & Fields areas.

Accidental Injury

MEASURE:

The age adjusted death rate due to accidental injury per 10,000 persons. Accidental injury deaths (sometimes called unintentional injury) include transportation accidents, burns, suffocation, drowning, falls, exposure, accidental poisonings, and other unintentional injuries. It does not include homicide or suicide deaths.

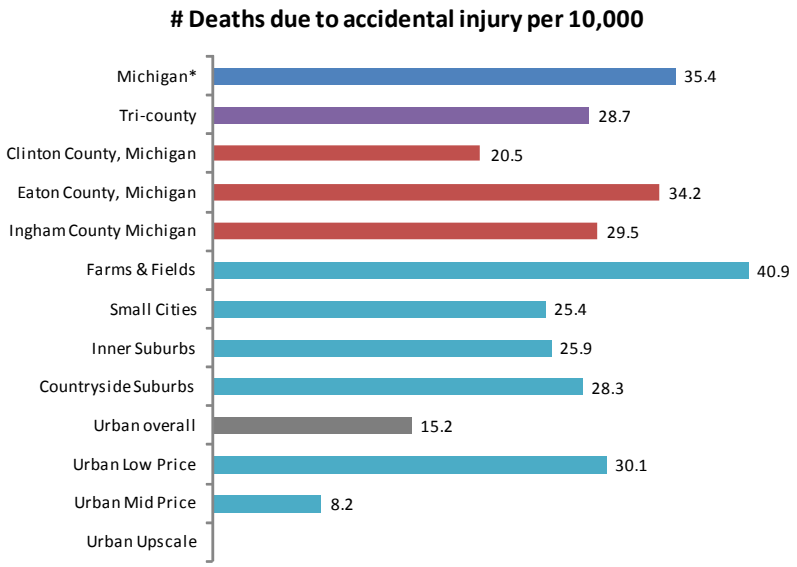
DATA SOURCE:

Michigan Department of Community Health

YEAR: 2010

REASON FOR MEASURE:

Deaths due to accidents are often the largest cause of death for children and young adults. Poor socioeconomic environments can lead to increased deaths from accidental injury. Deaths due to accidental injury can be reduced with through policy efforts to reduce hazards as well as individual and family safety precautions.



The **Farms & Fields** sub-group has the highest rate of deaths due to accidental injury. **Urban Mid-Price** has the lowest death rate due to accidental injury.

speaking of health

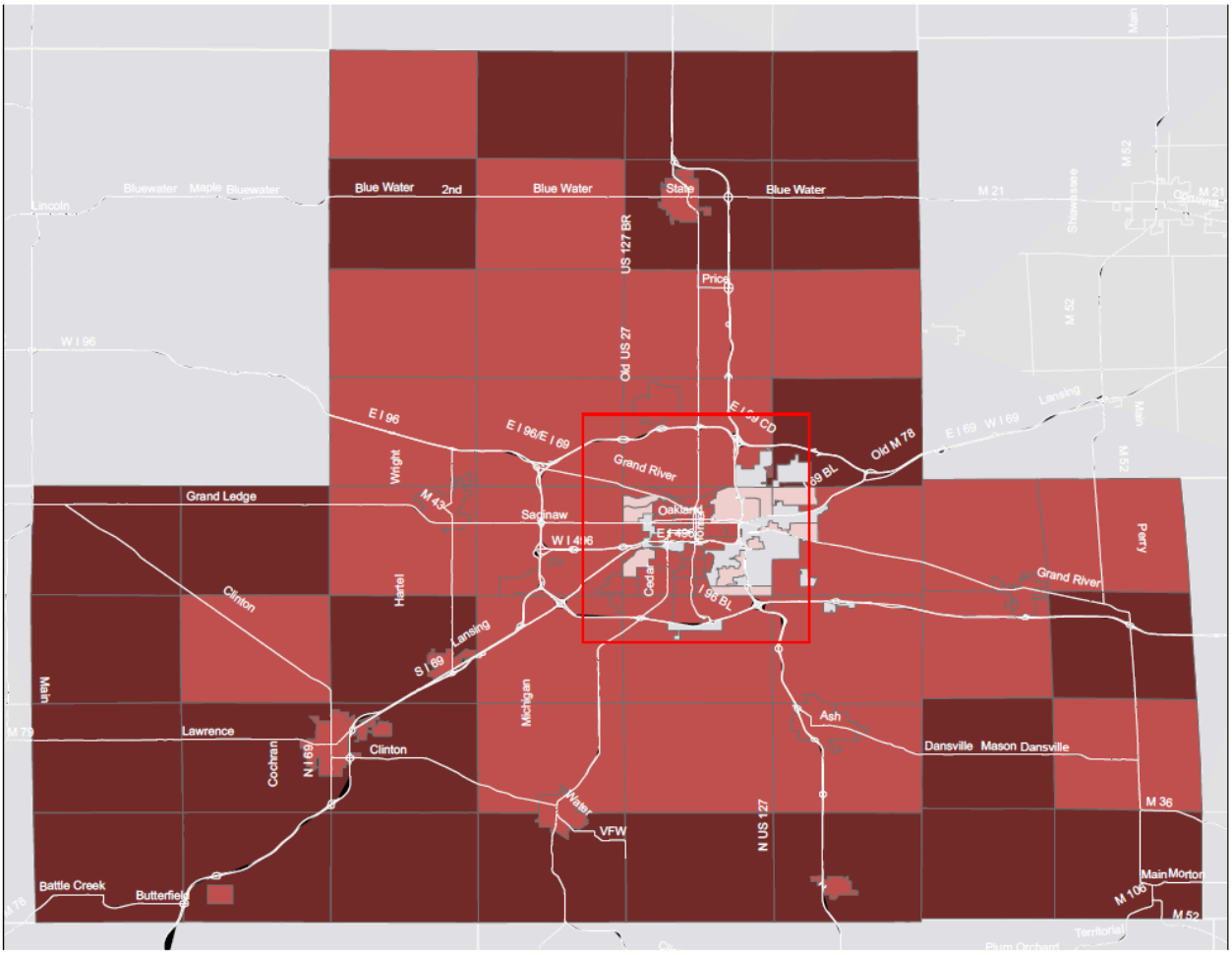
"When you fall now, as an adult, it's an ordeal. After four kids, I've gained weight, and it hurts a lot more."

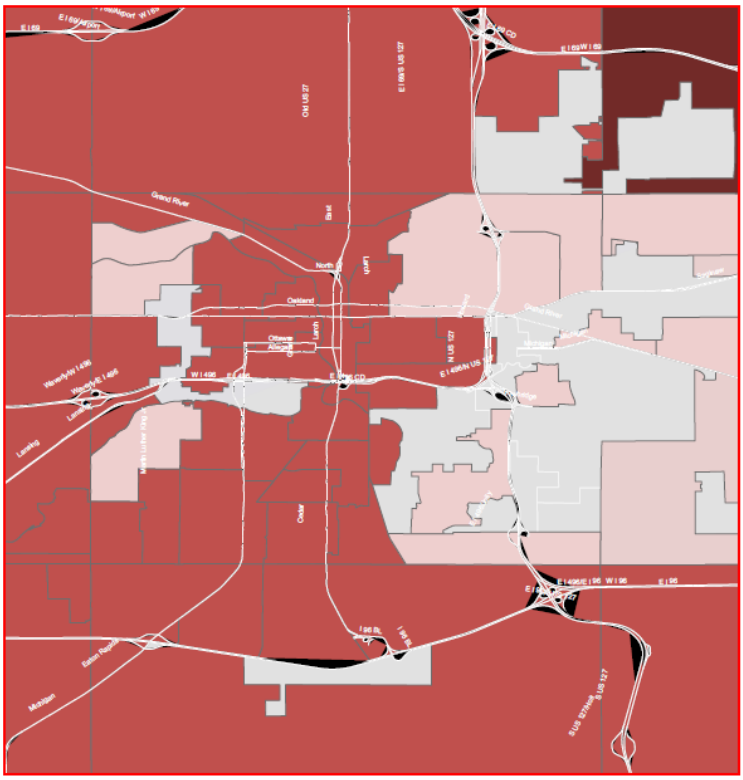
"People run stop signs in our neighborhood. They are driving and not paying attention, hitting pedestrians."

"We have sidewalks in our neighborhood (Meridian Township) which makes it easy to walk places"

Accidental Injury

Maps showing the rate of deaths due to accidental injury by Geographic Area Groups





Legend

Age-adjusted rate of death due to unintentional injuries per 10,000 residents

- < 16.9
- 16.9 - 24.9
- 24.9 - 32.9
- > 32.9

The Urban Mid Price area has the lowest rate of accidental injury deaths. The Urban Upscale area did not have adequate incidents to calculate a rate.

The highest rate of accidental injury deaths is in the Farms & Fields area.

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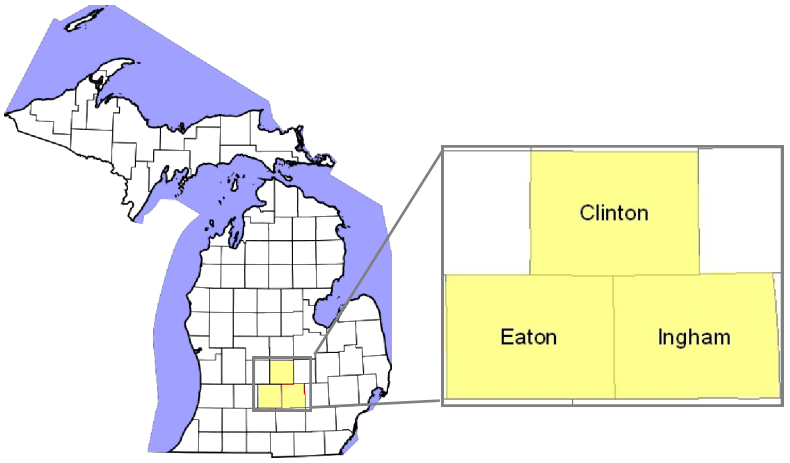
Geographic Section

This section presents data by geographic group, with all of the data for a given area on available indicators presented together.

Tri-County



Population Characteristics

464,506	Total Population
8	% Black/African American (not Hispanic)
6	% Hispanic/Latino, any race
79	% White (not Hispanic)
22	% under age 18
11	% aged 65 and older
15	% individuals in poverty
50	% households with incomes over $50,000

NOTE: Detailed descriptions of these measures, including definitions, years, and sources are available on pages 12-50

Opportunity Measures

			Compares to Michigan
INCOME INEQUALITY	Index of income inequality	0.43	☼
HOUSING SEGREGATION	Index of housing segregation	0.42	🗲

everyone has equal income — one person has all income
0 <<<<< equality — inequality >>>> 1

minorities distributed equally — complete apartheid
0 <<<< integration — segregation >>>> 1

The Tri-county region has a fairly moderate level of income ineq
Tri-county region has a higher level of minority segregation than the state, meaning that white-headed households are more unlikely to live alongside minority-headed households.

Social, Economic, and Environmental Factors

			Compares to Michigan
CHILD POVERTY	% children who live in poverty	17%	☼
EDUCATION	% adults 25+ with a bachelors degree or higher	31%	☼
SOCIAL CONNECTION	% adults with civic participation in past month	73%	n/a
COMMUNITY SAFETY	# violent crimes per 100,000 people	320	☼
AFFORDABLE HOUSING	% households with unaffordable housing	34%	=
PRIMARY CARE QUALITY	# preventable hospital-izations per 10,000 people	211	☼
ENVIRONMENTAL QUALITY	% water wells with nitrate contamination	0.9%	n/a
BUILT ENVIRONMENT	% population living in a food desert	12%	☼

0 200 400 600 800

of water wells
0% 1% 2%

The Tri-county area has a lower rate of child poverty than the state, as well as a higher percentage of the population who hold a bachelors degree or higher. Many residents report having participated civically in the past month. The Tri-county area has a lower rate of violent crime than the state as a whole. Many Tri-county residents must pay a large portion of their income for housing, although the rate is similar to the state. There is a lower rate of preventable hospitalizations than the state. Nearly 1 in 8 residents of the Tri-county region live in a food desert, meaning they don't have easy access to fresh food, however this rate is lower than the state as a whole.

KEY
☼ better
= similar
🗲 worse

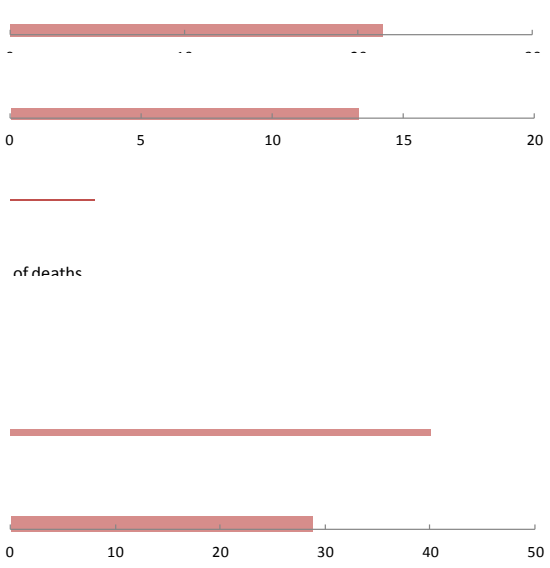
Behaviors, Stress, and Physical Condition

			Compares to Michigan
OBESITY	% adults who are obese	24%	☼
	% adolescents who are obese	15%	↯
TOBACCO	% adults who are current smokers	22%	=
	% adolescents who smoked in past month	12%	☼
ALCOHOL	% adults who binge drank in past month	18%	=
	% adolescents who binge drank in past month	15%	☼
ACCESS TO CARE	% adults with a primary care provider	75%	↯
	# residents to each primary care provider	1012	↯
DISEASE PREVENTION	% children 19-35 months with recommended vaccinations	77%	☼
MENTAL HEALTH	% adults whose mental health was not good	12%	=
	% adolescents with symptoms of depression	33%	↯

Comparisons between the Tri-county area and Michigan are mixed in the areas of obesity and smoking. Binge drinking rates in adults are comparable to the state, but lower than the state for adolescent binge drinking. There are fewer adults in the Tri-county area reporting that they have a primary care provider, and the ratio of residents to primary care providers is higher than the state, indicating lower access to clinical care. The Tri-county region has a similar rate of adult poor mental health, but adolescent mental health is a concern.

Health Outcomes

			Compares to Michigan
CHILD HEALTH	# preventable asthma hospitalizations per 10,000 children	21	↯
ADULT HEALTH	# preventable diabetes hospitalizations per 10,000 adults	13	☼
QUALITY OF LIFE	% adults with fair or poor perceived health status	16%	=
PREMATURE DEATH	% deaths before age 75	42%	☼
MATERNAL HEALTH	# infant deaths per 1000 live births	6.3	☼
CHRONIC DISEASE	# cardiovascular disease deaths per 10,000 people	181	☼
ACCIDENTAL INJURY	# accidental injury deaths per 10,000 people	29	☼

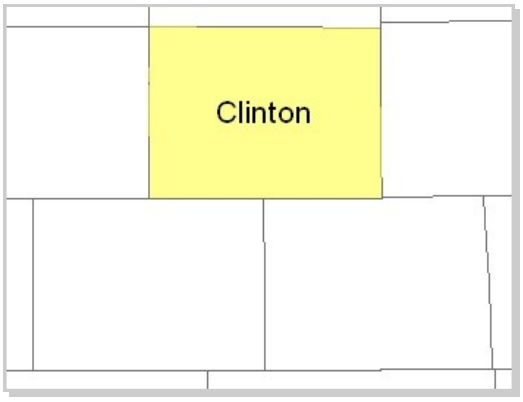


Tri-county children have poorer rates of preventable asthma hospitalization than Michigan. Adults have better rates of preventable diabetes hospitalizations. The percent of people with poor perceived health status is similar to the State. Over four in ten deaths in the Tri-county area can be called "premature", meaning they occur before the age of 75; however, this rate is lower than the State as a whole. The Tri-county area has a lower rate of infant deaths than Michigan. The rate of cardiovascular disease death and accidental injury death is better in the Tri-county region than the State as a whole.

KEY
☼ better
= similar
↯ worse

NOTE: Detailed descriptions of these measures, including year and source are available on pages 12-50

Clinton County



Population Characteristics

Total Population	75,382
% Black/African American (not Hispanic)	1.7%
% Hispanic/Latino, any race	3.7%
% White (not Hispanic)	91.4%
% under 18	24.7%
% 65+	12.9%
% Individuals in Poverty	8.5%
% Households with incomes over $50,000	58.1%

NOTE: Detailed descriptions of these measures, including definitions, years, and sources are available on pages 12-50

Opportunity Measures

				Compares to Tri-County
INCOME INEQUALITY	Index of income inequality	0.41	everyone has equal income … one person has all income; 0 <<<<< equality … inequality >>>> 1	=
HOUSING SEGREGATION	Index of housing segregation	0.35	minorities distributed equally … complete apartheid; 0 <<<< integration … segregation >>>> 1	☼

Clinton County has a fairly high level of income inequality, meaning that the available income is concentrated in a small percent of the population. Clinton County also has a moderate level of minority segregation.

Social, Economic, and Environmental Factors

				Compares to Tri-County
CHILD POVERTY	% children who live in poverty	6.8%		☼
EDUCATION	% adults 25+ with a bachelors degree or higher	27.2%		↗
SOCIAL CONNECTION	% adults with civic participation in past month	74.8%		☼
COMMUNITY SAFETY	# violent crimes per 100,000 people	60.9	0 200 400 600 800	☼
AFFORDABLE HOUSING	% households with unaffordable housing	29.1%		☼
PRIMARY CARE QUALITY	# preventable hospitalizations per 10,000 people	181.08	0 100 200 300	☼
ENVIRONMENTAL QUALITY	% water wells with nitrate contamination	0.5%	of water wells; 0% 1% 2%	☼
BUILT ENVIRONMENT	% population living in a food desert	12.3%		=

Clinton County has a very low rate of child poverty, as well as a high percentage of the population who hold a bachelors degree or higher. Many residents report having participated civically in the past month. Even though Clinton County has the lowest rate of crime in the capital area, Clinton County residents still pay the lowest portion of their income for housing in the capital area. There is a low rate of preventable hospitalizations, which indicates that many residents are able to access primary care appropriately. The water system in Clinton County shows a moderate level of nitrate contamination, which may indicate farm runoff. Many residents of Clinton County live in a food desert, meaning they don't have easy access to fresh food.

KEY
☼ better
= similar
↗ worse

Behaviors, Stress, and Physical Condition

			Compares to Tri-County
OBESITY	% adults who are obese	25%	worse
	% adolescents who are obese	12%	better
TOBACCO	% adults who are current smokers	16%	better
	% adolescents who smoked in past month	14%	worse
ALCOHOL	% adults who binge drank in past month	18%	similar
	% adolescents who binge drank in past month	16%	similar
ACCESS TO CARE	% adults with a primary care provider	85%	better
	# residents to each primary care provider	2,494	worse
DISEASE PREVENTION	% children 19-35 months with recommended vaccinations	80%	better
MENTAL HEALTH	% adults whose mental health was not good	7%	better
	% adolescents with symptoms of depression	29%	better

Clinton County compares favorably to the tri-county area in the area of tobacco, and has comparable rates of binge drinking and obesity as other areas. Adolescents in Clinton County report similar rates of obesity and tobacco use as youth in the other two counties. While Clinton County has the highest # people per primary care provider rate in the three counties, it still has a high rate of adults who report having a primary care provider, indicating that persons are travelling outside the county for primary care. Clinton County has a good rate of adult poor mental health, but adolescent mental health is a concern.

Health Outcomes

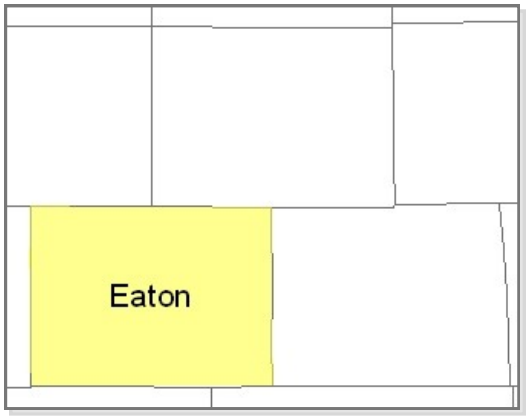
			Compares to Tri-County
CHILD HEALTH	# asthma hospitalizations per 10,000 children	12.4	better
ADULT HEALTH	# diabetes hospitalizations per 10,000 adults	10.3	better
QUALITY OF LIFE	% adults with fair or poor perceived health status	17%	worse
PREMATURE DEATH	% deaths before age 75	38%	better
MATERNAL HEALTH	# infant deaths per 1000 live births	3.1	better
CHRONIC DISEASE	# cardiovascular disease deaths per 10,000 people	174	better
ACCIDENTAL INJURY	# accidental injury deaths per 10,000 people	21	better

Clinton County children have significantly better rates for the asthma population as compared to the tri-county region, and adults have better rates for diabetes hospitalizations. The percent of people with poor perceived health status is very similar. About a third of all deaths in Clinton County can be called "premature", meaning they occur before the age of 75. Clinton County has a very low rate of infant deaths. Both rates of cardiovascular disease deaths and accidental injury deaths are better in Clinton County, as compared to the tri-county region

KEY
- better
- = similar
- worse

NOTE: Detailed descriptions of these measures, including year and source are available on pages 12-50

Eaton County



Population Characteristics

Total Population	107,759
% Black/African American (not Hispanic)	5.7%
% Hispanic/Latino, any race	4.5%
% White (not Hispanic)	85.6%
% under 18	23.3%
% 65+	14%
% Individuals in Poverty	9.1%
% Households with incomes over $75K	19.8%

NOTE: Detailed descriptions of these measures, including definitions, years, and sources are available on pages 12-50

Opportunity Measures

				Compares to Tri-County
INCOME INEQUALITY	Index of income inequality	0.37	↧everyone has equal income ... one person has all income ↧	☼
HOUSING SEGREGATION	Index of housing segregation	0.48	↧minorities distributed equally ... complete apartheid ↧ 0 <<<< integration ... segregation >>>> 1	🗲

Eaton County has a fairly low level of income inequality, meani
in a small percent of the population. Eaton County has a higher level of minority segregation, meaning that white-headed households are less likely to live alongside minority-headed households.

Social, Economic, and Environmental Factors

				Compares to Tri-County
CHILD POVERTY	% children who live in poverty	12%		☼
EDUCATION	% adults 25+ with a bachelors degree or higher	24%		🗲
SOCIAL CONNECTION	% adults with civic participation in past month	77%		☼
COMMUNITY SAFETY	# violent crimes per 100,000 people	160	0 200 400 600 800	☼
AFFORDABLE HOUSING	% households with unaffordable housing	29%		☼
PRIMARY CARE QUALITY	# preventable hospitalizations per 10,000 people	212	0 100 200 300	=
ENVIRONMENTAL QUALITY	% water wells with nitrate contamination	1.4%	0% 1% 2%	🗲
BUILT ENVIRONMENT	% population living in a food desert	11%		=

Eaton County has a low rate of child poverty, as well as a low percentage of the population who hold a bachelors degree or higher. Many residents report having participated civically in the past month. While Eaton County has a lower rate of crime in the capital area, many Eaton County residents pay a large portion of their income for housing. There is a moderate rate of preventable hospitalizations, which indicates that many residents are unable to access primary care appropriately. The water system in Eaton County shows a high level of nitrate contamination, which may indicate aquifer contamination. Some residents of Eaton County live in a food desert, meaning they don't have easy access to fresh food.

KEY
☼ better
= similar
🗲 worse

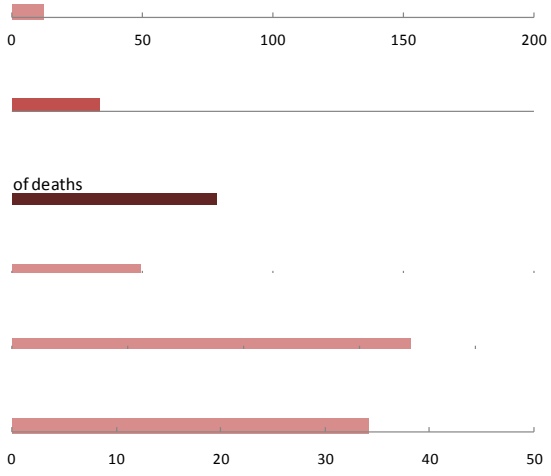
Behaviors, Stress, and Physical Condition

			Compares to Tri-County
OBESITY	% adults who are overweight or obese	58%	=
	% adolescents who are overweight or obese	31%	=
TOBACCO	% adults who are current smokers	29%	↗
	% adolescents who smoked in past month	13%	=
ALCOHOL	% adults who binge drank in past month	21%	↗
	% adolescents who binge drank in past month	17%	↗
ACCESS TO CARE	% adults with primary care provider	85%	☼
	# residents to each primary care provider	1,907	↗
DISEASE PREVENTION	% children 19-35 months with recommended vaccinations	78%	=
MENTAL HEALTH	% adults whose mental health was not good	15%	↗
	% adolescents with symptoms of depression	33%	=

Eaton County has similar or worse rates in the areas of obesity and tobacco, and has higher rates of binge drinking than many other areas. Adolescents in Eaton County report similar rates of obesity and tobacco use as youth in the other two counties. Eaton County has a high # people per primary care provider rate in the three counties, yet it still has a high rate of adults who report having a primary care provider, indicating that persons are travelling outside the county for primary care. Eaton County has a higher rate of adult poor mental health, and adolescent mental health is a concern.

Health Outcomes

			Compares to Tri-County
CHILD HEALTH	# preventable asthma hospitalizations per 10,000 children	18	=
ADULT HEALTH	# preventable diabetes hospitalizations per 10,000 adults	11	=
QUALITY OF LIFE	% adults with fair or poor perceived health status	16%	=
PREMATURE DEATH	% deaths before age 75	39%	☼
MATERNAL HEALTH	# infant deaths per 1000 live births	4.9	☼
CHRONIC DISEASE	# cardiovascular disease deaths per 10,000 people	172	☼
ACCIDENTAL INJURY	# accidental injury deaths per 10,000 people	34	↗



Eaton County children have similar rates of asthma population as the tri-county region, and adults have similar rates of diabetes hospitalizations. The percent of people with poor perceived health status is moderately low. About 4 in 10 of all deaths in Eaton County can be called "premature", meaning they occur before the age of 75. Eaton County has a low rate of infant deaths. The rate of cardiovascular disease death is better in Eaton County, but the rate of accidental injury deaths is fairly high.

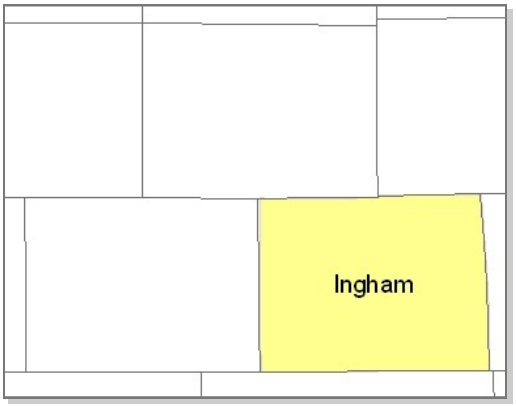
KEY
☼ better
= similar
↗ worse

NOTE: Detailed descriptions of these measures, including year and source are available on pages 12-50

Ingham County

Population Characteristics

Total Population	281,365
% Black/African American (not Hispanic)	11%
% Hispanic/Latino, any race	7%
% White (not Hispanic)	73.2%
% under 18	21.2%
% 65+	10%
% Individuals in Poverty	20%
% Households with incomes over $75K	24%



NOTE: Detailed descriptions of these measures, including definitions, years, and sources are available on pages 12-50

Opportunity Measures

Compares to Tri-County

INCOME INEQUALITY	Index of income inequality	0.462	↧everyone has equal income ... one person has all income ↧
HOUSING SEGREGATION	Index of housing segregation	0.30	↧minorities distributed equally ... complete apartheid ↧ <<<< integration ... segregation >>>> (0 ... 1)

Ingham County has a higher level of income inequality than th
is concentrated in a smaller percent of the population. Ingham County also has a low level of minority segregation, however, meaning that white-headed households are more likely to live alongside minority-headed households.

Social, Economic, and Environmental Factors

Compares to Tri-County

CHILD POVERTY	% children who live in poverty	22.4%	
EDUCATION	% adults 25+ with a bachelors degree or higher	35.5%	
SOCIAL CONNECTION	% adults with civic participation in past month	71%	
COMMUNITY SAFETY	# violent crimes per 100,000 people	439	0 200 400 600 800
AFFORDABLE HOUSING	% households with unaffordable housing	37%	
PRIMARY CARE QUALITY	# preventable hospitalizations per 10,000 people	218	
ENVIRONMENTAL QUALITY	% water wells with nitrate contamination	0.7%	0% 1% 2%
BUILT ENVIRONMENT	% population living in a food desert	13%	

Ingham County has a high rate of child poverty, as well as a high percentage of the population who hold a bachelors degree or higher. Many residents report having participated civically in the past month. Ingham County has a very high rate of crime in the capital area, and many Ingham residents must still pay a large portion of their income for housing. There is a high rate of preventable hospitalizations, which indicates that many residents are unable to access primary care appropriately. The water system in Ingham County shows a moderate evel of nitrate contamination. A greater portion of Ingham County residents live in a food desert than those across the region, meaning they don't have easy access to fresh food.

KEY
☼ better
= similar
worse

Behaviors, Stress, and Physical Condition

			Compares to Tri-County
OBESITY	% adults who are overweight or obese	54%	☼
	% adolescents who are overweight or obese	35%	=
TOBACCO	% adults who are current smokers	21%	=
	% adolescents who smoked in past month	10%	☼
ALCOHOL	% adults who binge drank in past month	17%	☼
	% adolescents who binge drank in past month	14%	☼
ACCESS TO CARE	% adults with primary care provider	71%	↗
	# residents to each primary care provider	762	☼
DISEASE PREVENTION	% children 19-35 months with recommended vaccinations	78%	=
MENTAL HEALTH	% adults whose mental health was not good	12%	☼
	% adolescents with symptoms of depression	34%	↗

Ingham County compares favorably to the tri-county area in the areas of obesity and tobacco, and has lower rates of binge drinking than many other areas. Adolescents in Ingham County report similar rates of obesity and lower tobacco use as youth in the other two counties. While Ingham County has the lowest # people per primary care provider rate in the three counties, it still has a lower rate of adults who report having a primary care provider. Ingham County has a good rate of adult poor mental health, but adolescent mental health is a concern.

Health Outcomes

			Compares to Tri-County
CHILD HEALTH	# preventable asthma hospitalizations per 10,000 children	26	↗
ADULT HEALTH	# preventable diabetes hospitalizations per 10,000 adults	16	↗
QUALITY OF LIFE	% adults with fair or poor perceived health status	16%	=
PREMATURE DEATH	% deaths before age 75	44%	↗
MATERNAL HEALTH	# infant deaths per 1000 live births	7.4	↗
CHRONIC DISEASE	# cardiovascular disease deaths per 10,000 people	189	↗
ACCIDENTAL INJURY	# accidental injury deaths per 10,000 people	30	↗

Ingham County children have higher rates of preventable asthma hospitalizations compared to the tri-county region, and adults have higher rates of diabetes hospitalizations. The percent of people with poor perceived health status is moderately low. Almost half of all deaths in Ingham County can be called "premature", meaning they occur before the age of 75. Ingham County has a moderate rate of infant deaths. The rate of cardiovascular disease death and accidental injury death is worse in Ingham County than the tri-county region.

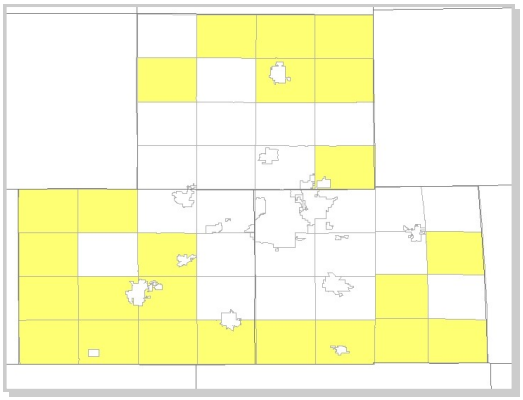
KEY
☼ better
= similar
↗ worse

NOTE: Detailed descriptions of these measures, including year and source are available on pages 12-50

Farms & Fields

Population Characteristics

Total Population	60,473
% Black/African American (not Hispanic)	0.6%
% Hispanic/Latino, any race	3.0%
% White (not Hispanic)	94.4%
% under 18	26.3%
% 65+	11.7%
% Individuals in Poverty	8.6%
% Households with incomes over $50,000	58.1%



This group includes

Townships in Clinton County:
Bath Charter, Bingham, Dallas, Duplain, Essex, Greenbush, Ovid
Townships in Eaton County:
Bellevue, Benton, Brookfield, Carmel, Hamlin, Kalamo, Eaton, Sunfield, Roxand, Vermontville, Walton
Townships in Ingham County:
Bunker Hill, Ingham, Leroy, Leslie, Onondaga,

NOTE: Detailed descriptions of these measures, including definitions, years, and sources are available on pages 12-50

Opportunity Measures

			Compares to Tri-County
INCOME INEQUALITY	Index of income inequality	0.36	☼
HOUSING SEGREGATION	Index of housing segregation	0.32	=

Farms & Fields subgroup has the lowest level of income inequality within the tri-county area, meaning income is distributed more equally. This area has a moderate level of minority segregation.

Social, Economic, and Environmental Factors

			Compares to Tri-County
CHILD POVERTY	% children who live in poverty	11.7%	☼
EDUCATION	% adults 25+ with a bachelors degree or higher	15.6%	↗
SOCIAL CONNECTION	% adults with civic participation in past month		
COMMUNITY SAFETY	# violent crimes per 100,000 people	90	☼
AFFORDABLE HOUSING	% households with unaffordable housing	28.9%	☼
PRIMARY CARE QUALITY	# preventable hospitalizations per 10,000 people		
ENVIRONMENTAL QUALITY	% water wells with nitrate contamination	1.9%	↗
BUILT ENVIRONMENT	% population living in a food desert	3.4%	☼

Farms & Fields subgroup has a moderate level of child poverty, as well as a low percentage of the population who hold a bachelors degree or higher. The Farms & Fields subgroup has both a low rate of crime and a low percentage of persons with unaffordable housing. The water system contamination for the Farm & Field area is the highest within the tri-county area, which may be due to agricultural runoff. Residents in these areas are not likely to live in a designated food desert.

KEY
☼ better
= similar
↗ worse

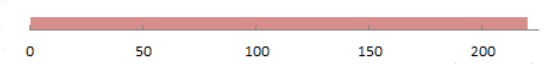
Behaviors, Stress, and Physical Condition

OBESITY	% adults who are obese
	% adolescents who are obese
TOBACCO	% adults who are current smokers
	% adolescents who smoked in past month
ALCOHOL	% adults who binge drank in past month
	% adolescents who binge drank in past month
ACCESS TO CARE	% adults with a primary care provider
	# residents to each primary care provider
DISEASE PREVENTION	% children 19-35 months with recommended vaccinations
MENTAL HEALTH	% adults whose mental health was not good
	% adolescents with symptoms of depression

Data is not reportable at the geographic subgroup level for these indicators.

Health Outcomes

Compares to Tri-County

CHILD HEALTH	# asthma hospitalizations per 10,000 children			
ADULT HEALTH	# diabetes hospitalizations per 10,000 adults			
QUALITY OF LIFE	% adults with fair or poor perceived health status			
PREMATURE DEATH	% deaths before age 75	44%		↗
MATERNAL HEALTH	# infant deaths per 1000 live births			
CHRONIC DISEASE	# cardiovascular disease deaths per 10,000 people	220		↗
ACCIDENTAL INJURY	# accidental injury deaths per 10,000 people	41		↗

Farms & Fields subgroup has third highest rate of premature death within the tri-county region. The rate of cardiovascular disease and deaths due to accidental injury in the Farms & Field area are the highest in the tri-county area.

KEY

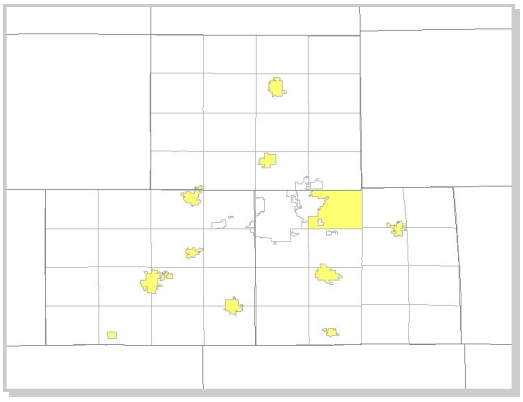
☼ better
= similar
↗ worse

NOTE: Detailed descriptions of these measures, including year and source are available on pages 12-50

Small Cities

Population Characteristics

Total Population	105,476
% Black/African American (not Hispanic)	5.3%
% Hispanic/Latino, any race	4.8%
% White (not Hispanic)	82.8%
% under 18	23.5%
% 65+	12.3%
% Individuals in Poverty	11.8%
% Households with incomes over $50,000	51.1%



This group includes

Cities in Clinton County:
DeWitt, St. Johns

Cities in Eaton County:
Charlotte, Eaton Rapids, Grand Ledge, Olivet, Potterville

In Ingham County:
Leslie, Mason, Williamston, Meridian Township

NOTE: Detailed descriptions of these measures, including definitions, years, and sources are available on pages 12-50

Opportunity Measures

				Compares to Tri-County
INCOME INEQUALITY	Index of income inequality	0.37	everyone has equal income … one person has all income; 0 <<<<< equality … inequality >>>> 1	☼
HOUSING SEGREGATION	Index of housing segregation	0.30	minorities distributed equally … complete apartheid; 0 <<<< integration … segregation >>>> 1	=

Small Cities has a lower level of income inequality, meaning that the available income is dispersed more evenly throughout the population. Small Cities also has a moderate level of minority segregation.

Social, Economic, and Environmental Factors

				Compares to Tri-County
CHILD POVERTY	% children who live in poverty	4.7%		☼
EDUCATION	% adults 25+ with a bachelors degree or higher	28.9%		=
SOCIAL CONNECTION	% adults with civic participation in past month			
COMMUNITY SAFETY	# violent crimes per 100,000 people	88	0 200 400 600 800	☼
AFFORDABLE HOUSING	% households with unaffordable housing	26.1%		☼
PRIMARY CARE QUALITY	# preventable hospitalizations per 10,000 people			
ENVIRONMENTAL QUALITY	% water wells with nitrate contamination			
BUILT ENVIRONMENT	% population living in a food desert	5.2%		☼

Small Cities have the lowest level of child poverty, as well as a moderate percentage of the population who hold a bachelors degree or higher. Small Cities have a low crime rate and have the lowest rate of the population with unaffordable housing. Residents in these areas do have relatively easy access to fresh food.

KEY
☼ better
= similar
↘ worse

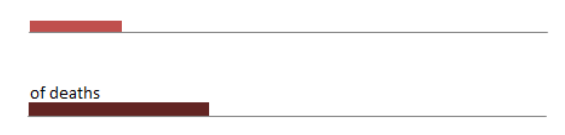
Behaviors, Stress, and Physical Condition

OBESITY	% adults who are obese
	% adolescents who are obese
TOBACCO	% adults who are current smokers
	% adolescents who smoked in past month
ALCOHOL	% adults who binge drank in past month
	% adolescents who binge drank in past month
ACCESS TO CARE	% adults with a primary care provider
	# residents to each primary care provider
DISEASE PREVENTION	% children 19-35 months with recommended vaccinations
MENTAL HEALTH	% adults whose mental health was not good
	% adolescents with symptoms of depression

Data is not reportable at the geographic subgroup level for these indicators.

Health Outcomes

			Compares to Tri-County
CHILD HEALTH	# asthma hospitalizations per 10,000 children	Not Available	
ADULT HEALTH	# diabetes hospitalizations per 10,000 adults	Not Available	
QUALITY OF LIFE	% adults with fair or poor perceived health status	18%	worse
PREMATURE DEATH	% deaths before age 75	35%	better
MATERNAL HEALTH	# infant deaths per 1000 live births	Not Available	
CHRONIC DISEASE	# cardiovascular disease deaths per 10,000 people	169	better
ACCIDENTAL INJURY	# accidental injury deaths per 10,000 people	25	better



Small Cities has a higher rate of people with poor perceived health, however this area has one of the lowest rates of premature death within the tri-county region. The rate of cardiovascular disease and deaths due to accidental injury is better in the Small Cities area than that of the tri-county area. Information on the child health, adult health, and maternal health indicators could not be obtained at the sub-county level to be included in this section.

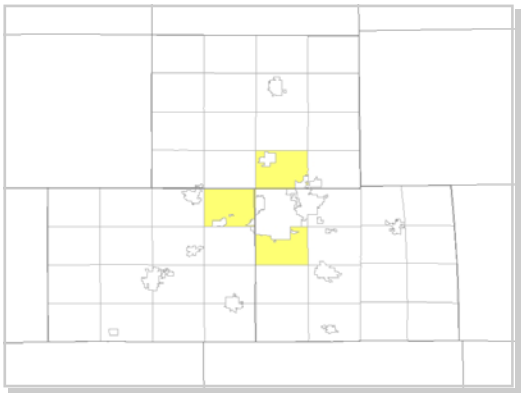
KEY
better
= similar
worse

NOTE: Detailed descriptions of these measures, including year and source are available on pages 12-50

Inner Suburbs

Population Characteristics

Total Population	73,113
% Black/African American (not Hispanic)	7.6%
% Hispanic/Latino, any race	4.8%
% White (not Hispanic)	81.4%
% under 18	23.4%
% 65+	12.3%
% Individuals in Poverty	11.8%
% Households with incomes over $75K	27.5%



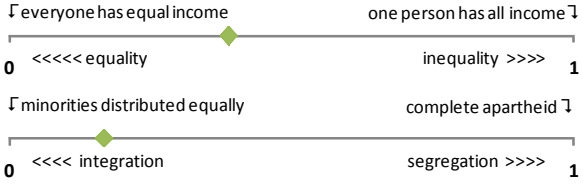
This group includes

Delhi Charter Township,
DeWitt Charter Township,
Delta Charter Township

NOTE: Detailed descriptions of these measures, including definitions, years, and sources are available on pages 12-50

Opportunity Measures

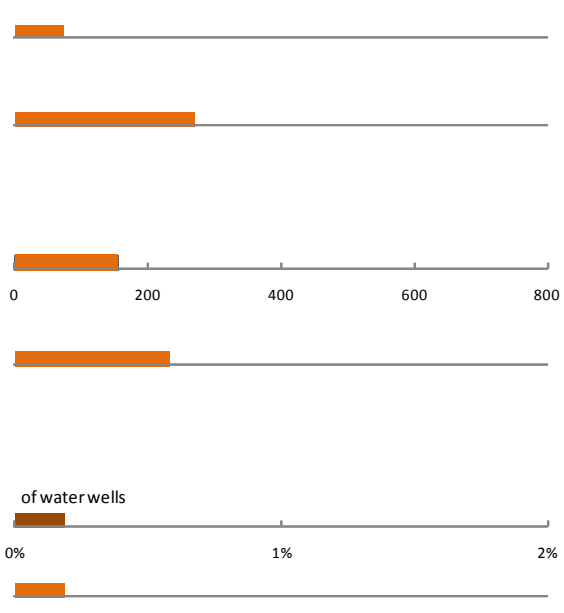
			Compares to Tri-County
INCOME INEQUALITY	Index of income inequality	0.389	☼
HOUSING SEGREGATION	Index of housing segregation	0.17	☼



Inner Suburbs have a fairly high level of income inequality, meaning that the available income is concentrated in a smaller percent of the population. Inner Suburbs have lower level of minority segregation, meaning that white-headed households are more likely to live alongside minority-headed households.

Social, Economic, and Environmental Factors

			Compares to Tri-County
CHILD POVERTY	% children who live in poverty	9%	☼
EDUCATION	% adults 25+ with a bachelors degree or higher	34%	☼
SOCIAL CONNECTION	% adults with civic participation in past month		
COMMUNITY SAFETY	# violent crimes per 100,000 people	156	☼
AFFORDABLE HOUSING	% households with unaffordable housing	29%	☼
PRIMARY CARE QUALITY	# preventable hospitalizations per 100,000 people		
ENVIRONMENTAL QUALITY	% water wells with nitrate contamination	0.2%	☼
BUILT ENVIRONMENT	% population living in a food desert	9%	☼



Inner Suburbs have a low rate of child poverty, as well as a high percentage of the population who hold a bachelors degree or higher. Many residents report having participated civically in the past month. The rate of crime in the Inner Suburbs is higher than in Farms and Fields and Small Cities, but lower than other areas. Many Inner Suburbs residents must pay a large portion of their income for housing. The water system in Inner Suburbs shows a low level of nitrate contamination. Many residents of Inner Suburbs have easy access to fresh food.

KEY
☼ better
= similar
worse

Behaviors, Stress, and Physical Condition

OBESITY	% adults who are overweight or obese
	% adolescents who are overweight or obese
TOBACCO	% adults who are current smokers
	% adolescents who smoked in past month
ALCOHOL	% adults who binge drank in past month
	% adolescents who binge drank in past month
ACCESS TO CARE	% adults with primary care provider
	# residents to each primary care provider
DISEASE PREVENTION	% children 19-35 months with recommended vaccinations
MENTAL HEALTH	% adults whose mental health was not good
	% adolescents with symptoms of depression

Data is not reportable at the geographic subgroup level for these indicators.

Health Outcomes

Compares to Tri-County

CHILD HEALTH	# asthma hospitalizations per 100,000 children			
ADULT HEALTH	# diabetes hospitalizations per 100,000 adults			
QUALITY OF LIFE	% adults with fair or poor perceived health status			
PREMATURE DEATH	% deaths before age 75	38%		☼
MATERNAL HEALTH	# infant deaths per 1000 live births			
CHRONIC DISEASE	# cardiovascular disease deaths per 100,000 people	159		☼
ACCIDENTAL INJURY	# accidental injury deaths per 100,000 people	26		=

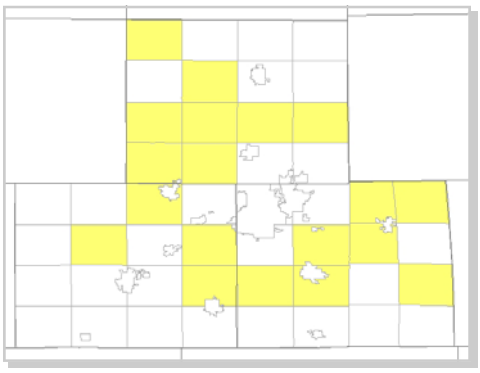
About 2/5 of all deaths in Inner Suburbs can be called "premature", meaning they occur before the age of 75. The rate of cardiovascular disease death is very high in Inner Suburbs , but the rate of accidental injury deaths is fairly moderate.

NOTE: Detailed descriptions of these measures, including year and source are available on pages 12-50

Countryside Suburbs

Population Characteristics

Total Population	67,082
% Black/African American (not Hispanic)	0.7%
% Hispanic/Latino, any race	3.1%
% White (not Hispanic)	93.0%
% under 18	23.1%
% 65+	13.1%
% Individuals in Poverty	6.5%
% Households with incomes over $75K	33.5%



This group includes

Townships in Clinton County:
Bengal, Eagle, Lebanon, Olive, Riley, Victor, Watertown Charter, Westphalia

Townships in Eaton County:
Chester, Eaton Rapids Township, Oneida Charter, Windsor Charter

Townships in Ingham County:
Alaiedon, Aurelius, Locke, Vevay, Wheatfield, White Oak, Williamston Township

NOTE: Detailed descriptions of these measures, including definitions, years, and sources are available on pages 12-50

Opportunity Measures

				Compares to Tri-County
INCOME INEQUALITY	Index of income inequality	0.429	↧everyone has equal income … one person has all income ↧ 0 <<<<< equality … inequality >>>> 1	=
HOUSING SEGREGATION	Index of housing segregation	0.19	↧minorities distributed equally … complete apartheid ↧ 0 <<<< integration … segregation >>>> 1	☼

The Countryside Suburbs group has a fairly high level of income inequality, meaning that the available income is concentrated in a small percent of the population. The Countryside Suburbs group has a low level of minority segregation—however, there are relatively few people of color living in these areas.

Social, Economic, and Environmental Factors

				Compares to Tri-County
CHILD POVERTY	% children who live in poverty	12.3%		☼
EDUCATION	% adults 25+ with a bachelors degree or higher	42%		☼
SOCIAL CONNECTION	% adults with civic participation in past month			
COMMUNITY SAFETY	# violent crimes per 100,000 people	180	0 200 400 600 800	☼
AFFORDABLE HOUSING	% households with unaffordable housing	33%		☼
PRIMARY CARE QUALITY	# preventable hospitalizations per 10,000 people			
ENVIRONMENTAL QUALITY	% water wells with nitrate contamination	0.6%	of water wells 0% 1% 2%	☼
BUILT ENVIRONMENT	% population living in a food desert	3%		☼

The High Value Suburban subgroup has a moderate rate of child poverty, as well as a high percentage of the population who hold a bachelors degree or higher. Many residents report having participated civically in the past month. The High Value Suburban subgroup has a lower rate of crime in the capital area, though many residents must pay a large portion of their income for housing. The water system in the High Value Suburban subgroup shows a moderate level of nitrate contamination, which may indicate farm runoff. Few residents of the High Value Suburban subgroup live in a food desert, meaning they don't have easy access to fresh food.

KEY
☼ better
= similar
worse

Behaviors, Stress, and Physical Condition

OBESITY	% adults who are overweight or obese
	% adolescents who are overweight or obese
TOBACCO	% adults who are current smokers
	% adolescents who smoked in past month
ALCOHOL	% adults who binge drank in past month
	% adolescents who binge drank in past month
ACCESS TO CARE	% adults with primary care provider
	# residents to each primary care provider
DISEASE PREVENTION	% children 19-35 months with recommended vaccinations
MENTAL HEALTH	% adults whose mental health was not good
	% adolescents with symptoms of depression

Data is not reportable at the geographic subgroup level for these indicators.

Health Outcomes

Compares to Tri-County

CHILD HEALTH	# asthma hospitalizations per 10,000 children			
ADULT HEALTH	# diabetes hospitalizations per 10,000 adults			
QUALITY OF LIFE	% adults with fair or poor perceived health status			
PREMATURE DEATH	% deaths before age 75	42%		=
MATERNAL HEALTH	# infant deaths per 1000 live births			
CHRONIC DISEASE	# cardiovascular disease deaths per 10,000 people	204		↗
ACCIDENTAL INJURY	# accidental injury deaths per 10,000 people	28		=

About four in ten of all deaths in the Countryside Suburbs area can be called "premature", meaning they occur before the age of 75. The rate of cardiovascular disease death is worse in this subgroup and the rate of accidental injury death is moderate.

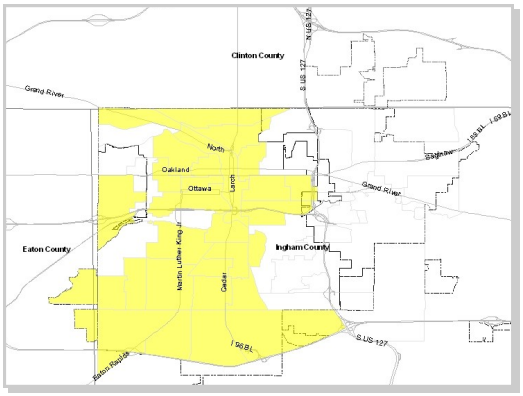
KEY
☼ better
= similar
↗ worse

NOTE: Detailed descriptions of these measures, including year and source are available on pages 12-50

Urban Low Price

Population Characteristics

Total Population	99,612
% Black/African American (not Hispanic)	20.6%
% Hispanic/Latino, any race	13.5%
% White (not Hispanic)	57.1%
% under 18	25.3%
% 65+	8.8%
% Individuals in Poverty	25.8%
% Households with incomes over $75K	13.4%



NOTE: Detailed descriptions of these measures, including definitions, years, and sources are available on pages 12-50

Opportunity Measures

				Compares to County
INCOME INEQUALITY	Index of income inequality	0.361	↧everyone has equal income — one person has all income↴	☼
HOUSING SEGREGATION	Index of housing segregation	0.25	↧minorities distributed equally — complete apartheid↴; 0 <<<< integration — segregation >>>> 1	🗲

The Urban Low Price subgroup has a moderately low level of inc
is not concentrated in a small percent of the population. Urban Low Price subgroup also has a very low level of minority segregation, meaning that white-headed households are much more likely to live alongside minority-headed households.

Social, Economic, and Environmental Factors

			Compares to Tri-County
CHILD POVERTY	% children who live in poverty	31%	🗲
EDUCATION	% adults 25+ with a bachelors degree or higher	29%	🗲
SOCIAL CONNECTION	% adults with civic participation in past month		
COMMUNITY SAFETY	# violent crimes per 100,000 people		
AFFORDABLE HOUSING	% households with unaffordable housing	37%	🗲
PRIMARY CARE QUALITY	# preventable hospitalizations per 10,000 people		
ENVIRONMENTAL QUALITY	% water wells with nitrate contamination		
BUILT ENVIRONMENT	% population living in a food desert	26%	🗲

The Urban Low Price subgroup has a very high rate of child poverty, as well as a high percentage of the population who hold a bachelors degree or higher. Urban Low Price residents must pay a large portion of their income for housing. Many residents of the Urban Low price subgroup live in a food desert, meaning they don't have easy access to fresh food.

KEY
☼ better
= similar
🗲 worse

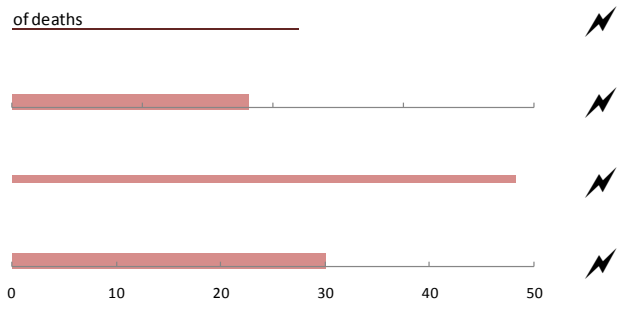
Behaviors, Stress, and Physical Condition

OBESITY	% adults who are overweight or obese
	% adolescents who are overweight or obese
TOBACCO	% adults who are current smokers
	% adolescents who smoked in past month
ALCOHOL	% adults who binge drank in past month
	% adolescents who binge drank in past month
ACCESS TO CARE	% adults with primary care provider
	# residents to each primary care provider
DISEASE PREVENTION	% children 19-35 months with recommended vaccinations
MENTAL HEALTH	% adults whose mental health was not good
	% adolescents with symptoms of depression

Data is not reportable at the geographic subgroup level for these indicators.

Health Outcomes

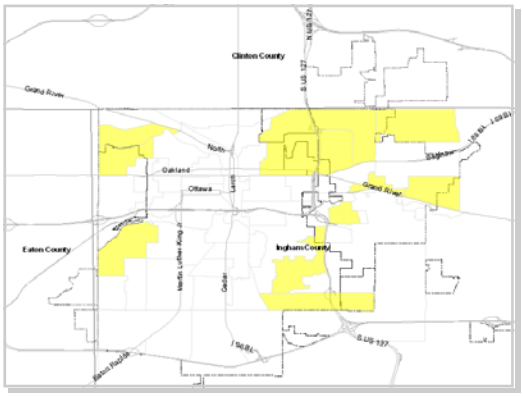
			Compares to Tri-County
CHILD HEALTH	# asthma hospitalizations per 10,000 children		
ADULT HEALTH	# diabetes hospitalizations per 10,000 adults		
QUALITY OF LIFE	% adults with fair or poor perceived health status		
PREMATURE DEATH	% deaths before age 75	55%	
MATERNAL HEALTH	# infant deaths per 1000 live births	9.1	
CHRONIC DISEASE	# cardiovascular disease deaths per 10,000 people	217	
ACCIDENTAL INJURY	# accidental injury deaths per 10,000 people	30	



Over half of all deaths in the Urban Low Price subgroup can be called "premature", meaning they occur before the age of 75, which is higher than the tri-county rate. The Urban Low Price subgroup also has a high rate of infant deaths. The rate of cardiovascular disease death is worse in the Urban Low Price subgroup and the rate of deaths due to accidental injury is also high.

NOTE: Detailed descriptions of these measures, including year and source are available on pages 12-50

Urban Mid Price



Population Characteristics

Total Population	109286
% Black/African American (not Hispanic)	6.8%
% Hispanic/Latino, any race	4.3%
% White (not Hispanic)	81.7%
% under 18	20.9%
% 65+	11.2%
% Individuals in Poverty	16.9%
% Households with incomes over $75K	24.6%

NOTE: Detailed descriptions of these measures, including definitions, years, and sources are available on pages 12-50

Opportunity Measures

			Compares to Tri-County
INCOME INEQUALITY	Index of income inequality	0.385	☼
HOUSING SEGREGATION	Index of housing segregation	0.46	🗲

↧everyone has equal income — one person has all income↴
0 <<<<< equality — inequality >>>> 1

↧minorities distributed equally — complete apartheid↴
0 <<<< integration — segregation >>>> 1

The Urban Mid Price subgroup has a fairly moderate level of income inequality, meaning that the available income is not concentrated in a small percent of the population. This subgroup also has a higher level of minority segregation, meaning that white-headed households are more unlikely to live alongside minority-headed households.

Social, Economic, and Environmental Factors

			Compares to Tri-County
CHILD POVERTY	% children who live in poverty	28%	🗲
EDUCATION	% adults 25+ with a bachelors degree or higher	35%	☼
SOCIAL CONNECTION	% adults with civic participation in past month		
COMMUNITY SAFETY	# violent crimes per 100,000 people		
AFFORDABLE HOUSING	% households with unaffordable housing	44%	🗲
PRIMARY CARE QUALITY	# preventable hospitalizations per 10,000 people		
ENVIRONMENTAL QUALITY	% water wells with nitrate contamination		
BUILT ENVIRONMENT	% population living in a food desert	8%	☼

Urban Mid Price subgroup has a very high rate of child poverty, as well as a high percentage of the population who hold a bachelors degree or higher. Many of the Urban Mid Price subgroup residents must pay a large portion of their income for housing. Some residents of the Urban Mid Price subgroup live in a food desert, meaning they don't have easy access to fresh food.

KEY
☼ better
= similar
🗲 worse

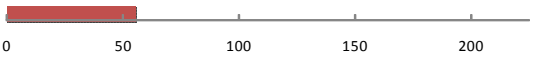
Behaviors, Stress, and Physical Condition

OBESITY	% adults who are overweight or obese
	% adolescents who are overweight or obese
TOBACCO	% adults who are current smokers
	% adolescents who smoked in past month
ALCOHOL	% adults who binge drank in past month
	% adolescents who binge drank in past month
ACCESS TO CARE	% adults with primary care provider
	# residents to each primary care provider
DISEASE PREVENTION	% children 19-35 months with recommended vaccinations
MENTAL HEALTH	% adults whose mental health was not good
	% adolescents with symptoms of depression

Data is not reportable at the geographic subgroup level for these indicators.

Health Outcomes

Compares to Tri-County

CHILD HEALTH	# asthma hospitalizations per 10,000 children			
ADULT HEALTH	# diabetes hospitalizations per 10,000 adults			
QUALITY OF LIFE	% adults with fair or poor perceived health status			
PREMATURE DEATH	% deaths before age 75	35%		☼
MATERNAL HEALTH	# infant deaths per 1000 live births			
CHRONIC DISEASE	# cardiovascular disease deaths per 10,000 people	56		☼
ACCIDENTAL INJURY	# accidental injury deaths per 10,000 people	8		☼

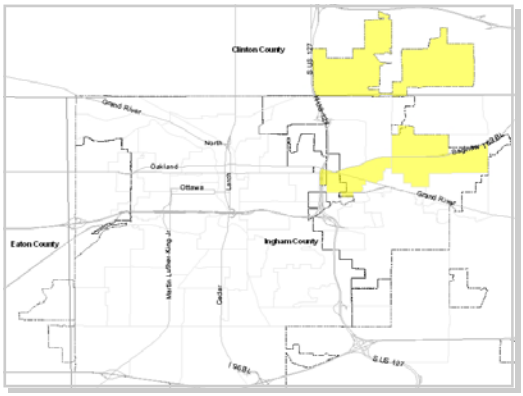
About a third of all deaths in the Urban Mid Price subgroup can be called "premature", meaning they occur before the age of 75, which is lower than the rate in the tri-county region. The rate of cardiovascular disease deaths is very low as well as the rate of accidental injury deaths.

NOTE: Detailed descriptions of these measures, including year and source are available on pages 12-50

Urban Upscale

Population Characteristics

Total Population	73,431
% Black/African American (not Hispanic)	4.9%
% Hispanic/Latino, any race	2.8%
% White (not Hispanic)	80.7%
% under 18	16.2%
% 65+	10%
% Individuals in Poverty	16.1%
% Households with incomes over $75K	38.8%



NOTE: Detailed descriptions of these measures, including definitions, years, and sources are available on pages

Opportunity Measures

Compares to Tri-County

INCOME INEQUALITY	Index of income inequality	0.395	↧everyone has equal income … one person has all income↧ 0 <<<<< equality … inequality >>>> 1	=
HOUSING SEGREGATION	Index of housing segregation	0.32	↧minorities distributed equally … complete apartheid↧ 0 <<<< integration … segregation >>>> 1	☼

Urban Upscale subgroup has a similar level of income inequality to the tri-county region, meaning that the available income is moderately concentrated in a small percent of the population. The Urban Upscale subgroup has a low level of minority segregation, meaning that white-headed households are more likely to live alongside minority-headed households.

Social, Economic, and Environmental Factors

Compares to Tri-County

CHILD POVERTY	% children who live in poverty	19.5%	↗
EDUCATION	% adults 25+ with a bachelors degree or higher	51%	☼
SOCIAL CONNECTION	% adults with civic participation in past month		
COMMUNITY SAFETY	# violent crimes per 100,000 people		
AFFORDABLE HOUSING	% households with unaffordable housing	44%	↗
PRIMARY CARE QUALITY	# preventable hospitalizations per 10,000 people		
ENVIRONMENTAL QUALITY	% water wells with nitrate contamination		
BUILT ENVIRONMENT	% population living in a food desert	0%	☼

The Urban Upscale subgroup has a moderately high rate of child poverty, as well as a very high percentage of the population who hold a bachelors degree or higher. Many residents must pay a high price for their housing. There are no residents of this area living in a designated food desert.

KEY
☼ better
= similar
↗ worse

Behaviors, Stress, and Physical Condition

OBESITY	% adults who are overweight or obese
	% adolescents who are overweight or obese
TOBACCO	% adults who are current smokers
	% adolescents who smoked in past month
ALCOHOL	% adults who binge drank in past month
	% adolescents who binge drank in past month
ACCESS TO CARE	% adults with primary care provider
	# residents to each primary care provider
DISEASE PREVENTION	% children 19-35 months with recommended vaccinations
MENTAL HEALTH	% adults whose mental health was not good
	% adolescents with symptoms of depression

Data is not reportable at the geographic subgroup level for these indicators.

Health Outcomes

Compares to Tri-County

CHILD HEALTH	# asthma hospitalizations per 10,000 children			
ADULT HEALTH	# diabetes hospitalizations per 10,000 adults			
QUALITY OF LIFE	% adults with fair or poor perceived health status			
PREMATURE DEATH	% deaths before age 75	20%	of deaths	☼
MATERNAL HEALTH	# infant deaths per 1000 live births			
CHRONIC DISEASE	# cardiovascular disease deaths per 100,000 people	45	0 50 100 150 200	☼
ACCIDENTAL INJURY	# accidental injury deaths per 10,000 people			

About a fifth of all deaths in the Urban Upscale subgroup can be called "premature", meaning they occur before the age of 75, which is lower than the rate in the tri-county region. The rate of cardiovascular disease death is lowest in the Urban Upscale subgroup.

KEY
☼ better
= similar
worse

NOTE: Detailed descriptions of these measures, including year and source are available on pages

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Speaking of Health Section

This section presents the data collected through eight focus groups conducted with traditionally hard-to-survey populations.

"Speaking of health…"

RESULTS FROM THE HEALTHY! CAPITAL COUNTIES FOCUS GROUPS

While quantitative (numbers) data presented elsewhere in the Community Health Profile is important, so too are the **experiences, thoughts, beliefs, and stories** from people in our community – particularly from persons who tend to have the significant health needs or belong to groups that have the greatest health disparities. These groups, unfortunately, also tend to groups that are underrepresented in conventional surveys. In keeping with our health equity paradigm, Healthy! Capital Counties deliberately sought out information about the health experiences and stories of traditionally hard to survey populations. To that end, we conducted a series of eight focus groups with an average of eleven people per group.

For our counties, the focus groups were designed to include the following groups:

- Persons with disabilities
- Persons recovering from substance addiction
- Persons who are uninsured
- Persons who have low incomes
- Persons who identify as Hispanic or Latino
- (including those who speak Spanish and those who speak English)
- Persons who identify as Black or African American
- Persons who are unemployed

Eight focus groups were held in February and March, 2012. These focus groups took place in various locations throughout the three county area; Charlotte, Lansing (Allen Neighborhood Center), Lasing (Black Child and Family Institute), Lansing (Foster Community Center), Lansing (Gier Community Center), Lansing (Peckham, Inc), Mason, and St. Johns. Each participant was awarded a $25 Meijer gift card upon completion of the group, and one person in each group was randomly selected to receive their choice of an additional $75 Meijer card or an Amazon Kindle. Many thanks to the following organizations for their generous assistance in coordinating and recruiting for these focus groups: Allen Neighborhood Center, Black Child and Family Institute, Capital Area Community Services, Clinton-Eaton-Ingham Community Mental Health, Cristo Rey Community Center, Lansing Latino Health Alliance, and Peckham, Inc.

Note about Spanish language focus group:
While most of the focus groups were conducted in English, one of the focus groups was conducted in Spanish. The audio file was transcribed first into Spanish language text, then professionally translated into English. The English translation is what is quoted in this document.

PARTICIPANT DEMOGRAPHICS:

93 total participants (91 completed registration forms)

Disability Status (participants may check more than one)	# participants
Not Currently Disabled	34
Mental Health Condition	10
Recovering from Substance Addiction	6
Physical, Developmental, or Sensory Disability	35

Employment Status (may check more than one)	# participants
Not working, looking for work	23
Not working, not looking	13
Working part-time	18
Stay at Home Parent / Homemaker	10
Disabled/Caretaker	11
Working full time	15

Race / Ethnicity (self-identified)	# participants
Black or African-American	17
Hispanic/Latino (any race)	34
More than one race	2
Native American	1
White/Caucasian	37
Not recorded	2

Age	# participants
18-21	10
25-34	10
35-44	8
45-54	18
55-64	25
65-74	6
75+	8

Health Care Coverage	# participants
Uninsured (total)	32
Ingham Health Plan	*13*
Barry-Eaton Health Plan	*6*
No program given	*13*
Medicaid	26
Medicare	20
Private Insurance	18
TriCare	2
Other	2

Gender	# participants
Female	66
Male	26
Not recorded	1

Summary of Key Issues

What were the **common concerns**?

Many people suffer from chronic diseases, often several at a time. This limits what they are able to do physically. Many blame genetics and their own personal behavior for their condition. People shared that affording healthy food was a common challenge. While persons might like to purchase fruits and vegetables, those with budgets that depend on food stamps cannot afford them. Some programs were praised that helped make produce affordable – community gardens, farmers' markets and the Double Up Food Bucks program. Many people felt that their children were likely to be less healthy than they are, due to screen time and lack of outdoor play.

What did these participants believe help to **make their health better**?

+ taking vitamins
+ eating healthy
+ time, skills, and money to prepare not-processed food
+ exercising
+ access to primary care
+ sidewalks and paths
+ social and neighborhood connection

What did these participants believe **make it harder to be healthy**?

- genetics & family history
- too many prescription medicines
- violence
- lack of medical care access
- stress
- affording food and medical care
- exposure to unhealthy food
- not enough help finding community resources
- manual labor jobs

What did participants say about **Health Reform**?

The medically underserved have a **whole spectrum of views about health reform** – ranging from people that know the details of the law and know what they will do, and people who are completely uninformed. Some are hoping to get health insurance, while **others plan to pay the fine** as it will be less expensive than paying for insurance. The participants do <u>not</u> wish to get information about heath reform or its new benefits at the Department of Human Services office. Instead, they **preferred neighborhood and community centers**, doctor's offices, community meetings, by mail and electronically.

What were suggestions for making the community healthier? (not ranked)

- ❖ Offer incentives to eat more healthy foods
- ❖ Help people cope better with stress and depression
- ❖ Make insurance affordable
- ❖ Increase access to specialty medical care, especially for children
- ❖ Improve transportation options for persons with disabilities
- ❖ More walkable neighborhoods
- ❖ Safe, well-lighted paths and trails
- ❖ Reduce violence
- ❖ Improve educational achievement

Health Outcomes

Illness and Death

What are the main health problems of the people participating in the groups?

Participants were asked to discuss their experience with chronic diseases. The most frequently mentioned were **chronic pain, diabetes, cancer, heart disease, and asthma**. Others shared that they suffered from injuries sustained while playing sports or in car accidents.

"Dealing with pain all the time, every day it's a struggle, I'm sure if I went in they'd diagnose me with at least mild depression. There's days when it's tough for me to want to get up and face the day. I enjoy the good days."

"I didn't care about my health my whole life and now I am paying the price for that. I have high blood pressure and diabetes now."

"I have diabetes and manage it through medications but also diet and exercise and have lost 30 lbs since I began doing that."

"I have a four and a half year old child (with asthma)…it has been a sort of partnership between the doctor and an asthma program that I heard about…it has been like some sort of team, including we, as parents, we have tried to improve and try to avoid giving him so much medicine."

FAMILY HISTORY

Many participants discussed health conditions that 'run in the family'. Participants discussed being vigilant or on the lookout for those conditions. Cancer, heart disease, and diabetes were the conditions most often mentioned. Several participants felt that genetics played a large role in predicting the health of an individual or a group.

Behaviors, Stress, and Physical Condition

Ways of living which protect from or contribute to health outcomes

DIET / EXERCISE / WEIGHT STATUS

"If I lived a healthy life and made good choices I would be healthier now."

EXERCISE

Exercise was commonly discussed as a way to get and/or stay healthy. People with chronic diseases discussed the paradox that they know they need to exercise more, but now that they have a chronic disease it's much more difficult to do so. Children were perceived as being less physically active than in the past. Many cited **walking** as an enjoyable exercise. Gyms were perceived as out of reach and expensive, however the YMCA and Alive! Center were discussed as having **scholarships or free programs** or facilities based on need. Many community attributes were seen as helping to encourage people to exercise, including **walkable neighborhoods, living in the country, parks, walking to school, and walking hallways at schools**. Ideas to encourage more people to exercise included more exercise facilities at worksites, places for families to go together to exercise, equipment loans, more low-cost fitness classes, and utilize the schools more to allow public to use gyms and pools.

COOKING FOOD

Generally, participants felt that today, people eat too much processed or convenience foods, and that in the past, people made healthier food from scratch. People cited **convenience** and **time** constraints as reasons for this change.

SCREEN TIME

Children spend too much time inside playing video games, watching TV, and playing on the computer. They spend **less time outside** and less time **being physically active**, which will make them unhealthy.

WEIGHT

Many participants discussed their weight as a personal health-related challenge. While some discussed successful weight loss, others struggled with gaining weight as they got older. People that were limited in their physical activity by chronic pain or disease felt that their weight was difficult to address. Some participants discussed their weight changing due to positive or negative lifestyle changes, including diet, exercise, and stress.

ACCESS TO MEDICAL CARE

"If you can't afford medical care, you suffer till you can't take it anymore and you wind up in an emergency room, where it you could've seen a doctor earlier, you wouldn't be there today."

PREVENTIVE CARE

Many participants valued preventive care but did not feel that the health insurance or health care system did enough to promote it or to pay for it.

DENTAL

Many participants do not have dental insurance, and can't afford to pay for private dental care. Those who are on Medicaid report that they c**annot find a private dentist** who will accept them as a patient. Some went to low-cost clinics like a health department dental clinic or LCC clinic for cleaning. Other strategies for managing without adequate access to dental care included asking family to pay for dental treatment, going to the Emergency Room to get pain medicine and antibiotics, and traveling back to their country of origin to get dental work done.

HOSPITALS and HOSPITAL BILLS

There was broad agreement that hospital care is incredibly **expensive**. Persons described being charged high prices for medicines while at the hospital, as well as receiving bills totaling hundreds of thousands of dollars. **Bills from hospitals were financially overwhelming.** Charity policies are not transparent. Even paying part of a bill under a charity policy is difficult for many people. People have no idea what they will owe when they go to a hospital for services. It was seen as **unfair** that while people 'who have nothing and don't work' don't owe anything for their hospital care, people who work and have homes and families do not get any help to afford the high cost of hospital care.

HEALTH DEPARTMENTS

Primary care delivered at the health departments was mixed – participants complemented doctors who offered **alternatives to medicines** for treatment, but some felt that often **doctors were rushed** and don't care about them personally. Other beneficial programs discussed included the **WIC** program, **Children's Special Health Care Services**, immunization programs, and **dental clinics** offered at all three health departments.

MEDICAL CARE

Only a few participants felt it was difficult to find a primary care physician. Access to pain treatment specialists locally was a concern. Participants with children with a serious medical condition reported the need to take their child out of the Capital area for treatment.

MEDICAID

While Medicaid recipients agreed that it was better than nothing, there were many problems with the coverage. Getting and maintaining Medicaid coverage is difficult due to caseworker turnover, changes in work hours, and miscommunication with DHS caseworkers. **Finding a physician** or a dentist who is accepting new Medicaid patients is very difficult. Several cited problems with medications or injections not being covered, and physicians who don't understand what's not covered under Medicaid. Many felt that the quality of care provided to Medicaid patients was inferior, both at the doctor's office and at the hospital.

"You can't get healthcare if you have Medicaid, and if you do the quality of care is not good."

"I have seen people with good insurance and those on Medicare/Medicaid go to the same hospital with the same condition and they are treated completely different."

MEDICINES and PRESCRIPTIONS

Many participants felt that there needed to be access to more low-cost prescription medicines. Several mentioned that they ration their own medicine to save on cost. Some get free prescriptions through drug company programs or use discount cards.

Commonly discussed was a feeling that their doctor prescribed them too many pills, and that those had too many side effects. Some people want to use more natural methods like herbs, supplements, or vitamins to manage those conditions, others want to use methods like exercise and diet to reduce their pills.

"Before I would take the medicine every day, and now – I know I shouldn't do it but I take it every other day, so it'll last me"

"People are not getting their children vaccinated now because they believe it leads to other health issues and I think it will be a major problem in the future with people not being vaccinated."

SUBSTANCE USE / MENTAL HEALTH

SMOKING

Many participants described being **raised by smoking parents** or being exposed to smoking while young through friends or celebrities. Some attributed present health conditions to this secondhand exposure. Some participants **started smoking at very young ages**, as early as 9 years old. A few smokers described their feelings when their children pretended to smoke in imitation of them. Many participants shared the story of **how they quit smoking**; often several times. Quit methods varied widely. Some felt that there should be programs to **help people deal with stress** as it's a trigger for smoking. Participants described family experiences with the serious health effects of smoking. While one participant felt that smoke-free policies were unfair, others stated that they enjoyed smoke-free restaurants.

MENTAL HEALTH

Participants suffered from mild to severe mental health problems. Several also had experienced a traumatic event, such as abuse, violence, or sudden death. Several were in recovery from substance addiction to drugs or alcohol. Some felt that their mental health treatment included too much medicine or too many pills. Some participants discussed a time when the mental health emergency or crisis system did not react appropriately.

Many persons with **chronic illnesses** discussed the intimate relationship between chronic disease and depression. When someone can no longer do what they've done previously, they become depressed. Many participants shared a belief in a **connection between their physical health and their mental health**.

Some participants discussed **stress** as a factor that limited their health. Stress from moving, from being a student, from work, or from life events makes it difficult to be healthy.

"I think that stress really ruins your health…I was much younger years ago, more energetic…but I had this stress because I had to keep moving forward with my home, my children, so they can be educated…And so, I was working day and night, and if you would have seen what I looked like, it seemed like I had more years than I do now."

PERSONAL ACTION

MOTIVATION

Many people cited **personal experience**s with family, particularly parents, as motivation for them to get or stay healthy. Also important to motivate was will power, incentives, and enjoyment of the activity.

VITAMINS

Many people discussed taking vitamins, supplements, herbs, or other holistic treatments. Some participants felt their doctor was not knowledgeable about vitamins or supplements.

FEAR

Many participants explained that they are very **fearful** of what will happen to them if they get sick or injured without health insurance. Others cited fear from seeing others in their family who have health problems as motivation to take positive actions. Many people shared their **fear for their personal safety**, and fear of crime.

CHILDREN

Most participants felt that children were likely to be **less healthy** than they are, because of obesity, poor diet, lack of exercise, and staying inside. However, many were hopeful that by living a good example or by **teaching children to make good choices**, their own children would be healthier than they are. Several participants mentioned the importance of their children getting a college education.

Parents are seen as **models** for their children's behavior. Kids who saw their parents doing healthy things are more likely to be healthy. Celebrities were seen as influencing what behavior was 'cool'.

"Kids do as they see, not as we say."

INFORMATION

Most participants felt **overwhelmed** by all of the information about health that they are being exposed to. They feel it's difficult to wade through it all to find what they need to know, and that **health advice is contradictory** and changes over time. They also feel like they and their children are overexposed to unhealthy choices through **advertising**.

Most participants were unaware of what health reform would mean for them or their family. Participants suggested a variety of ways they would **prefer to learn more about health reform**: billboards, 2-1-1, internet, via Capital Area Community Services agency, at neighborhood or community centers, meetings open to the community, at church, on the Secretary of State televisions, and in conversations with people.

Many people felt that finding out about what programs or resources are available was difficult. Not everyone had heard about the **2-1-1** information and referral service offered by the United Way. People felt that getting information at the Department of Human Services and other human service agencies was time-consuming and **frustrating** – and that you have to ask the right questions of the right people to get told about programs that might help you.

Social, Economic, and Environmental Factors

Factors that can constrain or support healthy living

SOCIAL / ECONOMIC

SOCIAL CONNECTION

Having social connections was one way participants discussed that they feel their community helps them to be healthier.

"The way we are today with this economy, there are more people joining together, there is much more contact with neighbors, they are sharing different things. Because they find that sharing more is sort of a relief and it improves your mental health when you have contact with other people, and in the neighborhood. I love where I am…in the group for older people, we have one every Wednesday for 2 hours, and I love it. Because you can go there and talk, and share a joke."

"In the area where I live there are so many robberies…but there is a Neighborhood Center, the Allen Street Neighborhood Center, where they seek solutions to problems, and they introduce one person to another. And they try to meet the needs that they can and they're always with the idea "well, let's do this thing." And I think; it's like an umbrella that opens up and covers many things."

RELIGION/CHURCH

In the course of the focus groups, many people mentioned the importance of **God or religious belief** in reference to their health or healing. A few discussed their church as a place where one can learn about **resources** available in the community as well as participate in **healthy activities**.

"As for health, I think about our great God who gives us health throughout life. God, if you pray to Him, if you fear Him, He gives you the great health that you need."

"I've had good health, because I've had three cancer operations, I thank God for saving me from death."

"At church we are going to start doing Richard Simmons (exercise)!"

"Our church is working on a resource center on the Northside (Lansing)."

WORK

Many participants viewed the worksite as a place where **healthy choices can be encouraged**. Others shared that the nature of their work negatively affected their health – through exposure to secondhand smoke and physical toil.

Many felt that there should be more **incentives at work** for being healthy, as well as facilities that encourage physical activity such as a gym and showers.

Employment was seen as something that should help people get insurance, but many participants' employers either **didn't offer health insurance** or the cost was too high to be affordable.

Some people discussed that if they work hard and get a better paying job or more hours, they **will no longer qualify** for programs that provide health coverage, such as the county health plans.

MIGRATION

"When I moved up here I thought I would be able to find a job quickly because I have always had a job. But there are none here that pay decent wages."

COST of FOOD and FOOD STAMPS

Many participants found that food that was 'good for you' or 'healthy' was the food that was most expensive. Many felt that they did not have enough money to purchase healthy foods.

"I am on a tight budget and cannot always purchase the foods that are the healthiest because they are more expensive"

Many participants **rely on food stamps to purchase food**; many felt that they did not receive enough to be able to afford healthy food items. Project Fresh program and WIC program were mentioned as helpful. Some felt that 'who got how much' in food stamps was not transparent or fair.

One participant suggested that an incentive program to purchase fruits and vegetables might work.

"If you buy so many percent of good food, you get so much off your bill. Give people an incentive and they'll do it."

AFFORD WEIGHT/ EXERCISE

Many programs or exercise facilities are **too expensive** for these participants to afford. The **YMCA** was mentioned as offering scholarships, some school-based programs for children have scholarships available, and one participant enjoyed visiting the **Alive! Center** at no cost. Weight Watchers and Curves were two programs mentioned that participants would have liked to do but could not afford.

EDUCATION

Teaching children good health habits, both at home and at school, is important. Additionally, **policies at schools** that reinforce healthy habits were also cited positively. Addressing **violence** in Lansing through teaching children better ways to solve problems was suggested.

A person's educational achievement and health were seen as linked by several participants.

"We don't know which of the two comes first: health or education opportunities."

"What would have prevented me from being in chronic pain? Education and a better job that was less physical. My problem was caused by wear and tear on my body. I know a lot of other construction workers in the same condition."

"The less educated you are… you don't live as long or have as healthy a life"

Participants identified a link between the educational opportunities or achievement in the community and the health of the community.

"Your community plays a role in what you have access to, specifically children and their education, opportunities offered to them and the stigmas attached to those communities."

"Latinos…have the highest dropout rate and the lowest graduation rate and this needs to be addressed in our community"

INSURANCE & HEALTH CARE SYSTEM

HEALTHCARE COST

Most participants agreed that the cost of healthcare was a barrier in a number of ways. Many people without any extra income have to **make difficult choices** when it comes to paying for healthcare services.

"The way the economy is right now you have to choose between your health and paying your living expenses."

Also discussed was the **lack of cost transparency** of healthcare. Many participants were surprised and shocked at the high cost of care, and that they do not have the knowledge ahead of time of what the service will cost.

"Healthcare is one of the only industries that you walk in blindly not knowing what to expect as it pertains to what you will be billed. I would like estimates or other options available."

AFFORD INSURANCE

Many participants discussed the **high cost** of health insurance. Most commonly, people wanted to purchase health insurance, but found that the price of the plan (premium) was too high given their income and their other expenses. For others, they could budget the premium into their household budget, but the cost sharing (deductibles and co-pays) were too high if they actually had to use healthcare services. Some were offered insurance through their employer but declined it as paying for insurance would mean a significant reduction in their take-home pay (up to 2/3 for one participant). Several participants mentioned that they were covered through a parent's insurance plan but weren't sure how they would afford to purchase insurance once they turned 26.

"Even if I don't use my insurance I still have to pay my fees but they never pay 100% of anything, I always have additional fees."

Solutions identified by participants included developing a plan similar to MiChild that adults can pay into and have nearly no cost-sharing, offer a low-cost plan for hospitalization coverage, offer affordable rates for people with pre-existing conditions, and making insurance offered by employers more affordable. Several participants mentioned that they delayed or skipped getting care because they could not afford it.

"The moment I canceled my insurance I've had this fear. If I go to a doctor, it's a bundle of money. So I do agree that if Obama gets insurance for all, because I really need it. I think if we weren't so afraid, we would be happier. So if we don't have insurance, we walk around in fear, and fear brings emotional problems, problems of all kinds."

UNINSURED

"You cross your fingers and hope you don't get sick."

"As far as insurance, I don't have any, because I worked as a child care, I watched children at home, and I was independent, and so I didn't have any insurance. And after I closed my daycare, I have been without insurance and without anything. I've been to the hospital, and I've gotten some hospital bills that I really could not afford."

One of the serious consequences of being uninsured discussed by participants was that **debt** caused by medical treatment could be devastating and overwhelming. One participant filed bankruptcy at age 26 because of medical bills. Some were able to get their bills reduced through charity care; however this was not always the case.

Several participants discussed the **working poor paradox** that those who did not work and who had nothing, were given free healthcare, while people who work and support themselves did not have affordable care available to them. Many felt that access to healthcare was a basic right.

"Medical care should be for everyone."

Being uninsured affected the medical care that was sought (people who are uninsured said they had **avoided or delayed** seeking care) and the uninsured perceived that the quality of care provided once they did seek it was of **lower quality**.

Many coverage programs for the poor, such as Medicaid and the County Health Plans, have large **coverage gaps** which makes it difficult to get the appropriate care. Some participants reported that they **deceived** medical providers in order to get medical treatment that they needed.

"I have asthma but no insurance, so I had to take my child to the doctor and act like he had asthma so I could get medications I needed."

HEALTHCARE LOCATION

Proximity to healthcare services was important to many people – however when some people felt they couldn't get the care they needed locally, they were willing to travel. A few reported that they **traveled a long distance** to reach a clinic that let them pay on a sliding scale according to their income.

ACCESS NETWORK

Participants identified a number of shortfalls with the healthcare safety net providers, including a lack of urgent appointments at health department clinics, the viability of Cristo Rey Health Clinic, the lack of providers willing to take Medicaid or accept cash for payment by the uninsured, and frustrations with DHS eligibility caseworkers. A few participants shared that not being fluent in English limited the healthcare options available.

COUNTY HEALTH PLANS

Many focus group participants were or had been members of one of the county health plans that cover those that live in Ingham, Clinton, or Eaton County **(Ingham Health Plan, Mid-Michigan Health Plan, Barry-Eaton Health Plan**). While the county health plans provided basic health care services, such as the ability to see a doctor, many participants mentioned things that the county health plans **did not cover** for them, such as emergency treatment, hospital services, specialty services, and pain services. For the Mid-Michigan and Barry-Eaton county health plans, several participants discussed how difficult it was

(and is) to get enrolled in the plans because they take so few new people each month.

"I have Ingham Health Plan and now I can actually go see a doctor and that wasn't available to me before I joined the plan."

"I've been on the waiting list for a spinal clinic for a year, have Mid-Michigan Health Plan, Plan B, getting nowhere."

"My husband is not covered yet (through Barry-Eaton Health Plan, Plan B), he has to be one of the ones who calls at the beginning of the month, and he needs his blood pressure medicine."

HEALTH REFORM

Most participants were **unsure** what the health reform law would mean for them personally. Some felt that they **didn't want to know** what the new law would mean for them. Some guessed that they **still wouldn't be able to afford** purchasing health insurance even under the new law. Some had doubts about the quality of care available to people who are newly covered, and about having access to care.

"I have no idea how the health reform law will affect me."

"Health reform is hidden from us."

"What do they expect us to live on if we are forced to pay for insurance?"

"In 2014 I'll pay the fines cause it'll be cheaper than getting insurance."

"I don't know what this is going to mean for my daughter and her husband, if they have to pay $500 a month for them to have health insurance, they just wouldn't have it."

"It's going to hurt the guy who is working and chooses not to have health care and force him to buy it."

"I don't think the quality of care will be there for these people who use the new care being provided to them."

"It'll take even longer till we get in to see a doctor."

When asked specifically how they would like to receive information or help with the health reform law, people replied with a wide variety of answers. Generally, **people agreed that they did NOT want to get information from the Department of Human Services** office. Many suggested going to a community or neighborhood center for information and help. Other suggestions included: mass mailing, computer/internet, at the doctor's office, churches, Secretary of State televisions, or community meetings. Information must be **written in everyday language** and accessible to those with different learning styles and disabilities.

COMMUNITY ENVIRONMENT

FOOD SYSTEM

Farmer's markets were repeatedly mentioned as positive additions to the food system, especially when they offer programs catering to low-income persons like Double Up Food Bucks and Project Fresh. Also listed as a benefit was the Salvation Army's **produce distribution** program. Some said they couldn't afford to shop at some Farmer's Markets as they were expensive or overpriced.

"Farmer's markets are great especially if you have food stamps because they double your buying power (Double Up Food Bucks Program)"

People desired to eat healthfully, but less healthy food was seen as both cheaper and more **convenient**.

"Because it is cheaper you are going to feed your family something out of a box instead of cooking something fresh for them."

Having a **neighborhood grocery store** was desirable, but not everyone had access to one.

"It'd be nice if there was a grocery store downtown by the capital. I have to walk to the Kroger in Frandor, it's closer than all the way out to Meijers. "

"Horrock's is affordable but there are not enough of them around to have good access."

Many people appreciated access to **community gardens** and mentioned gardening as a strategy to get more fruits and vegetables and to teach children about good food.

Several people discussed their concern with the quality of food available; particularly of concern were **additives, preservatives, and processed foods**.

"I don't think the food quality is good for them (children) with all of the additives in food now."

RESTAURANTS

While some restaurants offer healthier choices, many participants felt that there were **too many fast food restaurants** in their community. Some also mentioned that they felt overexposed to **unhealthy food advertising**.

TRANSPORTATION

Transportation to and from medical appointments was sometimes a barrier, although participants discussed programs that provide medical transportation. Persons with disabilities discussed the lack of **same-day or nighttime public transportation options** which limit their ability to access urgent medical care or participate in other social activities.

HOUSING

People discussed their housing in terms of environmental quality (black mold, asthma control) or **losing their home** and the stress that caused.

ENVIRONMENTAL HAZARDS

A wide variety of hazards in the environment were discussed in the focus groups, including new global diseases, **water quality, pollution, secondhand smoke** exposure, **noise** pollution, **black mold** in homes, and aspects of the **built environment**, including the proposed casino and liquor stores.

PARKS/RECREATION FACILITIES

While parks were often discussed as assets, some felt that fights in parks pose a safety threat.

PATHS/TRAILS/SIDEWALKS

Many participants mentioned trails and paths as assets that make it easier to be healthy in their community. Specifically mentioned were the **Lansing River Trail**, and trails in Mason, Delta Township, and St. Johns. Some were concerned about crimes being committed along the trails. Many felt that **more trails** would be better for their community.

The **walkability** of the community was important to several participants, many of whom lived in small towns. Specific improvements such as curb cuts and other improvements helped to increase access for disabled people, especially.

"We have sidewalks in our neighborhood (Meridian Township) which makes it easy to walk places."

COUNTRY

Living in the countryside was cited by several participants as helping them to be healthy, through being outside or learning to grow and eat healthy foods. Some felt that people who live in the country were less likely to want to travel in to town to take exercise classes.

SAFETY

An important theme was the need to feel safe at home and in your neighborhood. Many participants contrasted their feelings of safety living in different places in the capital area. Generally, people mentioned that they **felt safest in small towns**, but felt afraid living in Lansing. Some people **felt living in Lansing was safer in the past** than it is today.

Many discussed the **security measure**s they take to increase their feeling of personal safety, including locking doors and windows, not walking at night, walking with others, and walking with a weapon or dogs. Crime and violence was felt to negatively impact the community's health. Some people mentioned drive-by shootings, fights in parks, shootings, access to guns, and home break-ins. Medical marijuana abuse and drugs were also seen as things that made the community unhealthy.

Traffic safety was also a concern – some pedestrians and bicyclists did not feel safe using the streets and sidewalks.

Opportunity Measures

Evidence of power and wealth inequities

HELP

Getting help through the human services system and the medical system was widely discussed. For many, they did **not know where to start** getting help. Some were aware of the **2-1-1** information and referral phone service, some had used it, but others did not know about the service at all. Many felt that once you got started it would lead to find out about more services and programs. Some shared that asking for help was both **humbling and discouraging** when you are denied. When people get denied because they are slightly over the income guideline for a program, they are very upset.

Caseworkers at DHS need to be more knowledgeable about services. There needs to be **more education for everyday people** on services that are available. Create a website for the greater Lansing area that promoted community events and services.

"People just tell you you're denied they don't let you know where you can go for assistance or help."

POLICIES

While some felt that there were too many regulations, some participants mentioned some specific policy changes.

"I like how you can't smoke in restaurants or in certain areas."

"I feel that medical marijuana helps people with certain health conditions but it needs more regulation to cut down on people misusing the system."

RESPECT/DIGNITY

Many participants voiced a concern that people should be treated with **respect, dignity, and equality**, especially if they do not have health insurance, are from another country, speak another language, or are poor.

"Everybody needs to care about everyone else, not just themselves."

LANGUAGE

Spanish-speaking participants shared that they felt that both the opportunity to receive healthcare was reduced because they were not fluent in English, and also that the healthcare they did receive was not as high quality due to language barriers.

DISABILITY

Participants with disabilities discussed difficulty with **transportation** as well as the lack of appropriate materials and signage at health facilities in **accessible formats**, including Braille and large print.

Asset Inventory

CLINTON * EATON * INGHAM

Healthy!CapitalCounties℠
a community approach to better health

This asset inventory was compiled by the members of the Community Advisory Committee on March 1, 2012. This inventory will be used as part of the community health improvement planning process to explore the breadth and depth of community assets and resources that may be mobilized to address community health needs.

What is an **asset**?

An asset is anything that improves the quality of community life. It may be a person, group of people, place, or institution.

Individual Assets

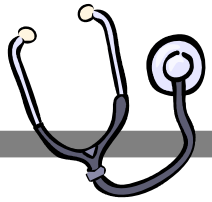
Personal assets held by each person residing in the three counties. Often personal assets may be leveraged into citizen and institutional assets through effective community organizing.

Citizen Assets

Assets held by small groups of people united around a common purpose, often closely tied to place, age, common identity, etc.
Grassroots associations, neighborhood associations, cultural organizations, faith-based organizations, parent organizations, youth organizations.

Institutional Assets

Assets held by institutions in the community. These are often well-established groups, employers, or governmental entities, and are both for-profit and not-for-profit organizations. Some institutions are comprised of groups of institutions — these are labeled 'organizational' assets.

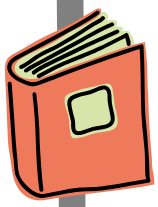


HEALTH CARE SYSTEM ASSETS
Hospitals
Urgent Care Centers
Private Physicians
Dentists & Dental Clinics
Pharmacies
Community Health Centers
Free Clinics
Public Health Departments
Community Mental Health
Mental Health Providers
Substance Abuse Treatment and Recovery Providers
Nursing Homes
Rehabilitation, Home Health & Hospice Providers
School/Parish Nurses
School-based/linked Health Centers
College Student Health Centers
Eye & Ear Care Providers
Disease-based Support Groups
Emergency Medical Transportation
Health Insurance Plans
County Health Plans
Alternative Medicine Providers
School Counselors/Psychologists
Physical and Occupational Therapists
Health Professions Schools
Medical Schools

RECREATIONAL ASSETS
School-based athletics
Community Education Programs
Community Centers
Swimming Locations
Parks and Public Recreation Programs
YMCA & Non-profit Recreation and Fitness Orgs
Private Membership Fitness Clubs
Bicycle Courses (BMX)
Bicycling Clubs
Community Dances
Conservation Activities (Stream Clean)
Lugnuts Minor League Baseball Team
Potter Park Zoo
4H and County Fairs
Golf Courses
Canoe/Kayak Rental
Riverboat
Horseback Riding/Stables
Walking/biking trails & Sidewalks

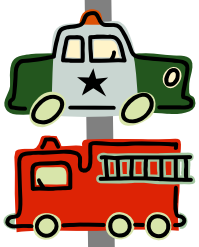
FOOD SYSTEM ASSETS
Full-service Grocery Stores
Farmer's Markets
Restaurants with healthy food choices
School Lunch Program
Corner Stores with produce
Food Policy & System Groups
Food Pantry/Bank/Commodities
Community Gardens
Garden Supplies
MSU Extension Service
Community Supported Agriculture Farms
Home-delivered Meal Services (Meals On Wheels)
Congregate Meal Sites (summer kids/senior)
Food Purchasing Programs (SNAP/WIC)
Project Fresh (WIC/Seniors)
Double Up Food Bucks Program

CULTURAL ASSETS
Museums
Michigan State University
Community Events and Festivals
Performing Arts Organizations
Neighborhood Identities (i.e. Old Town)
Media Organizations
Historical Organizations
Crafts and Enrichment Classes/Resources
Public Spaces
Nature Centers



EDUCATION ASSETS
Childcare and Preschool Providers (0-5)
Intermediate School Districts
Community Centers
K-12 School Districts
Public Libraries
Nature Centers
Senior Centers
Michigan Works!
MSU Extension Service
Colleges and Universities
Vocational/Trade Schools
Charter & Private Schools
Truancy Intervention
Refugee Development Center
Homeschool Organizations
Infancy to Innovation Collaborative
Tutoring/Mentoring Orgs
Virtual & Online Learning

ORGANIZATIONAL ASSETS
Economic Development (LEAP, Prima Civitas)
Non-Governmental Orgs
Multi-sector Coalitions (i.e. Substance Abuse Prevention, Great Start, etc)
Faith-based Organizations
Human Services Collaboratives
12-step Organizations (AA)
Chambers of Commerce
Local Charities, Grant-makers, & Foundations
Service Orgs (Lions, Kiwanis)
Crisis Intervention
Informal groups and meetings



PUBLIC SAFETY ASSETS
Neighborhood Watch
Police and Fire departments
Jails
Probation and Parole Officers
Anti-bullying Organizations
Domestic Violence & Crisis Response Orgs
Local Public Health Departments
State Police / Federal Agencies
Emergency Operations Centers
National Guard
Law Enforcement Training Centers
Environmental Protection Organizations
Emergency Preparedness Coalitions
School Liaison Officers

HOUSING ASSETS
Homeless Prevention and Housing Organizations
Home-building Charities (Habitat)
Aging In Place Efforts
Weatherization, Home Improvement, and Home Safety Programs
Rehab Programs
Foster Care Homes (Adult/Child)
Subsidized Housing Developments
Rental Housing Landlords and Developments
Assisted Living Facilities

TRANSPORTATION ASSETS
Public Transportation Providers
Park n' Ride & Carpool Services
Mobility Managers
Health & Senior Visit Transportation Providers
Ambulances
Regional Transportation and Land Use Planning
Bicycle Infrastructure
Trail System
Complete Streets Policies
Roads/Road Commissions
Taxis
Train Service
Long Distance Bus Services
Airport

EMPLOYMENT ASSETS
Major Employers
Small Employers
Farmers & Rural Employers
Self-Employed & Startups
Peckham, Inc.
Rehabilitation Services
Labor Organizations
Volunteer Organizations
Americorps/VISTA/Service Corps
Unemployment and Job-placement Services
Economic Development Departments
Public Employers (State of MI, local)
Chambers of Commerce
Business Associations
School Co-op & Internships

Next Steps

This report is only one step in our comprehensive Community Health Assessment and Community Health Improvement Planning process.

Next Steps

This report presents a wide array of data on the health of the community — both in breadth and in depth. **We want to share this report with the community as widely as possible.** Please contact us if you are interested in a presentation of the report and the process to your organization or community group.

E-mail info@healthycapitalcounties.org

COMMUNITY DIALOGUES in June and July

Following the publication of the report, we invite the community to participate in one of several community dialogues that will be held to gather additional input. These dialogues will allow us to incorporate the lived experience of Tri-County residents into our strategies for improving community health. In addition to determining the health issues which are most important to address in our communities, the dialogues will highlight the interconnections between our health and other social concerns such as housing, employment, safety, and inequality. The dialogues are open to all residents of Clinton, Eaton, and Ingham counties. They are an important opportunity for community members to have a voice in shaping priorities and strategies for improving community health.

Dansville	**Tuesday, June 26**	**7:00 pm**	**1362 Mason Street (the old fire station)**
East Lansing	**Thursday, June 28**	**1:00 pm**	**Hannah Community Center, 819 Abbot**
DeWitt	**Tuesday, July 10**	**6:00 pm**	**St. Francis Retreat Center, 703 E. Main St**
Eaton Rapids	**Thursday, July 12**	**6:00 pm**	**Eaton Rapids Medical Center, 1500 S. Main**
St. Johns	**Friday, July 13**	**11:00 am**	**Clinton Commons, 1105 S. Scott Rd**
Lansing	**Tuesday, July 17**	**7:00 pm**	**Cooley Temple Conference Center, 217 S. Capitol Ave**
Charlotte	**Thursday, July 19**	**5:30 pm**	**AL!VE, 800 W. Lawrence**

To register for a community dialogue, please visit www.healthycapitalcounties.org or call (517) 887-4428.

IMPROVEMENT PLAN

Following the community dialogues, we will be working to develop a Community Health Improvement Plan. This plan includes measureable goals, objectives, and strategies to improve the community's health.

Information gathered at the community dialogues will be considered along with data from this report, to determine strategic community health issues, community health improvement ideas, and ultimately a final improvement plan. This improvement plan is intended to present a coordinated plan of action for health improvement across Clinton, Eaton, and Ingham counties. The plan is not intended to supersede or replace current coalition-level plans, but rather to coordinate action across the region.

The improvement plan will then be used by hospitals, health departments, and community organizations to inform their own agency and organizational-level strategic plans.