Ingham County
Health Department

Ingham County Community Health Improvement Plan (CHIP) 2017

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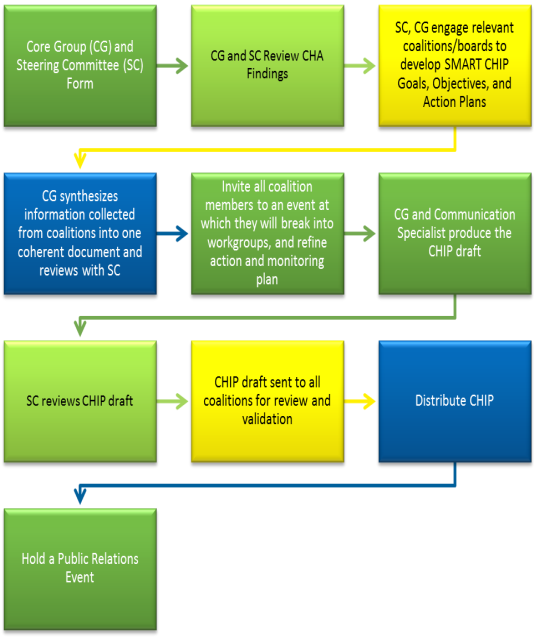
Executive Summary

Background: Ingham County Health Department (ICHD) promotes community health by monitoring health status, identifying major health problems and engaging stakeholders in partnership to develop strategies to achieve the highest possible level of health to local residents. The Community Health Assessment unit of ICHD convened a core coordinating staff group to follow up on the Healthy! Capital Counties Assessment. The group then engaged stakeholders in a steering committee to develop a Community Health Improvement Plan (CHIP). The CHIP includes common goals for five areas of needs, evidence based objectives and strategies, and specific tactics on how to implement the strategies by committed organizations and leaders in the community.

Data Sources: The CHIP steering committee relied mostly on the data from H!CC and how priority areas were identified, then looked at other community health improvement plans from areas in and out of Michigan and the Public Health Accreditation Board (PHAB) to agree on a structure for the CHIP report. The model of engagement we followed aligned with the national model of Mobilizing for Action through Planning and Partnership (MAPP) model. Where there were data gaps in the H!CC for some priority areas, the subcommittees focusing on that priority area were encouraged to seek supplemental data sources to understand needs and address them accordingly.



Data Review: The CHIP Steering Committees divided into subcommittees to have more elaborate discussions while reviewing data specific to the priority areas they signed up for and determined the problems then developed fish bone diagrams to better describe as a result of discussions, the roots causes behind the problems. For example ***lack of access to primary care providers*** that serve vulnerable groups is a problem rooted into five factors namely, recruitment, demand for services, retention, infrastructure, and lack of collaboration around primary care. ***The problem of access to quality care*** was defined as patients not knowing what to expect and therefore cannot determine whether or not they are receiving quality health care. This is rooted into communication gaps, ability and time for people to be empowered to speak up, technology and material gaps, and patient inclusion in discussing quality care with provider institutions. ***Problems linked to Chronic diseases*** in Ingham County account for seven of the top ten leading causes of death in Ingham County. These are rooted into factors limiting access to physical activity or healthy eating and factors conducive to chronic asthma and stress, all leading to high blood sugar, high cholesterol, and high blood pressure, which lead to diabetes and heart diseases. Stress from financial instability and the inability of someone to move from the bottom 20% to the top 20% household incomes in his/her lifetime contribute to disparities in health outcomes such as heart attacks, diabetes and depression; therefore the ***Financial Stability and Economic mobility*** subcommittee reported that 23% of Ingham county residents are living in poverty and 22% are employed but struggle to meet basic needs; and only 6.1% of Ingham County residents who are born in the lower income brackets are able to move up to the 20% in their lifetime. Finally, the priority ***behavioral and mental health*** is important because overall health is not limited to physical health and about one in twenty five adults in Ingham County suffer from poor mental health days that affect their daily living. Housing conditions, substance abuse, cultural stigmas and incompetence in first aid trainings to diagnose behavioral and mental health are some of the root causes linked to this problem.

Plan Summary: Priority Areas and Objectives

Access to Primary Care I	Access to Quality Care II	Chronic Diseases III	Financial Stability and Economic Mobility IV	Behavioral and Mental Health V
1. By September 30, 2018 the Access to Primary Care Providers workgroup will have defined the scope of the access problem in Ingham County. 2. By September 30, 2020, there will be a 5% increase in the enrollment into loan repayment programs among primary care providers (Family Practice, Internal Medicine, Pediatric, Obstetric and Gynecology physicians as well as psychiatric care residents and new providers.) 3. By September 30, 2020 Michigan based health professional schools and colleges will develop a local pipeline of college students to become primary care providers including physicians, physician assistants and nurses	1. By September 30, 2020 health care organizations and providers participating in this CHIP process will report a 5% increase in the number of patients who perceive that they are receiving quality health care according to US department of Health and Human Services. 2. By September 30, 2020, providers, particularly medical professionals, interns, practice providers, students and resident fellows will have the opportunity for continuous education on quality of care, through established training programs that are routinely evaluated for improvements. 3. By September 30, 2020 members of the Mid-Michigan Asthma Coalition will recruit providers to agree on a policy to implement evidence based guidelines that will improve the coordination of outreach, education and engagement between physicians, nurses and other clinicians. 4. By September 30, 2020, members of the Mid-Michigan Asthma Coalition will report an increase in the use of evidence based guidelines for asthma management, (e.g. asthma action plan, by at least one new school in Ingham County. 5. By September 30, 2020, the Mid-Michigan Asthma coalition will continue to work on policy and system changes across the sectors leading to at least one such change in one of the sectors.	1. By 2020 improve by at least 2% the variety of reduced cost fresh fruits and vegetables in neighborhoods known as food deserts in Lansing that have higher concentration of low income Black and Hispanic populations. 2. By September 2018, provide both indoor and outdoor physical activity opportunities within the Sparrow main campus facility. 3. By 2020 Sparrow Health Systems will increase by a 2% participation in their health education, risk identification and management strategies to increase chronic disease prevention opportunities. 4. By 2020, the YMCA of Lansing will increase by a 2% participation in their diabetes prevention and management programs. 5. By 2020, ICHD will increase by 2% participation in their chronic disease prevention and management programs. 6. By 2020, Tri-County Regional Planning Commission will create a Land Use and a Regional Non-Motorized Transportation Plan Advisory groups to initiate implementation plans that will residents' ability to safely and conveniently travel by foot, bike or other mobility devices for recreation or work purposes in parks and on/off-roads non-motorized facilities.	1.1 By December 2019, increase from three (3) to six (6) banks and credit unions in Ingham County offering bank accounts that meet the *Bank On* account standards promulgated by the national coalition of *Cities for Financial Empowerment.* 2.1. By December 2018, pilot a small loan program serving as a viable social enterprise for local lenders and a resource for people in need of emergency, short-term loans that are safe and accessible. 2.2. By December 2018, increase from five (5) to forty (40) Ingham County residents who open an *EARN* match-savings/ Individual Development Account through the Asset Independence Coalition (AIC) each year. 3.1. By December 2019, engage at least 300 county residents/ organizational leaders in dialogue regarding research-based and local connections between exposure to violence and economic mobility. 3.2. By December 2019, equip forty-five (45) local law enforcement, justice, education and health practitioners with tools and resources to identify and dismantle racial inequities. 3.3. By December 2019, increase the number of residents by 100, ranging from ages sixteen (16) through twenty-four (24) who are enrolled in the MY Lansing Mentoring Network.	1. By 2020, improve access and availability of Behavioral Health services (MH and SUD) in the tri-county area that will be measured by decreasing numbers of denials to inpatient psychiatric services and increasing numbers of mild to moderate non-emergency cases of clients who are offered Behavioral Health (BH) services. 2. 3. By September 30, 2020 increase the use of research based behavioral health interventions 3. By September 30, 2020, enhance and improve the behavioral health screening protocol and practices within primary care and behavioral healthcare settings. 5. By September 30, 2020 stakeholders will reduce stigma surrounding access to behavioral health services and improve community health and wellness

P.S. The number variation under column IV are due to three different goals in this priority area.

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Collaborative Partnership

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Acknowledgement

Many people and organizations across Clinton, Eaton and Ingham counties participated in the assessment and planning processes. Sincere thanks go to the members of the Healthy! Capital Counties Workgroup. In this planning phase, the steering committee continued to collaborate with regional partners and focused on Ingham County for specific goals, objectives and strategies.

Community Health Improvement Plan-Project Coordination

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Priority Areas

Access to Primary Care Providers and Access to Quality Care

Workgroup Members

Barbara Ball, McClure, MSU College of Human Medicine Outreach and Engagement
Brian Brown, McClaren Greater Lansing
Stella Cash, Sparrow Health System
Sheri Clark, McClaren Greater Lansing
Mary Anne Ford– Capital Area Physician Experience
Russ Kolski, Ingham County Health Department
Velma Kyser, Cristo Rey Community Center
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Chronic Diseases

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Cathie Webb, McLaren Health Plan
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Leslie Polack, Sparrow Hospital
Molly Polverento, Ingham County Board of Health, MSU College of Human Medicine
Casey Thompson, The YMCA of Lansing

Priority Areas	Workgroup Members
Financial Stability and Economic Mobility	Angela Waters Austin, MY Lansing MY Brother's Keeper Edythe Hatter-Williams, Capital Area Michigan Works Patricia Hemingway, Capital Area United Way Su A'lyn Holbrook, Ingham Department of Health and Human Services Velma Kyser, City of Lansing Jaclynn Lloyd, Ingham County Health Department Sruthi Naraharisetti, City of Lansing Shannon Nobles, Michigan League for Public Policy Amber Paxton, City of Lansing Jennie Pollack, Central Michigan 2-1-1 David Reyes, Asset Independent Coalition Eric Schertzing, Ingham County Treasurer and Land Bank Chair Michelle Strazs, Capital Area College Access Network Jessica Yorko, Ingham County Health Department
Mental and Behavioral Health	Marge Brehmer, Sparrow Behavioral Health Services Kevin Brooks, Michigan State University Jeff Brown, Communities In Schools of Michigan Julia Cawvey, Communities In Schools of Michigan Robert Glandon, Michigan State University Joel Hoepfner, Community Mental Health Authority of Clinton, Eaton and Ingham Counties Sara Lurie, Community Mental Health Authority of Clinton, Eaton and Ingham Counties Amy Moore, Ingham County Health Department Karika Parker, Michigan Public Health Institute Susan Peters, Barry-Eaton District Health Department Regina Traylor, Ingham County Health Department

Mission of Ingham County Health Department

Our mission is to protect, improve, and advocate for the health and well-being of our community by identifying and advancing the conditions under which all people can achieve optimum health. We do this through programs to prevent and control communicable diseases, programs to protect citizens from environmental hazards and several efforts and programs to link county residents to an organized system of health care. ICHD also conducts research to document the health status and health problems of the community and works with the community to develop strategies to improve health and well-being.

Vision of Ingham County Health Department

Excellence in health and well-being for all, honoring our diverse community.

Public Health Accreditation Board (PHAB)

The purpose of the community health improvement plan is to describe how the health department and the community it serves will work together to improve the health of the population of the jurisdiction that the health department serves. The community, stakeholders and partners can use a solid community health improvement plan to set priorities, direct the use of resources, and develop and implement projects, programs, and policies. This process is one of the PHAB compliance criteria.

Reflections On Process

"For me, the correlation of violence in a region with economic mobility was an eye opener." Amber Paxton, City of Lansing

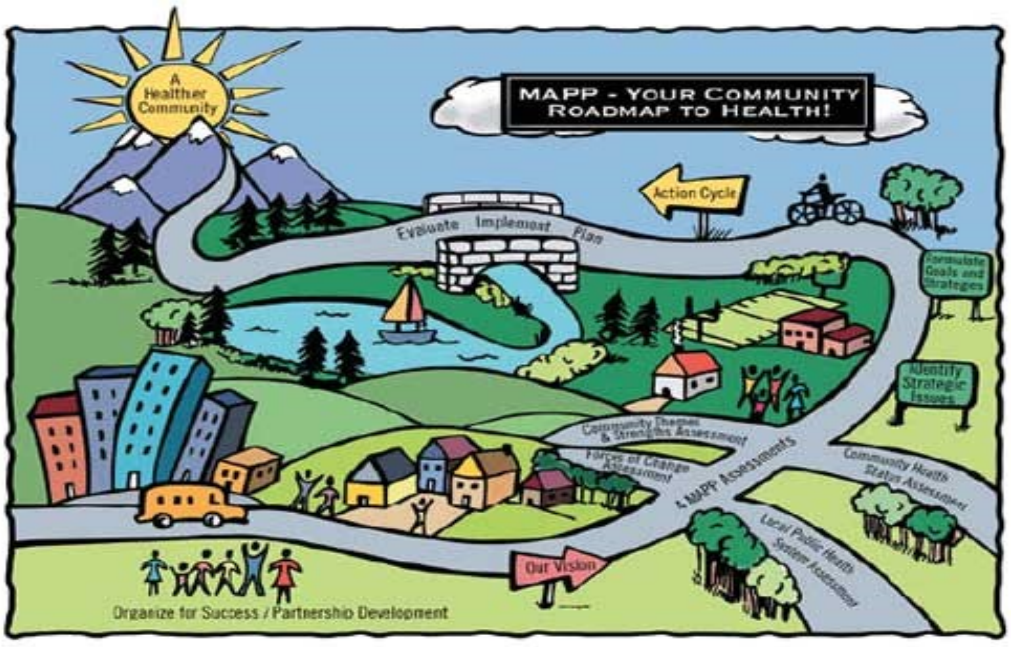
"Impressed by thoughtful and committed participants." Robert Glandon, Michigan State University

"Connection to all priority objectives and plans was great to allow additional connections and activities identified between groups/priorities." Joel Hoepfner, Community Mental Health Authority of Clinton, Eaton and Ingham counties.

"I took away all the learning from experts around the table and commit to lead the Healthy Lifestyle committee of the Capital Area Health Alliance in their goals as it relates to the CHIP." Kathleen Hollister, Capital Area Health Alliance.

"The process is an always evolving process and goals and objectives should reflect necessary changes as needed; I will be assisting with the data collection related to Access to Primary Care providers to identify those that are planning to retire within the next 1-5 years window." Joe Tran, Michigan Primary Care Association

"MSU College of Human Medicine will be involved in several of the implementation strategies." Molly Polverento, MSU College of Human Medicine.



BACKGROUND

The Ingham County Community Health Improvement Plan (CHIP) was developed based on the results of Healthy! Capital Counties (H!CC), a regional Community Health Assessment for Ingham, Eaton and Clinton counties conducted in collaboration with Barry-Eaton District Health department and Mid-Michigan District Health department in 2015.

A Community Health Improvement Plan (CHIP) is an action-oriented plan outlining the priority community health issues (based on the community health assessment findings and input from stakeholders, community members), 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.

Vision: The vision of the Healthy! Capital Counties Community Health Improvement Process and CHIP 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

Mission: ICHD's mission is to protect, improve, and advocate for the health and well-being of our community by identifying and advancing the conditions under which all people can achieve optimum health.

ICHD does this through programs to prevent and control communicable diseases, programs to protect citizens from environmental hazards and several efforts and programs to link county residents to an organized system of health care. ICHD also conducts research to document the health status and health problems of the community and works with the community to develop strategies to improve health and well-being.

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 the Community Health Profile included all of the residents living in Clinton, Eaton, and Ingham counties.

The CHIP however, will be using a collaborative process in each of the counties to develop and implement objectives that are specific to the needs of each county, measurable, achievable, relevant and timely for the partners involved in the planning process.

H!CC Model

The H!CC project model was adapted from The Association for Community Health Improvement Model. 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 workgroup and project 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.

CHIP Overview

What is the Ingham County CHIP?

- A plan of attack to drive improvements in our top health priority areas through multiple, simultaneous interventions
- A response to Ingham County-specific priorities in the *Healthy! Capital Counties* Community Health Needs Assessment

Why do it?

- To drive categorical improvements in the top health priority areas in Ingham County
- To establish rally points and collective approaches that we can integrate into strategic plans and action plans of organizations throughout the county
- To create even more fertile ground for attracting new residents, encouraging economic development, and improving opportunities for better life and health outcomes among Ingham County residents

How?

- Workgroups emanating from the Steering Committee will focus on specific a priority.
- Create strategic priorities from the five priority areas identified through Healthy! Capital Counties; in this case two of these were combined into one. (Access to Primary Care and Access to Quality Care were addressed in one workgroup)
- Elaborate on the problems.: nuances, data, trends, research, and social contexts within Ingham County
- Develop 2-3 overarching goals for each strategic priority
- Develop 2-3 SMART objectives for each of the overarching goals
- Within each SMART objective, outline 2-4 strategies with action plans
- When possible include specific tactics leading to the strategies
- Include process and outcome measurement for strategies and objectives
- Identify the evidence supporting the strategies

Glossary Of Terms

Evidence-base: Strategies that are backed by findings and recommended by trusted sources; for examples of evidence based programs addressing socio-economics root causes of health, check this link http://www.ncjp.org/saas/ebps/registries

Goals: Broad or general statement of desired change or end state; Can refer to a population's (or sub-group's) health status; Can refer to characteristics of the public health system; Should be measurable, but does need to have means to measure it embedded

Lead Role: Partner on that strategy for one of the priority areas, that will be the primary contact for monitoring of tactics implementation of a certain strategy. You may collaborate on data collection, the priorities and the plan, but… maintain flexibility for each partner to tackle the priorities and take the actions for which they feel best suited.

Objectives: Measurable statement of specific desired change / end state. *Contains an "Outcome Indicator/measure "that quantifies achievement of the Objective.;* SMART objectives are a common framework. **S**pecific, **M**easurable ,**A**ttainable, **R**elevant, and **T**ime-bound

Outcome Measure: Objectives documented with Outcome Indicators reflecting the data. Can be short-intermediate-and/or long-term. Question to ask: What can we track at the highest level, to measure whether or not we are moving the needle and making a difference in this priority?

Performance Indicators/ Measurement: Measures that quantify how well a strategy's tactic(s) are working, or "performing."

Strategic Priority Area: One of few community health and/or public health system needs or assets identified during a data synthesis process, as the targets/subjects of a Community Health Improvement Plan. Determination is based on a combination of factors (Check Kansas CHIP handbook for examples of factors)

Strategy: A general approach or coherent collection of actions which has a reasoned chance of achieving desired objectives.

Tactic: Specific programmatic, policy or other action that implements or "operationalizes" a strategy.

Sources and examples:

http://www.ncjp.org/saas/ebps/registries;

http://assets.thehcn.net/content/sites/kansas/CHIP_Handbook_2014.pdf

http://www.naccho.org/uploads/downloadable-resources/NACCHO_GoalsandObjectives_05-09-12Final-Slides.pdf

http://www.naccho.org/uploads/downloadable-resources/Final-Planning-for-CHIP-Monitoring-and-Evaluation-Participants-Slides.pdf

CHIP Process

Prioritization Methodology:

The Healthy! Capital Counties (H!CC) Community Health Profile and Health Needs Assessment produced a variety of data from a variety of sources about the health issues in the tri-county area. The report was used to identify the health issues to be prioritized for a unique CHIP in each of the counties. The work group and project staff utilized the consensus criteria method, as outlined below:

- Identifying the criteria to be considered when evaluating the issues;
- Selecting weights for each criteria; Identifying the issues to be evaluated, based upon the community profile and health needs assessment report;
- Engaging stakeholders in selecting the most important issues for each criteria; and
- Applying the weights to the stakeholder feedback

Details of the prioritizing methodology can be found in the Next Steps section of the Healthy! Capital Counties report on page. 120.

Priority Areas (according to the H!CC report):

1. Chronic Disease priority workgroup
2. Mental Health priority workgroup
3. Financial Stability
4. Access to Primary Healthcare providers and
5. Access to Quality Healthcare

CHIP Development Process:

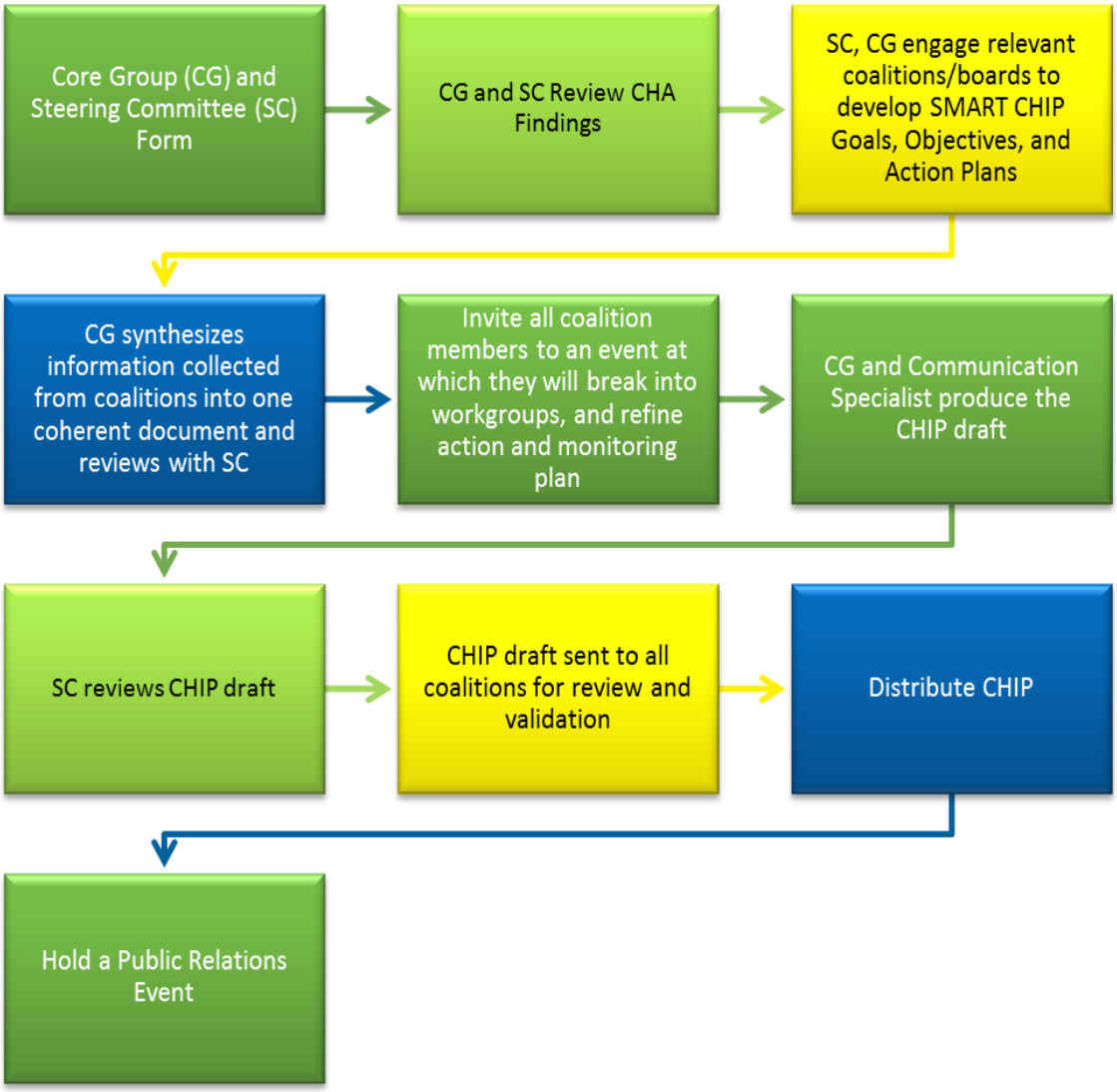
In Spring of 2016 a core group of ICHD staff convened as a core group to initiate and lead the CHIP process for Ingham County. The core group soon after formed a Steering Committee of about 50 members from lead health care providers to non profits and community members representation. The role of the steering committee is to participate in and monitor the development and implementation of the plan. Following the first Steering Committee meeting in June, four workgroups were formed to cover the five priority areas identified by the assessment workgroup members, two of which were then combined into one workgroup for the CHIP.

Workgroup members dived into the priority area to develop strategic priorities, goals and objectives and connect the core group staffing this process to coalitions or boards that would be interested in including to specific strategies, tactics and performance measures for each of the objectives. Lead organizations had to be identified for various objectives and strategies to facilitate the monitoring process.

Communication:

From March to September 2016, the core group met on average every other week, the steering committee met monthly and workgroups met on average 2-3 times within a month period. Coalitions and boards convened meeting times as needed and staff from the core group facilitated the strategies development process. After September 2016 to July 2017, the core group continued to follow up with individual workgroups members to develop the plan. All the documents produced during the process were shared on an electronic project management platform.

CHIP Flow Process



Building On Collective Impacts

In the first CHIP steering committee meeting, members laid out the assets this community brings to the table and what components we need for a successful CHIP. Listed below is their collaborative findings:

What are we good at?

- Collaboration and Coordination: ICHD gathers data from many sources to measure programming needs in the community. ICHD works with many partners such as the Neighborhood Network Centers to provide neighborhood level community health improvement. Staff engages the coordinators of these centers in a monthly dialogue about the needs of the residents in their neighborhoods. Employees also staff the Board of Health and the Community Center Board to evaluate existing programs, services and public health issues in the community. Staff also works with the Power of We Consortium which brings together many agencies and organizations to address the need for improved services and programs.

- Desire to improve: ICHD staff along with the community partners have proven their desire to improve their reach to the population they serve, especially the special population groups. A number of satellite clinics encourage access to primary care; those include Cristo Rey, Care Free Medical, Veterans' clinic (VOA); Community Health Centers.

What do we really need for a successful CHIP?

- The planning process needs to include staff and community partners' input to increase the likelihood of implementation.
- The planning and implementation with partners will benefit from leverage from staff and other resources and build on those as a way to improvement.
- We need to have a clear plan to go forward and move into action and monitor the progress.
- Community Ownership/Voice: The plan and a monitoring methods need to be endorsed by the community for easier implementation of goals and objectives.
- Navigation of Resources: We hope that as a result of this plan, the population we serve in Ingham County will be better able to access community resources that help them improve their health and wellbeing.
- Understanding the needs of the community is a continuous process and this plan is built on a good understanding of the needs.
- Define success: This plan will have clearly defined measurable objectives for each of the priority areas and related strategies and tactics that the team will be able to monitor over time to measure success.

Organization and Structure

The next sections of this plan describe the goals, objectives, and strategies for each priority area: Each section includes relevant data from Ingham County describing the current status related to the priority, as well as reference to relevant state and national objectives and the evidence base underlying selected strategies. The plan also describes, in table format the goals, objectives, strategies, tactics, leading entities, refer to evidence base when possible and monitoring tools through process and outcome measurements', the partners who developed the plan, and appendices with community-developed action plans for priority strategies.

In the final Steering Committee meeting, goals, objectives and strategies developed by workgroups were reviewed by members who had not been part of that priority area workgroup, to allow for cross pollination. Reviewers commented on strategies against several criteria, such as the strategy is directly linked to an objective, a goal, and the priority area.

Then Core Group members forming the coordinating team revised their priorities sections and checked the strategies proposed against evidence indicating the strategy is effective.

- The strategy reflects the needs, values, and preferences of the population.
- The strategy addresses a service, policy, or system gap.
- Resources are available or the will to pursue resources exists to implement the strategy. Action plans were then developed for high priority strategies. Action planning began with the identification of an agency or agencies that could coordinate the implementation of each strategy.
- Coordinating agencies were asked to submit along with strategies and tactics, adequate measurement to monitor the progress of implementation from 2017 through 2020.
- The Core Group compiled the various sections into a table format that included Goals, Objectives, Strategies, Measurements and whether any policy or environmental change was going to be included for implementation.

Ingham County
Health Department

Access to Primary Health Care, Access to Quality Health Care

Strategic Priority: Access to Primary Care

The Problem

Over three months local healthcare stakeholders gathered together to look at the strategic priority area 'lack of access to primary care providers' that was identified via the Healthy! Capital Counties community health assessment. The stakeholders narrowed the strategic priority area to a problem statement: There is a lack of access to primary care providers that serve underserved and vulnerable population in Ingham County.

The Factors Linked to the Priority

The stakeholders identified several factors related to the lack of primary care providers that serve vulnerable populations. Those factors can be broken down into five major areas: recruitment, demand for services, retention, infrastructure, and lack of collaboration around primary care. Within recruitment the group surmised that there was a lack of support for brand-new primary care providers and incentives to encourage new doctors to go into primary care. Poor coordination of care, repeated readmissions, insufficient time devoted to prevention were viewed as factors that increase the demand for services within a given population. Burnout of new primary care providers , lower reimbursement, and fewer facility amenities compared to their non-primary care provider peers were considered barriers to the retention of primary care providers in the field. Although the affordable care act has included provisions meant to increase collaboration around primary care the stakeholders felt that there is still insufficient incentive and competing interest that percent true collaboration amongst providers around primary care.

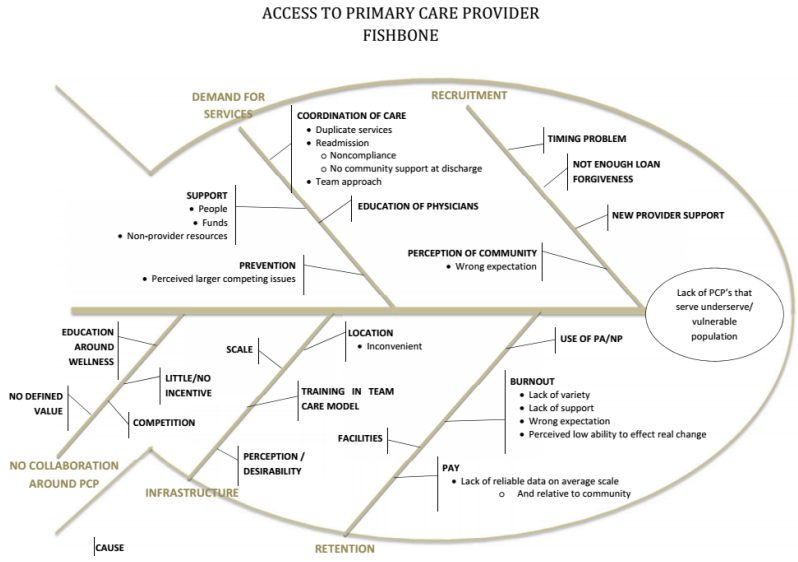


Figure 1:

Significance

The Institute of medicine in its document entitled, 'Access to healthcare in America,' defines access to care as: the timely use of personal health services to achieve the best health outcome. It list three steps that are required to attaining good access to care: 1. gaining entry into the healthcare system; 2. gaining access to sites of care where patients can receive the needed services; and 3. finding providers to meet the needs of individual patients and with whom the patient can develop a relationship based on mutual communication and trust. General internist, family doctors, geriatricians, general pediatrics , and obstetricians/gynecologists are all types of primary care providers. These providers are responsible for diagnosing new illnesses, managing chronic illnesses, advocating for preventive care, and protecting wellness in their patients. The lack of such physicians, which can occur for a variety of reasons, is a signify

cant problem for the health of the general population, particularly those who are poor or are a part of marginalized groups.

Lack of primary care tends to drive persons into emergency medical departments for exacerbated chronic conditions or for primary care services, both of which are more expensive than regular primary care visits. This, in turns, drives up the amount of uncompensated care that hospitals have to either absorb or pass on to other patients.

Ingham County is the location of three Health Resource and Services Administration (HRSA) designated Medically Areas (MUAs) and therefore lack sufficient primary care services. Those areas are: the central Lansing service area, the southwest Lansing service area, and the Ingram service area. Approximately 1/4 of the county's population resides in these three medically underserved areas.

Community Health Improvement Action Plan
Priority Area: Increase Access to Primary Care

Goal: Increase the number of Primary Care Providers (PCP), serving the populations in our community particularly low income.

Objectives:

1.) By September 30, 2018 the Access to Primary Care Providers workgroup will have defined the scope of the access problem in Ingham County.

Strategy:

- Access to Primary Care workgroup partners and Capital Area Physicians Experience (CAPE) partners will gather the current capacity vs current need for primary care providers' data.

Lead roles:

- Capital Area Health Alliance
- Ingham Community Health Centers
- Sparrow Health Centers
- McLaren

Tactics::

- Identify the county's total number of primary care providers, internal medicine physicians, pediatricians, physician assistants and nurse practitioners, then estimate the number who may be expected to retire or leave the community in the next one to five years, and examine trends in the recruitment of primary care providers into the community and the retention of primary care residents.
- Collect data on number and FTE for current primary care providers accepting new patients with commercial insurance and those accepting Medicaid patients. to determine actual capacity.
- Define the actual need for services in the next 10 years based on estimates projected from current data such as: Number of patients per primary care practices, number of providers and/or practices taking new patients with Medicaid, waiting time for a new patient to see a provider, wait time for appointments for existing patients, and use of urgent care for ongoing care (repeat visits by same patients).

Measurements:

- Number of primary care providers retiring or leaving the area.
- Number of residents in primary care programs and numbers retained,
- Net changes in primary care capacity
- Other metrics suggested by hospitals, MSU and community health centers.

Evidence base: Health Resources & Services Administration (HRSA) Strategy

Outcome Measures: Scope of the problem is clearly defined

Community Health Improvement Action Plan

Priority Area: Increase Access to Primary Care

Goal: Increase the number of Primary Care Providers (PCP), serving the populations in our community particularly low income.

Objectives:		
2.) By September 30, 2020, there will be a 5% increase in the enrollment into loan repayment programs among eligible primary care providers (Family Practice, Internal Medicine, Pediatric, Obstetric, and Gynecology physicians, as well as psychiatric care residents and new providers.)	Strategy: Health Systems and professional schools/colleges at Michigan State University, will promote loan repayment programs to students by offering regular presentations about the loan repayment opportunities as a recruitment tool for potential primary care students.	Lead role: • ICHD Community Health Centers and Michigan State University Tactics: • Compile loan repayment program information • Collect data on current percentage of students enrolled in a loan repayment program option. • Collect data on median salaries of physicians in different specialties • Review best practices that are being implemented around the nation to expand education in primary care • Use the Medical Group Management Association (MSMA) as a source of data on Medical Practice. Measurements: Before and after surveys to first and second year students on awareness about program, interest in primary care
	Data Source: MGMA.com Data Drive Practice Operations. Evidence base: Health Resources & Services Administration (HRSA) Strategy	
	Outcome Measures: A 5% increase in loan repayment program enrollment	

Community Health Improvement Action Plan

Priority Area: Increase Access to Primary Care

Goal: Increase the number of Primary Care Providers (PCP), serving the populations in our community particularly low income.

Objectives:		
3.) By September 30, 2020 Michigan based health professional schools and colleges will develop a local pipeline of college students to become primary care providers including physicians, physician assistants and nurses.	Strategy: CAPE will continue to collaborate with other community and health providers to assist students studying to become physicians, physician assistants or nurses, with opportunities for networking events with physicians, mentoring and job shadowing and linkages to engage them in the community beyond medical school.	Lead role: • Capital Area Physician Experience (CAPE) Committee of the Capital Area Health Alliance. • Michigan State University • Central Michigan University
		Tactics: • Inventory of current activities by health professional schools/ colleges to engage students into practice in the capital Area at graduation.
		Measurements: • Inventory of current activities completion records.
	Evidence base: Health Resources & Services Administration (HRSA) Strategy	
	Outcome Measures: Increase in the number of primary care physicians from the participating schools who express willingness to practice in this community.	

Strategic Priority: Access to Quality Care

The Problem

Over three months local healthcare stakeholders gathered together to look at the strategic priority area *access to quality healthcare* that was identified in the *Healthy! Capital Counties* community health assessment. The stakeholders narrowed the strategic priority area to this problem statement: *Patients, not knowing what to expect, cannot determine if they are receiving quality healthcare.*

The Factors Linked to the Priority

There are many factors that influence the quality of healthcare provided to patients. One obvious factor is communication between the patent and the provider. Low English proficiency and low health literacy on the part of the patients can make communicating health concerns difficult. This is compounded when the provider does not have easily accessible translation services or is themselves struggling to convey medical information in simple and plain language. Other interests competing for patient attention can also impact the quality of care. This is especially true for vulnerable population who struggle to fulfil basic needs (i.e. food and shelter). The patient's feeling of powerlessness, whether it is due to the patients' lack of choice of providers or the paternalistic nature of the relationship, can relegate the issue of quality in healthcare to a low level for patients. Unfortunately, patients are typically left out of discussions among providers and health systems about healthcare. This lack of transparency helps to exclude their perspective and their cultural norms are absent when institutional policies and regulations about quality are developed. There is also a general lack of transparency about individual provider performance and pricing which makes the conversation about quality difficult to have. Additionally differences and technological advances makes accessing information about healthcare quality difficult for patients particularly underserved and marginalized groups

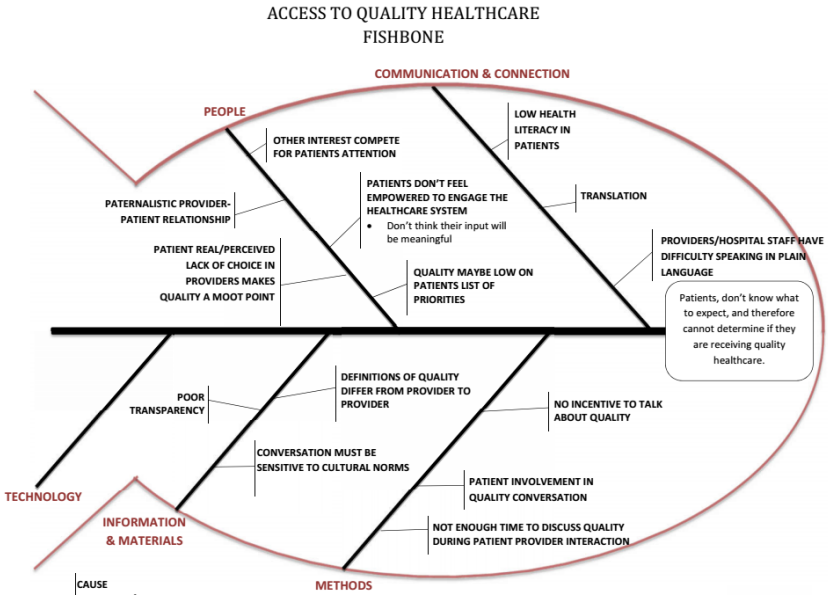


Figure 2:

Significance

Quality in healthcare has a variety of definitions both official and unofficial. The Institute of Medicine's report, Crossing the *Quality Chasm: A New Health System for the 21st Century* that came out in 2001, defines quality healthcare as *the degree to which health services for individual and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge*. Another definition, this one from the Agency of Healthcare Research and Quality (AHRQ) - a federal agency, defines quality healthcare *as doing the right thing for the right patient at the right time and in the right*

way to achieve the best possible results. For patients quality can mean a variety of things it could mean going to the doctor of their choice or to the hospital of their choice at the time of your choosing. Regardless of all the definitions of quality healthcare is about improving the health and life of the patient being treated.

Problems in healthcare quality fall, according to the National Committee For Quality Assurance (NCQA) document, *The Essential Guide to Health Care Quality*, into three broad categories: underuse, misuse, and overuse where 'underuse' is not receiving the care that is medically necessary; 'misuse' is receiving the wrong care; and 'overuse' is receiving care that is not needed or for which there is there is an equally effective alternative that cost less money and uses fewer side effects. The underuse of health care can allow chronic conditions to manifest and fester until the development of serious and debilitation co-morbidities emerge. Misuse can result in traumatic medical errors or near-miss medical errors. The overuse of healthcare services, sometimes resulting from a defensive practice of medicine, can increase invasive unnecessary procedures. All of these categories ultimately lead to an increase in healthcare cost without a corresponding increase positive health outcomes.

Community Health Improvement Action Plan

Priority Area: Increase Access to Quality Care

Goal 1: Increase the number of patients who perceive that they are receiving quality care as defined by the US department of Health and Human Services

Objectives:

1.) By September 30, 2020 health care organizations and providers participating in this CHIP process will report a 5% increase in the number of patients who perceive that they are receiving quality health care according to US department of Health and Human Services.

E.g. Consumer Tips for choosing a good primary Doctor: https://healthfinder.gov/healthtopics/population/men/doctor-visits/choosing-a-doctor-quick-tips

Strategy 1.

Partnering Health Care provider organizations develop and pilot a patient-care knowledge's assessment, education and communication to increase awareness among clients.

Strategy 2.

Enhance resource sharing on healthy communities and medical health services during patient appointment.

Lead roles:

- Ingham Community Health Centers
- Sparrow Health Systems
- McLaren Greater Lansing Hospital

Tactics:

- Recruit a pilot focus group of partners with primary care providers (Residents, Family Practice, internal medicine, pediatrics, Obstetricians), Physician Assistants, and Nurse Practitioners from major providers groups and associations in Ingham County
- Partners agree on a communication campaign to promote knowledge among clients about specific chronic diseases prevalent in Ingham County.
- Make resources information available during waiting room or inside clinic rooms
- Implement the communication plan
- Monitor the implementation process for 2 years with 6-8 outcome data points.

Measurements:

- Before and after knowledge client intake questions developed and piloted.
- Number and types of resources distributed every quarter
- Clinical outcome test results compiled to measure impact of education on longer term outcome
- Partner providers assess the progress made since the baseline

Evidence base: Agency for Healthcare Research and Quality (AHRQ) strategy

Outcome Measures: 5% increase in the number of patients that can determine they have received quality care

Community Health Improvement Action Plan
Priority Area: Increase Access to Quality Care

Goal 1: Increase the number of patients that can determine they are receiving quality care as defined by Michigan Quality Improvement Consortium.

Objectives		
2.) By September 30, 2020 providers, particularly medical professionals, interns, practice Providers, students and resident fellows will have the opportunity for continuous education on quality of care, through established training programs that are routinely evaluated for improvements.	Strategy 1. Examine the interns, residents, practice providers understanding of the components of client satisfactions feedback to increase quality of care. Strategy 2. Develop, implement and evaluate knowledge of interns, residents/fellows and practice providers about quality care, through structured modules provided on Ingham Community Health Centers Health Streams and hospital Equivalents.	Lead role: • ICHD Community Health Centers • Michigan State University Tactics: • Gather resources necessary to develop training materials for medical professional student residents/fellows to improve communication with patients. • Partner providers improve their patients' feedback tools to increase visibility of client satisfaction forms on website and in the clinics in multiple languages or simple opportunity for patient feedback at check-out of appointments thumbs up or down. • Partner providers compile and report on client satisfaction forms to review committee to discuss and make improvements as needed. Measurements: • Partner providers evaluate the success of this project by collecting feedback on trainings and on the types and number of improvements made as a result of client satisfaction reports. (Healthstream completion and tests and hospital equivalents of that). • Offer a before and after knowledge assessment.
	Evidence base: https://www.ahrq.gov/professionals/prevention-chronic-care/improve/index.html	
	Outcome Measures: A training program on quality care developed and tested by knowledge feedback. .	

Chronic Asthma Condition-A special Quality of Care issue

Asthma is a lifelong chronic breathing disease that causes inflammation of the lungs and airways and leads to serious breathing problems such as wheezing, tightness of chest and chronic coughs as a results of triggers. Though it cannot be cured, it can be prevented or controlled if provided with proper quality care. In case patients in a community do not access quality asthma management support, emergency hospitalizations rise. Rates of asthma hospitalizations are often used as an indicator for accessing asthma quality care. The higher rates indicate poor access.

In Ingham County, asthma hospitalization rates were higher than state averages per 10,000 people for the years 2012-2014 based on Michigan Impatient Database. Black rates were almost three times as high as white in Ingham County and State of Michigan and females were more often hospitalized than males in both county the state levels. Asthma death rate was 8.7 per 100,000, seven death in 2013-15.

Group	Average Number of Hospitalizations per Year in INGHAM County	INGHAM County Asthma Hospitalization Rate per 10,000 People	Michigan Asthma Hospitalization Rate per 10,000 People
Sex			
Male	149	12.5	10.0
Female	228	16.9	15.5
Race			
White	244	11.7	8.7
Black	114	32.3	36.7
Age			
0 to 17	100	17.2	13.0
18 and Older	277	14.0	12.9
All Ages	377	14.9	12.9

Table: Annual Average Numbers and Age-Adjusted Rates Per 10,000 of Asthma Hospitalizations by Gender, Age and Race in INGHAM County and Michigan, 2012-2014[3]
[Michigan Inpatient Data Base]

What can be done about it?

A new study published by the American Academy of Asthma and Immunology indicated that Health Care Access and mold in homes were both associated with higher adults asthma hospitalization rates. Financial barriers limited patients ability to purchasing medication, seeing a primary care physician or seeing a specialist for asthma, all contributed to lower access quality care.

Therefore, addressing the financial barriers through incentives to care coverage, encouraging the use of best practices in asthma management, and addressing mold issues in homes are ways to cut back on costly asthma hospitalization emergencies and to provide a better quality of life for asthma patients. For more information on this study please refer to the following document: http://www.prweb.com/releases/2017/07/prweb14535419.htm

Chronic Asthma Condition-A special Quality of Care issue

Children's asthma (0-17 years)

Ingham County children visited the hospital emergency on average a 100 times at a rate of 17. 2 per 10,000 children between 2012 to 2014, according to Michigan Inpatient Database. Many children who are taken to hospital as a result of asthma have persistent asthma attacks.

Persistent asthma is defined according to the National Committee for Quality Assurance as having

- at least four occasions where asthma medicine is given out or
- at least one visit to an emergency room where the primary reason was asthma or
- at least one visit to the hospital where the primary reason was asthma or
- at least four visits to a doctor where the primary reason was asthma and at least two occasions where asthma medicine is given out

Ingham County children experienced the fifth highest prevalence of persistent asthma (6.7%) in the State of Michigan according to 2013 County Maps Report by MDHHS. (http://getasthmahelp.org/documents/County-Maps-2013-FINAL.pdf)

Pediatric asthma management in Ingham County was compared to the State of Michigan and captured in the following table.

Characteristic of Asthma Management	Ingham County Percent	Michigan Percent
Two or More Office Visits for Asthma[4]	33.2%	30.4%
One or More Emergency Department Visit for Asthma[5]	21.3%	27.5%
Seven or More Prescription Refills for SABA[6]	13.2%	13.7%
One or More Long Term Control Medication[7]	86.1%	78.8%

Table: Characteristics of Asthma Management for Children Enrolled in Medicaid with Persistent Asthma, Ingham County and Michigan, Age ≤17 Years, 2013, Age-Adjusted[1,2,3]
[Michigan Medicaid Data Warehouse]
Source: http://getasthmahelp.org/current-michigan-county-asthma-statistics.aspx?ctyID=33

What can be done about it?

"The use of statewide quality improvement learning collaborative can improve asthma care, with the amount of physician rated well-controlled asthma increasing from 59% to 74%, according to a study published in *Pediatrics".* Collaborations between community asthma advocates, providers, schools, and trusted community leaders to adopt evidence based guidelines for asthma management and quality improvement, should help local communities measure similar improvements in controlling asthma . Find the study at: Dolins JC, et al. Pediatrics. 2017. doi:10.1542/peds.2016-1612

Community Health Improvement Action Plan

Priority Area: Increase Access to Quality Care

Goal 2. By 2020, reduce by 2% the current asthma rates status among adults in Ingham County. (current rate 11.7%)

Objectives:

1) By September 30, 2020 members of the Mid-Michigan Asthma Coalition will recruit providers to agree on a policy to implement evidence based guidelines that will improve the coordination of outreach, education and engagement between physicians, nurses and other clinicians.

Strategy 1.

Improve the frequency and quality of Interface between members of the Mid-Michigan Asthma Coalition and with healthcare providers in Ingham County to develop, implement or monitor guideline that are evidence based for asthma management.

Lead roles:

- TBD- Willow Clinic is a good place to pilot since they already do that.
- Mike Jones- ThermoFisher Scientific
- Kristen Donnelly-IHP- Asthma Awareness, outreach and communication
- Ken Fletcher-American Lung Association KFS/AAFA MI
- Adrienne DeFord- Ingham County Health Department.

Tactics:

- MMAC presentation to Ingham Community Health Center physicians (start with one-on-one conversation with Dr. Eric Wert, the Medical Director for the 11 FQHCs (federally qualified health centers/clinics).
- Engage the Nurse Practitioners and Physician Assistants at Willow, the Asthma & Allergy Foundation, to advocate for better implementation of the use of guideline-based asthma management by primary care doctors.
- Reach out to local potential partners such as the Willow Community Health Center to pilot and/or monitor the implementation of guideline-based asthma management.
- Discuss the possibility to offer Continuing Education Credit classes for primary care providers, nurse practitioners and interns on asthma prevention care, using Ingham County Health Stream trainings.

Measurements:

- Process meeting notes.
- Guidelines prepared to share with providers.

Evidence base: CDC National Asthma Control Program: An Investment in America's Health (2013) http://www.cdc.gov/asthma/pdfs/investment_americas_health.pdf
Pathways to managing your asthma http://getasthmahelp.org/documents/ALA_Asthma.

Outcome Measures: Number of provider practices that agree to implement the guidelines and provide education on it.

Community Health Improvement Action Plan

Priority Area: Increase Access to Quality Care

Goal: By 2020, reduce by 2% the current asthma rates status among adults in Ingham County. (current rate 11.7%)

Objective		
2.) By September 30, 2020 members of the Mid-Michigan Asthma Coalition will report an increase in the use of evidence based guidelines for asthma management, such as the asthma action plan, by at least one new school in Ingham County.	Strategy 1. Pursue avenues for increasing awareness of evidence based guidelines on asthma management, including the use of Asthma Action Plans at schools.	Lead roles: • Ingham County Health Department • Sharon Rogers– Community Resource Manager. Capital Area Community Services Head Start
		Tactics: • Advocate for requirement of asthma Action Plans on file at school for students with asthma, to be completed and brought in at the start of school or upon diagnosis. • Check the research regarding Asthma Action Plans or other evidence based guidelines for asthma management. • Develop and implement an awareness campaign for .asthma management, such as for example including asthma table/info and help with Asthma Action Plans at a station in the ICHD Back to School Health Fair.
		Measurements: • Number of schools administrators informed about the evidence based guidelines. • Number of schools that agree to adopt an evidence based plan to manage asthma. • Number of visitors at the back to school asthma awareness table.
	Evidence base: CDC National Asthma Control Program: An Investment in America's Health (2013) http://www.cdc.gov/asthma/pdfs/investment_americas_health.pdf	
	Outcome Measures: At least one new school in Ingham County show that it is using the asthma action plan guideline for quality care asthma management.	

Community Health Improvement Action Plan

Priority Area: Increase Access to Quality Care

Goal: By 2020, reduce by 2% the current asthma rates status among adults in Ingham County. (current rate 11.7%)

Objectives:		
3.) The Mid-Michigan Asthma coalition will continue to work on policy and system changes across sectors leading to at least one such change in one of the sectors by September 30, 2020.	Strategy 1. Conduct research, outreach and advocate for policy and system changes across sectors	Lead roles: • Ken-American Lung Association KFS/AAFA MI • Tina– Michigan Environmental Council • Brad– Sierra Club • KFS/AAFA MI
		Tactics: • Advocate regarding ozone standards and clean power plant rules (federal issues). • Continue to engage on environmental policies. • Build on successes with PHP for in-home case management and replicate with other insurers. • Find a way to reach more pastors. Or, is there a stigma associated with churches that keeps people away from church-based events? • Back track and find out why asthma hospitalizations and deaths are happening in our area.
		Measurements: • Records on advocacy efforts • Outreach meeting records • Qualitative assessment records
	Evidence base: CDC National Asthma Control Program: An Investment in America's Health (2013) http://www.cdc.gov/asthma/pdfs/investment_americas_health.pdf	
	Outcome Measures: One policy or systems change attributed to the coalition efforts in at least one of the various sectors reached.	

Ingham County
Health Department

Chronic Disease

Decrease the prevalence of Chronic Disease

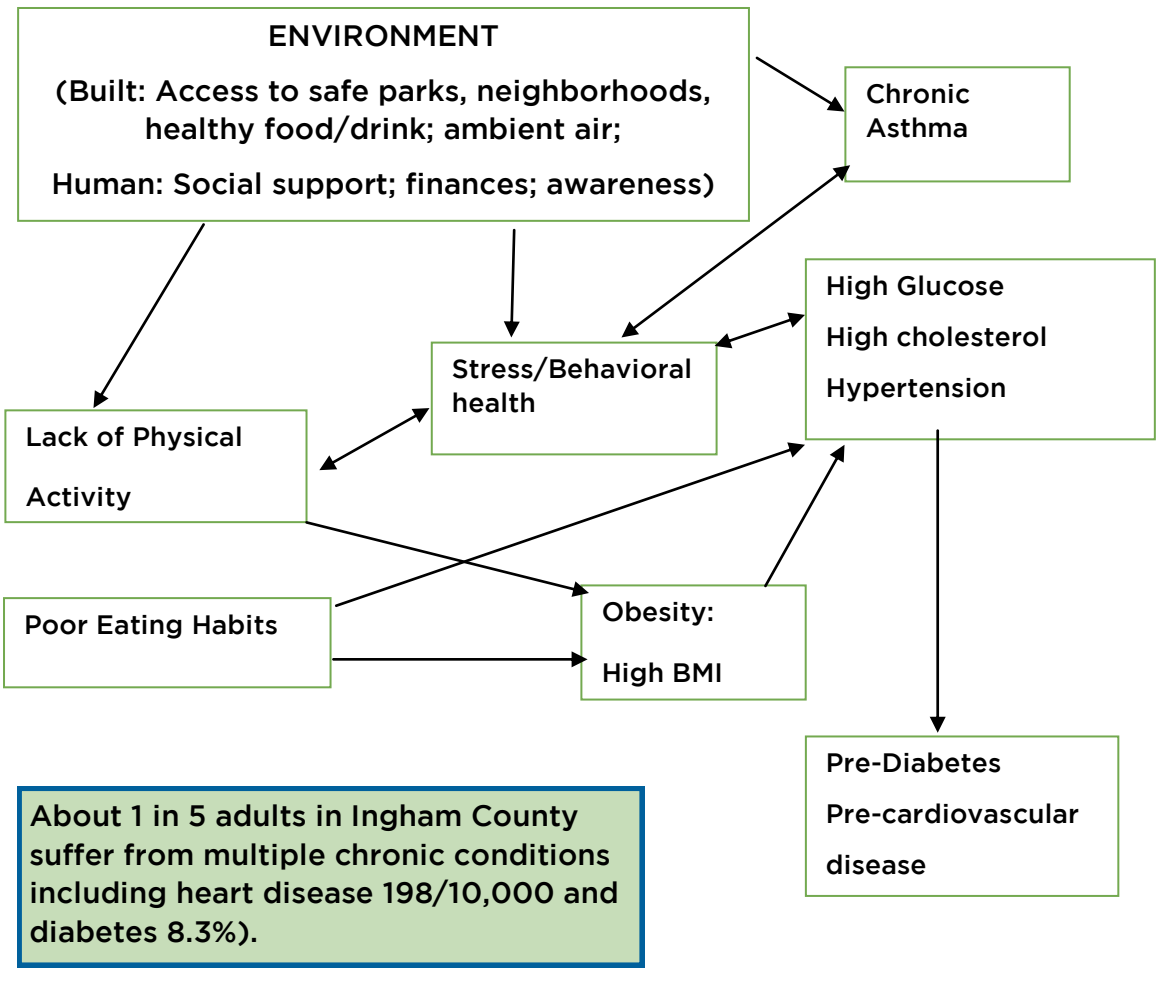
Strategic Priority: Decrease the prevalence of chronic diseases among adults in Ingham County.

The Problem

Chronic diseases is a disease that limits usual activities and lasts three months or longer. Chronic diseases account for most leading causes of deaths in Ingham County.

Chronic diseases account for 7 out of 10 leading causes of death in Ingham County according to 2014 Michigan death records. Risk factors associated with two chronic diseases (heart disease and diabetes) include hypertension, high cholesterol and high BMI. According to the 2014 Capital Area BRFSS 25.6% of the adults in Ingham County had been told that they have hypertension, 24.7% were told they had high cholesterol, 27% had at BMI>30 or considered obese and 11.7% have chronic asthma conditions. Secondary risk factors include Poor nutrition/eating habits, lack of Physical activity, tobacco Use, behavioral Health conditions (Stress, depression), and related environmental Factors have direct or indirect effect on chronic diseases. The CHIP Chronic Disease work group mapped these relationship in the following path diagram.

Factors linked to chronic diseases

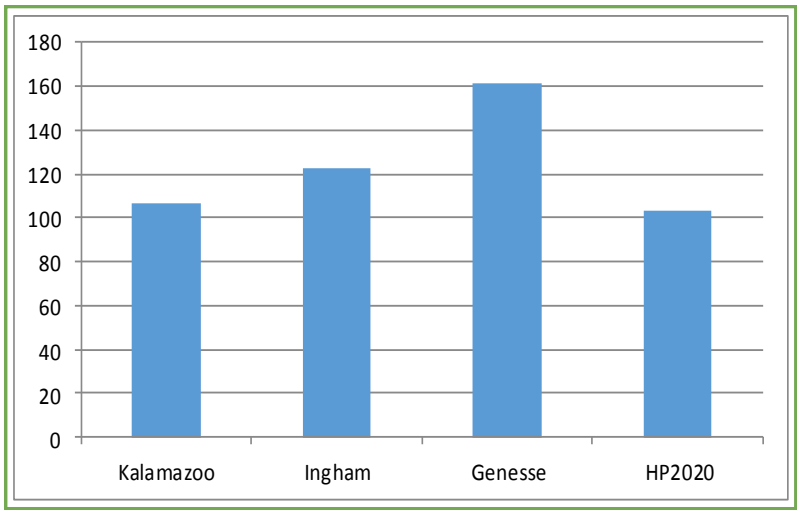


About 1 in 5 adults in Ingham County suffer from multiple chronic conditions including heart disease 198/10,000 and diabetes 8.3%).

Heart Disease and Diabetes

Significance:

Heart diseases is the leading cause of death in Ingham County claiming over 500 deaths in 2014 at a rate of 182.7 per 100,000 population. Compared to nearby counties, Ingham is doing better than Genesee county and worse than Kalamazoo. HP2020 target is 103.4 per 100,000 population.



Diabetes is the 7th leading cause of death in Ingham County 9.2/100,000 and in the US. Aside from death, diabetes leads the causes of kidney failure, lower limb amputations and adult onset blindness. Over 20% of health care cost in the US goes to treat people diagnosed with diabet4s.

Both heart disease and Type 2 diabetes (which accounts for 95% of diabetes cases) are preventable and follow common risk factors linked to obesity (high body mass index); lack of physical activity, diets low in fruits and vegetables, and high in sodium and saturated fats; High blood pressure and tobacco exposure are also factors associated with heart disease.

Heart Disease and Diabetes Prevention:

The Center for Disease Control and Prevention (CDC) recommends coordinating chronic disease prevention efforts into four key domains.

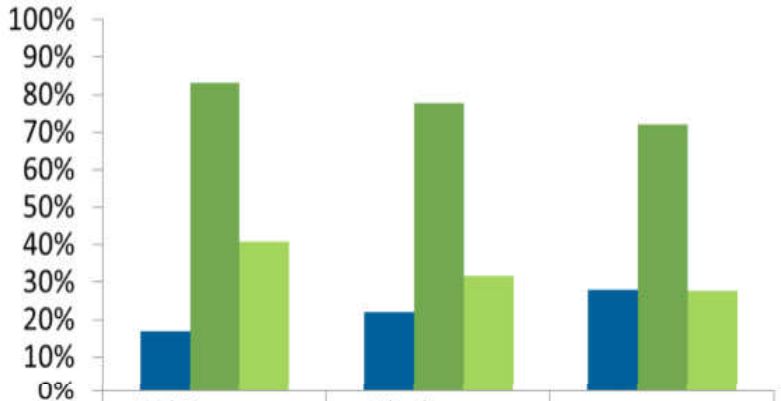
1. Epidemiology and Surveillance: Tracking chronic disease and their risk factors
2. Environmental approaches: changes in policies and physical surroundings to make healthy choices the easier choice.
3. Health care system interventions that improve the diagnosis and management of the disease
4. Community programs to prevent and manage their chronic diseases with guidance from their doctors.

Community Health Improvement plans need to take into account these key domains among partners working to address chronic diseases; Ingham county will work with local partners to develop objectives that address these four domains as a way to prevent heart disease and diabetes. Special attention will be given to disparities in the environment leading to heart disease and diabetes.

Data source: http://www.mdch.state.mi.us/osr/chi/profiles/standard/profilestand.asp?CoCode=33&CoName=Kalamazoo

The Disparity

Chronic diseases are not equally distributed among ethnic and racial groups. Black and Hispanic present higher prevalence of heart disease and diabetes and related risk factors. One way to start addressing the problem is to understand the underlying disparities in consumption of fruits and vegetable and in physical activity levels. The recommended level of consumption(1) of fruits and vegetables is 5 servings in cups per day. Over 83,000 residents of Ingham County (30% of the county population) live in lower-income communities with limited access to healthy food retail. Over 17,000 children and youth 19 and under live in these underserved communities; nearly 5,000 residents 65 and older live in these communities. Nearly 9,000 residents live in lower-income, underserved communities that experience high rates of diet-related death. About 1,300 of these residents are children and youth; nearly 1,000 are elderly (2). Local efforts to facilitate and promote food access need to be sustained in order to close the disparities and increase the percentages meeting recommended daily intake of fruits and vegetables in all racial groups.



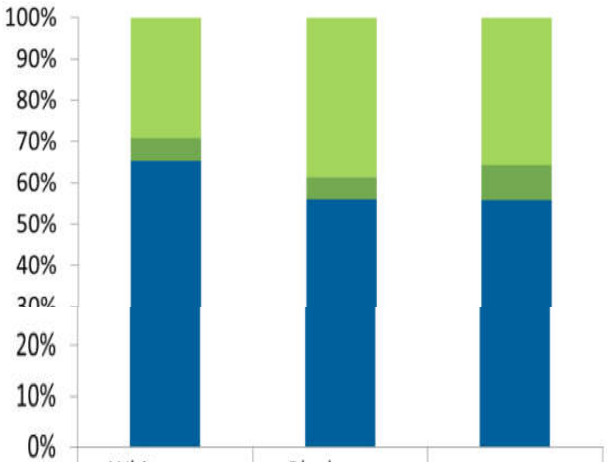
	White, non-Hispanic	Black, non-Hispanic	Hispanic
No fruit|vegetable serving a day	16.8%	22.1%	28.0%
At least 1 fruit|vegetable serving a day	83.2%	77.9%	72.0%
5+ fruit|vegetable serving a day	40.7%	31.6%	27.6%

Figure: Fruit and vegetable consumption by race/ethnicity among adults in Ingham, County, 2011-2013 Capital Area BRFS (Ingham only)

(1) http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6426a1.htm
(2) http://thefoodtrust.org/uploads/media_items/michigan-mapping-final.original.pdf

The Disparity

For adults with less than 30 min daily physical activity. Using this criteria, only 27% of the Hispanic population in Ingham County met this recommendation, which is 13% less than White and 4% less than Black. Still, even the lowest rate in Ingham county is twice as good as the national rate (13%) in 2013 (1).



	White, non-Hispanic	Black, non-Hispanic	Hispanic
No physical activity	29.2%	38.7%	35.7%
some physical activity	5.5%	5.2%	8.4%
adequate physical activity	65.3%	56.1%	55.9%

Figure: Physical activity (moderate or vigorous) levels by race/ethnicity among adults in Ingham County, 2011-2013 Capital Area BRFS (Ingham only)

Indicators: Percentage of adults in the state who engaged in no leisure-time physical activity • Some: Percentage of adults in the state who met the 150 minute aerobic activity guideline • Adequate: Percentage of adults in the state who met the 300 minute aerobic activity guideline

Community Health Improvement Action Plan
Priority Area: Chronic Diseases (Heart Disease, Diabetes focus

Goal: Increase awareness of and engagement in chronic disease prevention opportunities and resources to decrease the prevalence of adults exhibiting risk factors leading to heart disease and diabetes.

<table>
<tr><td>Objectives:</td><td colspan="2"></td></tr>
<tr><td rowspan="4">1.) By 2020, improve by 2% the variety of reduced cost fresh fruits and vegetables in neighborhoods known as food deserts in Lansing that have higher concentration of vulnerable groups (low income, Black and Hispanic populations.)
P.S. The baseline used refers to existing corner stores in the neighborhoods and surveys

And the United State Department of Agriculture Economic Research Service city of Lansing mapping data on Low Income plus low access and not using vehicle access.

https://www.ers.usda.gov/data-products/food-access-research-atlas/go-to-the-atlas/</td><td rowspan="3">Strategy 1.

Ingham County will use the Urban Redevelopment Grant funds to support a food truck project that increase food distribution and nutrition education in targeted neighborhoods of Lansing where the current baseline is zero access within 1/2-1 mile of target areas</td><td>Lead roles:
• Northwest Initiative will coordinate the project funded by Ingham County through an Urban Redevelopment Grant
• Evaluations administered through Public Policy Associates.</td></tr>
<tr><td>Tactics:
• Follow NWI action plan steps and make adjustments as needed.</td></tr>
<tr><td>Measurements: Include type of produce, number of sales per stop, number of people, $ sales (Cash, SNAP, Credit/Debit, or Senior market), pre-post surveys, and qualitative data.</td></tr>
<tr><td colspan="2">Evidence base: CDC recommends using Environmental approaches: Changes in policies and physical surroundings to make healthy choices the easier choice.</td></tr>
<tr><td colspan="2">Outcome Measures: food trucks show at least a 2% increase in availability at the targeted locations, by 2020.</td></tr>
<tr><td rowspan="3"></td><td rowspan="3">Strategy 2.

Ingham County Healthy Communities coordinator will work with partner organizations in the Mid-Michigan Food Council (Food System Workgroup) and other partners of the Power of We Consortium to report on updates from neighborhood-based farmers markets, farm stands, urban gardening and farming to address access issues</td><td>Lead roles:
• Mid-Michigan Food Council (previously known as the Food Systems Workgroup)
• Community Economic Development partner organizations within the Power of We Consortium</td></tr>
<tr><td>Tactics:
• Healthy Communities coordinator will collect relevant data updates on a yearly basis to report to the CHIP on increased access to fruits and vegetable in Ingham County.</td></tr>
<tr><td>Measurements:
• In 2018 a list of indicators will be determined with the two partnerships. Examples may include reports from the Greater Lansing Food Bank on Community Gardens, and on Michigan Farmers Market Association reports on Farmers Markets.</td></tr>
<tr><td></td><td colspan="2">Evidence base: CDC recommends using Environmental approaches: Changes in policies and physical surroundings to make healthy choices the easier choice. http://www.mapc.org/sites/default/files/Municipal%20Strategies%20to%20Increase%20Food%20Access.pdf</td></tr>
<tr><td></td><td colspan="2">Outcome Measure: A 2% increase in availability of fresh fruits and vegetables in Lansing through local farmers' markets and community gardens.</td></tr>
</table>

Community Health Improvement Action Plan
Priority Area: Chronic Diseases (Heart Disease, Diabetes focus)

Goal: Increase awareness of and engagement in chronic disease prevention opportunities and resources to decrease the prevalence of adults exhibiting risk factors leading to heart disease and diabetes.

Objectives:		
2.) By September 2018, provide both indoor and outdoor physical activity opportunities within the Sparrow main campus facility.	Strategy 1. Designate an outdoor walking path with distance mapping located between Sparrow main campus and Eastern High School to be utilized by Sparrow Caregivers and visitors.	Lead role: • Sparrow Health Systems
	Strategy 2. Designate a highly visible stair well walking path with distance mapping inside Sparrow main campus to be utilized by Sparrow Caregivers and visitors.	Tactics: • Implement the necessary environmental changes outdoor and indoor • Follow SHS action plan steps.
		Measurements: • Walking audit shows the environmental changes are in place as planned. • Sparrow Health Systems progress reports twice a year presented in the Healthy Lifestyle committee or other special meetings.
	Evidence base: S1 and S2 CDC recommends using Environmental approaches: Changes in policies and physical surroundings to make healthy choices the easier choice. https://www.healthypeople.gov/2020/implement/workplacewellnesshttps://www.cdc.gov/obesity/downloads/pa_2011_web.pdf	
	Outcome Measures: Physical space changes in and around the hospital; traffic observation before and after noted by staff observations.	

<table>
<tr><td colspan="3">Goal: Increase awareness of and engagement in chronic disease prevention opportunities and resources to decrease the prevalence of adults exhibiting risk factors leading to heart disease and diabetes.</td></tr>
<tr><td>Objectives:</td><td colspan="2"></td></tr>
<tr><td rowspan="4">3. By 2020 Sparrow Health Systems will increase by a 2% participation in their health education, risk identification and management strategies to increase chronic disease prevention opportunities.</td><td rowspan="3">Strategy 1:

Sparrow Health System (SHS) will increase awareness of chronic disease risk factors by providing risk identification tools through worksite wellness programming</td><td>Lead role:
• Sparrow Health System (SHS)</td></tr>
<tr><td>Tactics:
• Provide an online health management portal that includes a Personal Health Assessment to Sparrow Caregivers and area employers.
• Provide onsite health screenings to area employers including body composition, cholesterol, blood pressure, and health educator consult to identify potential chronic disease risk factors.</td></tr>
<tr><td>Measurements:
Yearly presentation to the Power of We Consortium including baseline vs yearly data on portal usage and onsite health screening tools in worksite wellness programs.</td></tr>
<tr><td colspan="2">CDC Evidence base: https://www.healthypeople.gov/2020/tools-resources/evidence-based-resource/worksite-assessment-of-health-risks-with-feedback-ahrf</td></tr>
<tr><td colspan="2">Outcome Measures: Participation summary report in 2020 shows a 2% increase in participation in education, risk identification and chronic disease management from baseline taken in 2017.</td></tr>
<tr><td rowspan="4"></td><td rowspan="3">Strategy 2:

SHS will provide targeted health education opportunities to seniors and caregivers regarding risk factors associated with chronic disease.</td><td>Lead roles:
• Sparrow Health Systems</td></tr>
<tr><td>Tactics:
• Offer monthly education series for seniors titled “Lunch with a Doctor” featuring a health care professional focusing on topics such as Diabetes, Heart Disease, Arthritis, Healthy Eating.
• Offer “10 Weeks to Wellness” program for Sparrow Caregivers featuring weekly group exercise sessions, pre/post program health screening, and wellness seminars.</td></tr>
<tr><td>Measurements: Yearly presentation of process updates to the Power of We Consortium</td></tr>
<tr><td colspan="2">CDC Evidence base: Health care system interventions that improve the diagnosis and management of the chronic diseases risk factors. https://www.healthypeople.gov/2020/tools-resources/evidence-based-resource/worksite-assessment-of-health-risks-with-feedback-ahrf</td></tr>
<tr><td colspan="2">Outcome Measures: Participation summary report in 2020 shows a 2% increase in participation from baseline taken in 2017.</td></tr>
</table>

<table>
<tr><td colspan="3">Goal: Increase awareness of and engagement in chronic disease prevention opportunities and resources to decrease the prevalence of adults exhibiting risk factors leading to heart disease and diabetes.</td></tr>
<tr><td>Objectives</td><td colspan="2"></td></tr>
<tr><td rowspan="4">4.) By 2020, the YMCA of Lansing will increase by a 2% participation in their diabetes prevention and management programs.</td><td rowspan="3">Strategy 1.

The YMCA of Lansing will provide Risk Assessments and A1C testing to bring awareness to Type II Diabetes.</td><td>Lead role:
• The YMCA of Lansing</td></tr>
<tr><td>Tactics:
• Identify Partners to host screenings.
• Work with Ingham County employers to explore insurance coverage.</td></tr>
<tr><td>Measurements: Yearly presentation to the Power of We Consortium</td></tr>
<tr><td colspan="2">CDC Evidence base:
Health care system interventions that improve the diagnosis and management of the chronic diseases risk factors in community settings: https://www.healthypeople.gov/2020/tools-resources/evidence-based-resource/diabetes-self-management-education-in-community

Outcome Measures: Participation and process summary report in 2020 show a 2% increase from the baseline in 2017.</td></tr>
<tr><td rowspan="4"></td><td rowspan="3">Strategy 2.

The YMCA of Lansing will provide Diabetes Prevention Classes throughout Ingham County.</td><td>Lead role:
• The YMCA of Lansing</td></tr>
<tr><td>Tactics:
• Identify team of community partners to research high needs areas to hold programs.
• Secure funding to provide program scholarships for those in need of financial resources to participate in program</td></tr>
<tr><td>Measurements:

Yearly presentation of process updates to the Power of We Consortium</td></tr>
<tr><td colspan="2">CDC Evidence base:
Health care system interventions that improve the diagnosis and management of the chronic diseases risk factors.
https://www.healthypeople.gov/2020/tools-resources/evidence-based-resource/diabetes-self-management-education-in-community

Outcome Measure:
Participation summary report in 2020 show a 2% increase from the baseline in 2017</td></tr>
</table>

<table>
<tr><td colspan="3">Goal: Increase awareness of and engagement in chronic disease prevention opportunities and resources to decrease the prevalence of adults exhibiting risk factors leading to heart disease and diabetes.</td></tr>
<tr><td>Objectives:</td><td colspan="2"></td></tr>
<tr><td rowspan="4">4.) By 2020, the YMCA of Lansing will increase by a 2% participation in their diabetes prevention and management programs.</td><td rowspan="3">Strategy 3:

The YMCA of Lansing will create a referral system to the YMCA's Diabetes Prevention Program</td><td>Lead roles: The YMCA of Lansing</td></tr>
<tr><td>Tactics:
Create marketing materials to disseminate to medical providers so direct and indirect referral systems can be put in place.
Meet with medical providers and pharmacist to create a calendar of office visits to update and stock materials</td></tr>
<tr><td>Measurements: Yearly presentation to the Power of We Consortium</td></tr>
<tr><td colspan="2">CDC Evidence base: Health care system interventions that improve the diagnosis and management of the chronic diseases risk factors.</td></tr>
<tr><td colspan="2">Outcome Measures: Referral system created; participation and process summary report in 2020</td></tr>
<tr><td rowspan="4">5.) By 2020, ICHD will increase by a 2% participation in their chronic disease prevention and management programs.</td><td rowspan="3">Strategy 1:

ICHD will Increase heart disease, diabetes and cancer screening for at risk women to allow for early detection, increased understanding and awareness of chronic disease risk factors.</td><td>Lead roles:
Ingham County Health Department</td></tr>
<tr><td>Tactics:
Tactic: Providing screening services for cholesterol, hypertension, diabetes and BMI for women 40-64 and below 250% Federal Poverty Level free of charge.
Tactic: Provide thorough explanation of results, educate regarding screenings and review risk factors for heart disease and diabetes.
Tactic: Provide education and navigation for cancer screening services</td></tr>
<tr><td>Measurements:

Yearly presentation of quantitative and process updates to the Power of We Consortium</td></tr>
<tr><td colspan="2">CDC Evidence base: Health care system interventions that improve the diagnosis and management of the chronic diseases risk factors.</td></tr>
<tr><td colspan="2">Outcome Measure: Participation summary report in 2020</td></tr>
</table>

<table>
<tr><td colspan="3">Goal: Increase awareness of and engagement in chronic disease prevention opportunities and resources to decrease the prevalence of adults exhibiting risk factors leading to heart disease and diabetes.</td></tr>
<tr><td>Objectives:</td><td colspan="2"></td></tr>
<tr><td rowspan="4">5.) By 2020, ICHD will increase by a 2% participation in their chronic disease prevention and management programs.</td><td rowspan="2">Strategy 2:

ICHD will increase healthy lifestyle activities by providing health coaching and connecting to community resources that support health goals.</td><td>Lead roles:
• Ingham County Health Department;. Sarah Bryant.</td></tr>
<tr><td>Tactics:
• Tactic: Provide risk reduction counseling and assess readiness to change.
• Tactic: Assist with navigation to resources that support healthy behavior.</td></tr>
<tr><td colspan="2">Measurements:
Yearly presentation to the Power of We Consortium</td></tr>
<tr><td colspan="2">CDC Evidence base:
Health care system interventions that improve the diagnosis and management of the chronic diseases risk factors.</td></tr>
<tr><td colspan="3">Outcome Measures: Participation and process summary report in 2020</td></tr>
<tr><td rowspan="4">5.) By 2020, ICHD will increase by a 2% participation in their chronic disease prevention and management programs.</td><td rowspan="2">Strategy 3:

ICHD will decrease chronic disease disparity by increasing connection and navigation to health care for the underserved population.</td><td>Lead roles:
• Ingham County Health Department—Sarah Bryant</td></tr>
<tr><td>Tactics:
• Tactic: Provide grass roots outreach and awareness to high risk populations.
• Tactic: Provide navigation services to remove barriers to health care and address social determinants of health.
• Tactic: Provide home visiting services to perform system navigation and bridge the connection between clients, social services and community resources.</td></tr>
<tr><td colspan="2">Measurements: Yearly presentation of quantitative and process updates to the Power of We Consortium</td></tr>
<tr><td colspan="2">CDC Evidence base: Health care system interventions that improve the diagnosis and management of the chronic diseases risk factors.</td></tr>
<tr><td colspan="3">Outcome Measures: Participation summary report in 2020</td></tr>
</table>

Goal: Increase awareness of and engagement in chronic disease prevention opportunities and resources to decrease the prevalence of adults exhibiting risk factors leading to heart disease and diabetes.		
Objectives:		
6.) By 2020, Tri-County Regional Planning Commission will create a Land Use and a Regional Non-Motorized Transportation Plan Advisory groups to initiate implementation plans that will residents' ability to safely and conveniently travel by foot, bike or other mobility devices for recreation or work purposes in parks and on/off-roads non-motorized facilities.	Strategy 1: TCRPC will gather partners from the State, counties, local planning and safety agencies, in addition, transit, health, economic and various advocacy groups to form a Non-motorized transportation Plan (NMTP), and a Regional Land Use Plan that sets a vision to develop and improve issues that address people of all ages and abilities.	Lead roles: • Tri-County Regional Planning Commission and state, county, and local partners • Land Use and Health Resource Team.
		Tactics: • Tactic: In 2017 gather partners to participate in the non-motorized plan development. • Promote parks and trails. Opportunities for offering physical activity opportunities for all ages. • Develop policy for allotting points to projects to encourage safe non-motorized transportation.
		Measurements: Process meeting notes and document development.
	CDC Evidence base: Forging Multi-sectoral partnerships to improve physical activity through policies and environmental changes.	
	Outcome Measures: Non-Motorized point system plan and Land Use Park promotion is documented	

Ingham County
Health Department

Financial Stability
Economic Mobility

Strategic Priority: Increase the proportion of community members who are building assets and experiencing economic mobility

The Problem

The ability to achieve financial stability and economic mobility is an intricate equation with variables that generally include:

- family income and wealth at time of birth
- geographic location, and the social factors embedded in one's locale

Financial stability is defined as one's ability to pay for basic costs of living while also setting aside emergency funds and savings, and developing assets such as home equity and retirement funds. A person with financial stability has savings to ride out temporary loss of income, unexpected medical or funeral expenses, and other unplanned emergencies without losing housing or accumulating insurmountable debt. Factors influencing financial stability include: availability of good-paying jobs and affordable banking and loan products, housing and healthcare affordability, and asset-friendly policies.

FINANCIAL STABILITY

45% of Ingham County residents are either living in poverty

(23%) or are "Asset Limited, Income Constrained, Employed"

(22%), meaning they are employed but struggle to meet basic needs and are unable to set aside savings for emergency needs or building assets.

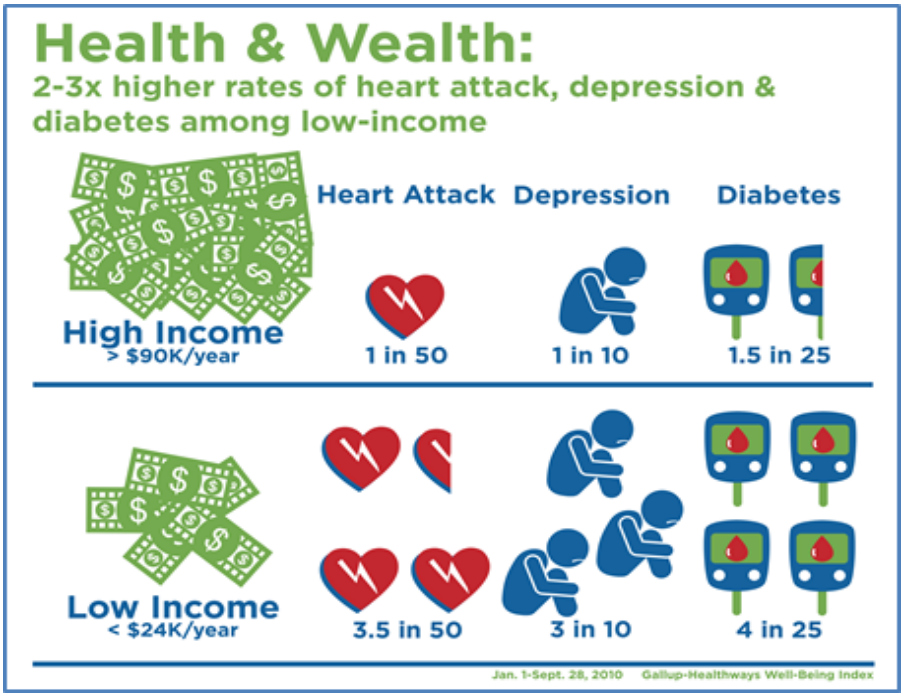
Economic mobility refers to the likelihood that someone born in the bottom 20% of incomes is able to become a top 20% earner at any point in their lifetime. In the U.S., that likelihood is estimated to between 4% and 11%. The most economically-mobile countries in the world are found in Scandinavia, where between 11% and 14% of those born in the bottom fifth of incomes move into the top fifth. Unfortunately, the likelihood of being able to move to the top income-rung in the U.S. is extremely limited for those born at the bottom, and it is even further restricted for people of color, those without a high school diploma, and people whose parents never marry anyone.

ECONOMIC MOBILITY

In Ingham County, only 6.1% of people born in the bottom fifth of incomes move into the top-fifth of incomes.

Factors linked to increased economic mobility

Factors found to drive increases in economic mobility include: reducing rates of violent crime, improving quality of schools, and increasing economic and income integration. Children raised in areas with lower crime, less segregation and better schools are more likely to move from the bottom income quintile to the highest, and this is especially true for boys. Reducing violence and associated trauma leads to higher graduation rates, and can lead to greater economic investment in a community. People living in communities with greater economic and racial integration are less likely to experience discrimination in hiring and promotion. Share of two-parent households is also positively correlated with economic mobility. However, among Black Americans, higher rates of two-parent households are often seen as an *outcome* of *increased economic mobility among black men and women,* as opposed to a *determinant* of economic mobility.



ALICE IN INGHAM COUNTY

Population: 281,723 | **Number of Households:** 109,008
Median Household Income: $43,337 (state average: $46,859)
Unemployment Rate: 7.4% (state average: 9.1%)
Gini Coefficient (zero = equality; one = inequality): 0.49 (state average: 0.46)

How many households are struggling?

ALICE, an acronym for **A**sset **L**imited, **I**ncome **C**onstrained, **E**mployed, are households that earn more than the U.S. poverty level, but less than the basic cost of living for the county. Combined, the number of poverty and ALICE households equals the total population struggling to afford basic needs.

Poverty	ALICE	STRUGGLING	Above ALICE
25,367 HH	24,507 HH		59,134 HH
23%	22%		54%

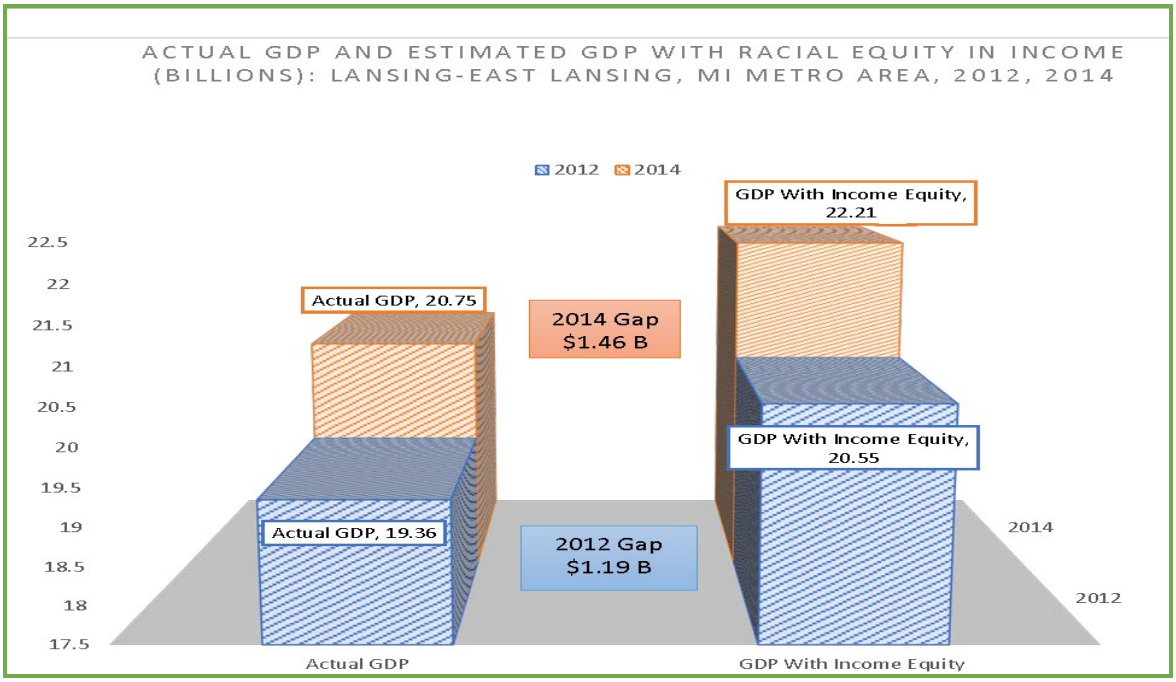
What are the economic conditions?

The **Economic Viability Dashboard** evaluates community conditions for ALICE in three core areas. Each is an index with a scale of 1 (worst) to 100 (best).

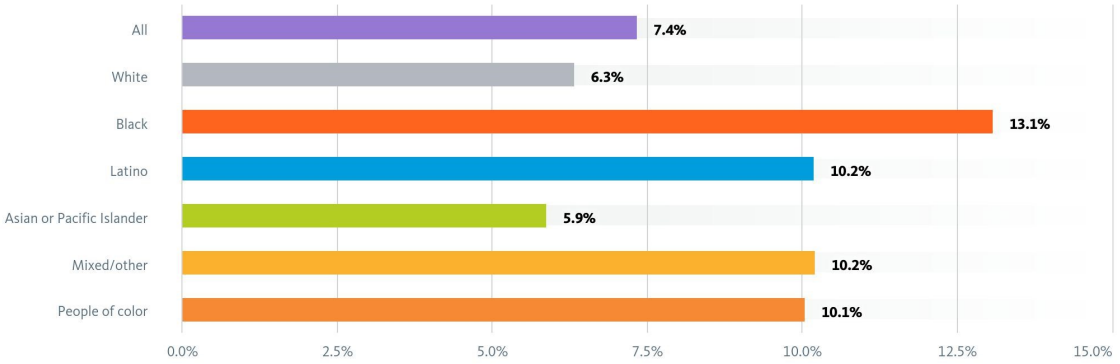
Housing Affordability	Job Opportunities	Community Support
poor (34)	poor (46)	good (80)

Ingham County, 2012

Town	Total HH	% ALICE & Poverty
Alaiedon Township	1,106	22%
Aurelius Township	1,258	22%
Bunker Hill Township	758	32%
Delhi Charter Township	10,088	31%
East Lansing City	12,644	57%
Ingham Township	782	23%
Lansing Charter Township	3,697	52%
Lansing City	45,774	56%
Leroy Township	1,298	42%
Leslie City	611	49%
Leslie Township	859	29%
Locke Township	590	15%
Mason City	3,168	40%
Meridian Charter Township	17,280	34%
Onondaga Township	1,103	31%
Stockbridge Township	1,335	34%
Vevay Township	1,268	21%
Wheatfield Township	611	16%
White Oak Township	435	22%
Williamston City	1,587	36%
Williamstown Township	1,850	13%

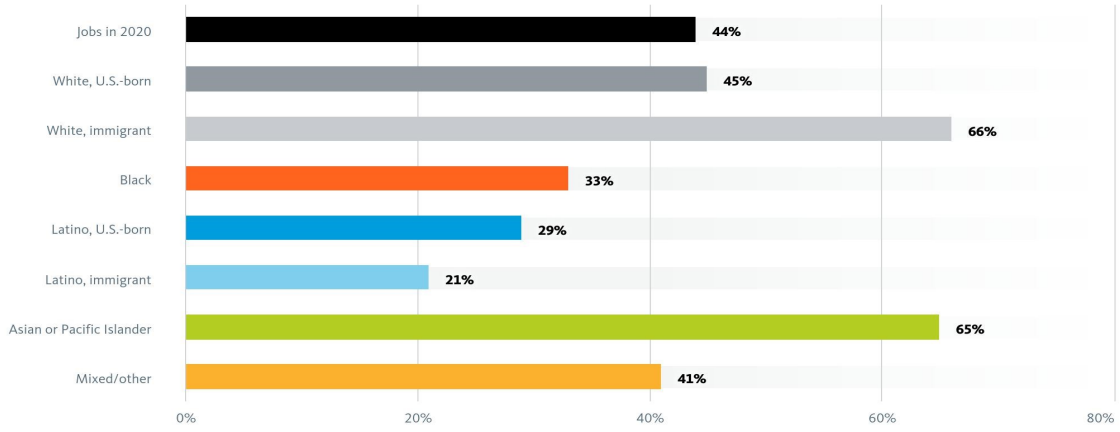


Percent of 16 to 24 year olds not working or in school by race/ethnicity: Lansing-East Lansing, MI Metro Area, 2014

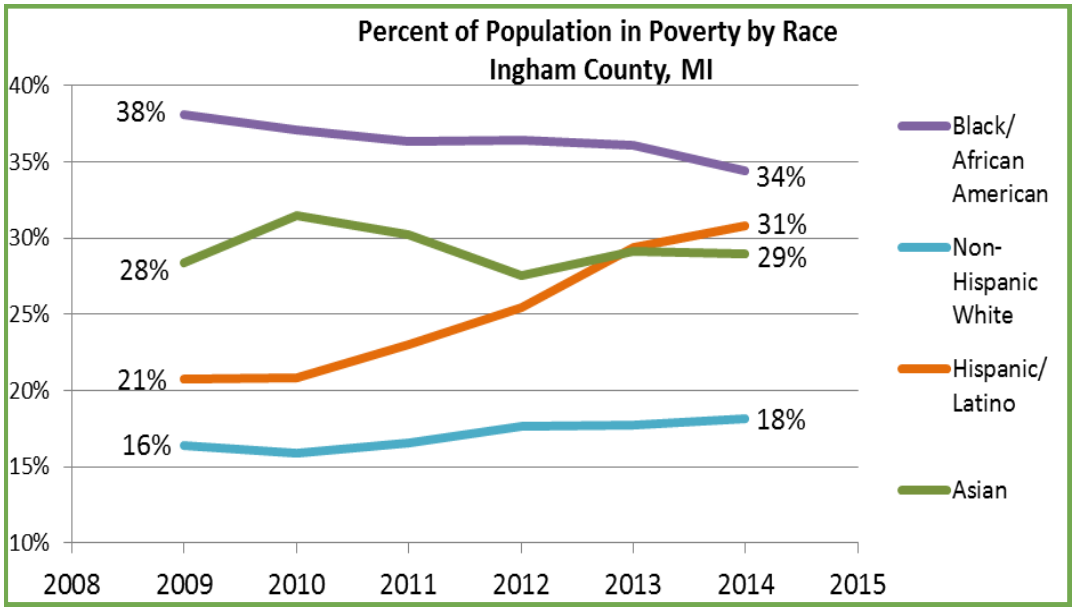


IPUMS
PolicyLink/PERE National Equity Atlas, www.nationalequityatlas.org

Current educational attainment and projected state/national-level job education requirements by race/ethnicity and nativity: Lansing-East Lansing, MI Metro Area, AA degree or higher, 2014



IPUMS; Georgetown University Center on Education and the Workforce
PolicyLink/PERE National Equity Atlas, www.nationalequityatlas.org



While the 2017-2019 CHIP does not contain goals and objectives related to housing affordability, this is an area that should be considered for inclusion in the next CHIP update. Data reviewed by the financial stability workgroup indicates:

- 53% of Ingham County renters are considered "extremely housing burdened", meaning they pay more than 35% of their income to housing
- The need for affordable rental housing units for households living below the "ALICE" threshold in Ingham County is 19,696 greater than the supply of available affordable units
- Among renters in Ingham County, those in Lansing and East Lansing experience the greatest housing burden, with 59% and 68% of renters in these communities paying more than 30% of their income toward housing
- In 2014, 66% of Black/African American residents in Ingham County rented a home, as compared to 36% of White residents and 55% of Hispanic/Latino residents
- Homeownership rates dropped 4% in the county from 2009 to 2014, plummeting by 8% among Black/African American residents and dropping by 5% among Hispanic residents and 3% among White residents.

Data from American Community Survey 2009-2014 5-year estimates and ALICE in Michigan report, published September 2014 by United Ways of Michigan UnitedWayALICE.org/Michigan

Priority Area: Financial Stability and Economic Mobility

Goal 1: Increase asset-friendly policies among Ingham County businesses and institutions.

Objectives:

1.) By December 2019, increase from three (3) to six (6) banks and credit unions in Ingham County offering bank accounts that meet the *Bank On* account standards promulgated by the national coalition of *Cities for Financial Empowerment.*

Strategy 1.

Raise awareness of *Bank On* national account standards among banks and credit unions located in Ingham County.

Strategy 2.

Increase adoption of *Bank On* national account standards among banks and credit unions located in Ingham County.

Lead roles:

- City of Lansing Office of Financial Empowerment

Tactics:

- Hold meetings with banks and credit unions to explain the *Bank On* national account standards and ask them to discuss their current standards.
- Offer technical assistance and promotional benefits to banks and credit unions willing to adopt the *Bank On* national account standards.

Measurements:

- Number of banks and credit unions engaged in meetings to learn about the *Bank On* national account standards.
- Number of banks and credit unions participating in technical assistance and promotional benefits of adopting the *Bank On* national account standards.

Evidence base: Franz, Chelsey Erbaugh, "The relationship between financial empowerment and health related quality of life in Family Scholar House participants." (2015). Electronic Theses and Dissertations. Paper 2029. https://doi.org/10.18297/etd/2029

Cities for Financial Empowerment, Bank On National Account Standards:

http://cfefund.org/bank-on-national-account-standards-2017-2018/

Cities for Financial Empowerment Fund Comments Submitted to the Commission on Evidence-Based Policymaking, Docket ID USBC-2016-0003, December 14, 2016.

Outcome measures: Number of banks and credit unions in Ingham County offering bank accounts that meet the Bank On national account standards promulgated by the coalition of Cities for Financial Empowerment.

Priority Area: Financial Stability and Economic Mobility

Goal 2: Increase use of asset-friendly programs among Ingham County residents.		
Objectives:		
2.1.) By December 2018, pilot a small loan program serving as a viable social enterprise for local lenders and a resource for people in need of emergency, short-term loans that are safe and accessible.	Strategy 1. Explore prospective financial institutions and financial education providers.	Lead roles: • Capital Area United Way Tactics: • Host round table discussions with prospective vetting agencies to conduct referrals for short-term loans. • Identify prospective vetting agencies to conduct referrals for short-term loans. Measurements: • Pilot program executed in Ingham County.
	Evidence base: Drowning in Debt: A Health Impact Assessment of How Payday Loan Reforms Improve the Health of Minnesota's Most Vulnerable. Health Impact Partners and ISAIAH, March 2016. www.humanimpact.org Pew Charitable Trust Issue Brief on Consumer Financial Protection Bureau (CFPB) Proposal for Payday and Other Small-Dollar Loans; A Survey of Americans. July 28, 2015. www.pewtrusts.org/small-loans	
	Outcome Measure: Number of financial institutions participating in pilot small loan program.	

Priority Area: Financial Stability and Economic Mobility

Goal 2: Increase use of asset-friendly programs among Ingham County residents.

Objectives:

2.2.) By December 2018, increase from five (5) to forty (40) Ingham County residents who open an *EARN* match-savings/Individual Development Account through the Asset Independence Coalition (AIC) each year.

Strategy 1.

Streamline *EARN* referral process in partnership with local organizations offering financial coaching and Central Michigan 211.

Strategy 2.

Inform residents who use AIC's VITA income tax-preparation assistance about *EARN* savings opportunities in advance of their tax appointment.

Lead roles:

Asset Independence Coalition

Tactics:

- Work with Center for Financial Health, Capital Area Housing Partnership, Office of Financial Empowerment and Capital Area Community Services to integrate referrals to *EARN* into their financial coaching programs.
- Work with Central Michigan 211 to establish a protocol to offer *EARN* referrals to Ingham County residents who call to schedule an appointment for financial coaching or VITA tax services.
- Mail *EARN* educational materials to all VITA appointment-holders in advance of their tax preparation appointment.

Measurements:

- Number of local financial coaching programs and referral services that integrate EARN referrals into their protocols.
- Number of individuals scheduled for VITA tax appointments receiving EARN information in advance of their tax appointment.

Evidence Base: Building Savings for Success Early Impacts from the Assets for Independence Program Randomized Evaluation, Opportunity and Ownership Initiative, OPRE Report #2016-59 December 2016 http://www.urban.org/sites/default/files/publication/86146/building_savings_for_successfinal_1.pdf. -Ten-Year Impacts of Individual Development Accounts on Homeownership: Evidence from a Randomized Experiment. Michal Grinstein-Weiss, Michael Sherraden, William G. Gale, William M. Rohe, Mark Schreiner, and Clinton KeyFriday, March 4, 2011 https://www.brookings.edu/research/ten-year-impacts-of-individual-development-accounts-on-homeownership-evidence-from-a-randomized-experiment/ Individual Development Accounts: a Vehicle for Low-Income Asset Building and Homeownership, Fall 2012, Evidence Matters (a publication of the U.S. Department of Housing and Urban Development's Office of Policy Development and Research. https://www.huduser.gov/portal/periodicalsemfall12highlight2.html#title

Outcome Measures: Number of residents who open an *EARN* match-savings/Individual Development Account through the Asset Independence Coalition (AIC).

Priority Area: Financial stability and economic mobility

Goal 3: Narrow gaps in income by race in Ingham County.

Objectives:

3.1.) By December 2019, engage at least 300 county residents/ organizational leaders in dialogue regarding research-based and local connections between exposure to violence and economic mobility.

Strategy 1.

Throughout 2017 and 2018, host community events to engage residents in conversation about economic mobility and violence.

Strategy 2.

Conduct four (4) small group dialogues in neighborhoods with reported violence to cultivate neighborhood partnerships.

Strategy 3.

Conduct one (1) community-wide forum on violence reduction and economic mobility.

Strategy 4.

Draft and submit (1) one grant to focus on violence prevention from a public health and harm reduction approach.

Lead roles:

One Love Global-MY Lansing My Brother's Keeper

Tactics:

- Schedule and promote community events, small group dialogues and community-wide summit.
- Apply for Roadmaps to Health Team Coaching from County Health Rankings & Roadmaps for coaching regarding public health partnerships to reduce youth, domestic and community violence.
- Invite representatives from Cities United to present at the community-wide forum.

Measurements:

- Number of community events, group dialogues and community summits held.
- Submission of Roadmaps to Health Team Coaching Application completed.
- Invitation issued to Cities United representative(s) to present at community-wide forum.

Evidence base: Marilyn Metzler[a, b, ·] (RN, MPH), Melissa T. Merrick[a] (PhD), Joanne Klevens[a] (MD, PhD, MPH), Katie A. Ports[a] (PhD), Derek C. Ford[a] (PhD) "Adverse childhood experiences and life opportunities: Shifting the narrative" *Children and Youth Services Review* Volume 72, January 2017, Pages 141–149

- Patrick Sharkey and Gerard Torrats-Espinosa. 2016. "The Effect of Violent Crime on Economic Mobility." Working Paper.
- Sharkey, Patrick (in press). "Neighborhoods, Cities, and Economic Mobility." RSF: The Russell Sage Foundation Journal of the Social Sciences.
- Patrick Sharkey, Nicole Tirado-Strayer, Andrew V. Papachristos, and C. Cybele Raver (December, 2012), "The Effect of Local Violence on Children's Attention and Impulse Control," American Journal of Public Health; 102(12): 2287-2293
- Patrick Sharkey, Amy Ellen Schwartz, Ingrid Gould Ellen, and Johanna Lacoe (2014) "High Stakes in the Classroom, High Stakes on the Street: The Effect of Community Violence on Students' Standardized Test Performance," Sociological Science; 1: 199-200.
- Raj Chetty, Nathaniel Hendren, and Lawrence F. Katz (2015) "The Effects of Exposure to Better Neighborhoods on Children: New Evidence from the Moving to Opportunity Experiment" Harvard University and NBER. http://www.equality-of-opportunity.org/images/mto_paper.pdf
- Gary Slutkin (2013) "Violence is a Contagious Disease" in Contagion of Violence: Workshop Summary, National Forum on Global Violence Prevention; Board on Global Health; Institute of Medicine; National Research Council. Washington (DC); National Academies Press (US); 2013 Feb 6. II.9, Available from: www.ncbi.nlm.nih.gov/books/NBK207245/

Outcome Measures: Number of people engaged in dialogue regarding existing research base and local connections between exposure to violence and economic mobility.

Priority Area: Financial stability and economic mobility

<table>
<tr><td colspan="3">Goal 3: Narrow gaps in income by race in Ingham County.</td></tr>
<tr><td>Objectives:</td><td colspan="2"></td></tr>
<tr><td rowspan="4">3.2.) By December 2019, equip forty-five (45) local law enforcement, justice, education and health practitioners with tools and resources to identify and dismantle racial inequities.</td><td rowspan="2">Strategy 1.

By December 2017 equip law and justice system practitioners with a public health and health equity frame for violence prevention and reduction.

Strategy 2.

Recruit a minimum of three (3) public and private health professionals to serve on Michigan Truth, Racial Healing & Transformation Law, Economy and Separation Teams.

Strategy 3.

Connect local healthcare leaders and community members to national leaders who help communities reduce violence.</td><td>Lead roles:

One Love Global. MY Lansing My Brother's Keeper</td></tr>
<tr><td>Tactics:

• Develop and facilitate a series of webinars for healthcare leaders and members of the Michigan Truth, Racial Healing & transformation Teams to increase knowledge of violence interruption and prevention approaches.

Measurements:

• Number of webinars developed and facilitate

• Number of participants in webinars</td></tr>
<tr><td colspan="2">Evidence base: Violence Trends, Patterns and Consequences for Black Males in America: A Call to Action. A Cities United Report by Arnold Chandler. March 2017.

Framing the Dialogue on Race and Ethnicity to Advance Health Equity. Proceedings of a Workshop, Darla Thompson, Rapporteur. Roundtable on Population Health Improvement, Board on Population Health and Public Health Practice, Health and Medicine Division. The National Academies of Sciences, Engineering and Medicine. The National Academies Press, Washington DC, 2016.</td></tr>
<tr><td colspan="2">Outcome Measures: Number of local law enforcement, justice, education and health practitioners equipped with tools and resources to identify and dismantle racial inequities.

Change in proficiency among law enforcement, justice, education and health practitioners identifying and dismantling racial inequities</td></tr>
</table>

Priority Area: Financial stability and economic mobility

Goal 3: Narrow gaps in income by race in Ingham County.

Objectives:

3.3.) By December 2019, increase the number of residents by 100, ranging from ages sixteen (16) through twenty -four (24) who are enrolled in the MY Lansing Mentoring Network.

Strategy 1.

Promote high school and post-secondary completion as determinants of health and a targeted approach to violence prevention.

Strategy 2.

Increase regional participation in summer and year-round youth employment in collaboration with schools, neighborhood groups, public housing agencies, employers and workforce development agencies.

Strategy 3.

Increase opportunities for youth leadership and civic engagement.

Strategy 4.

Increase opportunities for youth entrepreneurship in partnership with regional higher education institutions.

Lead roles:

- One Love Global- MY Lansing My Brother's Keeper

Tactics:

- Host neighborhood-level engagement
- Coordinated outreach through faith-based organizations
- Coordinate media campaign
- Explore diversion partnerships with judicial system partners

Measurements:

- Number of people reached through neighborhood-level engagement
- Number of people reached through faith-based organizations
- Number of meetings/ contacts to explore diversion partnerships with judicial system partners

Evidence base: Heller S, Pollack HF, Ander R, Ludwig J. Preventing Youth Violence and Dropout: A Randomized Field Experiment. National Bureau of Economic Research Working Paper 19014; Cambridge, MA: 2013.

Panel Paper: Brain Science, Mentoring, and Incentives: A New Approach to Promoting Economic Mobility Among Recipients of Housing Subsidies. November 14, 2015. James Riccio, MDRC and Michael L Wiseman, George Washington University

Education and Economic Mobility VIII by Ron Haskins, The Brookings Institution.

Outcome Measures: Number of residents ages sixteen (16) through twenty-four (24) enrolled in the MY Lansing Mentoring Network.

Ingham County
Health Department

Behavioral and Mental Health

Strategic Priority:

The Problem

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. Approximately one in twenty-five adults in the tri-county area reported have a mental health or emotional problem that severe enough to affect normal activity. Within the tri-county area, the prevalence varied slightly between the counties. Clinton County had the lowest proportion of adults with poor mental health. Eaton County had the highest.

A higher proportion of adolescents in the capital area reported "symptoms of depression" as compared to Michigan adolescents (31.0% compared to 26.0%). The proportion of adolescents who reported "symptoms of depression" varied between counties within the local region, About a third of Ingram and Eaton Counties youths (33% and 32.8%) 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. That figure was 26.8% in Clinton County.

Stakeholders from hospital behavioral health, communities schools, Ingham Health Plan, Community Mental Health Authority and Michigan State University all agreed that mental health is a key underserved area of need in Mid-Michigan.

Gaps identified by stakeholders include:

- Huge shortage in psychiatrists and hard to find licensed Master Social Workers and there are even fewer pediatric psychiatry .
- Our region doesn't qualify for reimbursement
- The general fund that help us address non-emergency cases has been severely cut from $12M in 2014 to $4-6M in 2016; on one hand we do have money to expand Healthy Michigan and on the other hand we are limited.
- There are limited hospitals equipped truly for ER services access centers. These would need to include the following features: 1) Specific wing for people who need more secure area; 2) Specialized physicians; 3) Psychiatric backup staff; 4) Ability to transition the person and follow up services
- There is a big gap in addressing Substance Use Disorders (SUD)- New name for commonly known before as substance abuse. Behavioral Health services include both SUD and Mental Health.
- There is a huge gap in pediatric services but Margie will talk about that.
- Pain killers issue nowadays surpassed alcoholism as a contributing factor to behavioral health disorders.
- Not enough beds for kids; Even when admitted they need one on one which isn't available

> *Many of the Ingham Health Plan clients are homeless and we see a relation between that and substance abuse; we should address both issues when treating patients. We should also address the culture regarding the stigma of seeking mental health services because it is also often a barrier to seeking help; people still think addiction is a moral failure while providers see it more as a chronic disease. Training health care workers in motivational interviewing is one way to start changing that culture stigma"*

Ways to address the behavioral/mental health problem

Stakeholders agree that one way to address the problem is to increase community awareness among community members who are more likely to be the first responders to a crisis.

- Promote the Mental Health First Aid class
- Develop a directory of resources to build community awareness
- Create awareness on the process of how to access services
- Improve the ability of people to access and navigate the behavioral/mental health system
- Increase collaborations among existing providers

Community Health Improvement Action Plan

Priority Area: Mental and Behavioral Health

Goal: Increase number of individuals that access behavioral health services inclusive of mental health (MH) and substance use disorder (SUD) services.

<table>
<tr><td>Objectives:</td><td colspan="2"></td></tr>
<tr><td rowspan="3">1.) By 2020, improve access and availability of Behavioral Health services (MH and SUD) in the tri-county area that will be measured by decreasing numbers of denials to in-patient psychiatric services and an increasing numbers of mild to moderate non-emergency cases of clients who are offered Behavioral Health (BH) services.</td><td rowspan="2">Strategy 1.

Improve access/availability of treatment for Substance Use Disorders and mild to moderate conditions (i.e. co-occurring mental health and SUD)

Strategy 2

Support the implementation of the Tri-County Crisis Intervention Team Training

Strategy 3

Improve access/availability tracking of psychiatric in-patient services

Strategy 4.

Development of a Youth Mobile Crisis Unit

Strategy 5

Support and assist in the community mapping activity to inform the CHIP behavioral health committee for further planning

Strategy 6

Continue to explore data and Integrated Care opportunities, grants, and partnerships between primary care, mental health, and substance use disorder provider networks.</td><td>Lead roles:

• Community Mental Health Authority (Clinton-Eaton-Ingham) (CMH-CEI)

• Lansing Police Department

• Sparrow Health Centers

• National Alliance on Mental Illness.</td></tr>
<tr><td>Tactics:

• Improving the care coordination, access and referral protocols, policies, and practices of the behavioral healthcare service delivery system

• Work with Tri-County CIT steering committee to coordinate training./opportunities.

• Track denials and advocating for improved policies, practices, and statewide mandates . (Strat. 3)

• Establish stakeholder planning meetings to develop Youth Mobile Crisis Unit plan. (Strat. 4)

• Follow Sparrow action plan steps for Strategy 5.

• Identify how many individuals do not have access to BH services for mild to moderate and/or co-occurring conditions. (Strat. 6)

• Promote and share tri-county eligibility data due to Healthy Michigan / Medicaid Expansion and identify recommendations. (Strat. 6)</td></tr>
<tr><td></td><td>Measurements:

• Decrease in denials in psychiatric in-patient services

• Increased access to BH services (inclusive of non-emergency and mild to moderate conditions) and numbers served

• Mapping project progress reports to the Power of We Consortium once a year.</td></tr>
<tr><td></td><td colspan="2">Evidence base: https://www.samhsa.gov/capt/tools-learning-resources/finding-evidence-based-programs</td></tr>
<tr><td></td><td colspan="2">Outcome : Increased Access to Behavioral Health Services. Reduction of Crisis Hospitalization with increased in-patient services and Reduction if Emergency care Access based on Team Assessments at Sparrow Hospital.</td></tr>
</table>

Goal: Increase number of individuals that access behavioral health services inclusive of mental health (MH) and substance use disorder (SUD) services.		
Objectives:		
2.) By September 30, 2020 increase the use of research based behavioral health interventions.	Strategy 1. Create list of behavioral health interventions and support, then promote, and expand the implementation of these efforts.	Lead roles: • Community Mental Health • American Foundation for Suicide Prevention • Ingham County Health Department
		Tactics: • MHFA training to improve understanding of BH, reduce stigma, improve supports • Safe talk training—– half day workshop that prepares anyone to become a suicide-alert helper. • ASTST training Applied Suicide Intervention Skills Training is a two-day workshop to learn how to reduce immediate risk of suicides. • Seeking safety curriculum training • Trauma informed communities
		Measurements: Number of educational opportunities provided, training in MHFA, Safe Talk, ASIST, Seeking Safety, etc.
	Strategy 2. Provide continuing medical education to behavioral health provider networks and behavioral health education and to primary care networks	Lead roles: • Community Mental Health Authority (Clinton-Eaton-Ingham)
		Tactics: • Coordinate with partner agencies to set up training opportunities. • Process updates including number of trainings and participation records and evaluation.
	Evidence base: https://www.samhsa.gov/capt/tools-learning-resources/finding-evidence-based-programs	
	Outcome: • Increased Community capacity to more appropriately respond, intervene and refer in crisis situations	

Goal: Increase number of individuals that access behavioral health services inclusive of mental health (MH) and substance use disorder (SUD) services.		
Objectives:		
3.) By September 30, 2020 enhance and improve the behavioral health screening protocol and practices within primary care and behavioral healthcare settings.	Strategy 1. Screening Brief Intervention Referral to Treatment (SBIRT) in Clinical Practice.	Lead roles: • Community Mental Health • Sparrow Health Centers • Ingham Health Plan
		Tactics: • Recruit new practices to join the implementation of SBRT in their clinics.
		Measurements: Number of new sites implementing SBIRT protocols and # of patients screened for Behavioral Health (MH & SUD) conditions. # of treatment referrals initiated from expanded screening protocol.
4.) By September 30, 2020 stakeholders will reduce stigma surrounding access to behavioral health services and improve community health and wellness.	Strategy 1. Develop and begin implementation of a Behavioral Health Promotion Campaign (inclusive of suicide prevention, substance abuse prevention, and wellness activities, events, and opportunities)	Lead roles: • Community Mental Health Authority (Clinton-Eaton-Ingham) • ICHD • American Foundation for Suicide Prevention • National Alliance on Mental Health. • Association for Children Mental Health (ACMH)
		Tactics: • To be determined by stakeholders (January 2017) • Campaign developed and successful turn out participation and process data.
	Evidence base: • SBIRT is recommended by https://www.samhsa.gov/sbirt • Four approaches to combat stigma on mental and behavioral health: https://www.nap.edu/read/23442/chapter/1#xi	
	Outcome: • Increased Behavioral Health Screenings and referrals • Reduced Behavioral Health Stigma on Service s and access to care	

Implementation Plan

Using The Plan

There is a role for each member in our Ingham County community to contribute to health improvement whether in our homes, schools, workplaces, churches, or in our communities at large. It is much easier to encourage and support healthy behaviors early on and in various settings than to alter unhealthy habits. Below are simple ways various sectors may use this document to improve our community health.

Employers

- Understand priority health issues that affect your community
- Develop worksite wellness program
- Use some of the objectives as discussion topics that may affect health of your employees.

Educators

- Understand the impact of healthy habits built in childhood
- Integrate some of the strategies into the school wellness policies.
- Collaborate with Ingham County Health Department by sharing your school healthy practices that fall under some of the strategies in this plan

Faith-based Organizations

- Invite members of this plan steering committee to present the plan at your congregation.
- Talk with your members regularly about the importance of practicing healthy lifestyles
- Identify specific strategies or tactics in the plan that your organization can help advance.

Community residents

- Understand how health issues are changing and prioritized in your community.
- Use the plan to improve your health and that of people in your circles.
- Use the information to generate leaders' support
- Get involved in future planning activities

Health Care Affiliates

- Advocate the strategies and tactics in this plan to eliminate barriers to quality health care.
- Offer patients the resources they need to make change relevant to the needs identified in this plan
- Get involved in future health planning projects

State and Local Public Health Professionals

- Use the Plan to understand and improve the health of Ingham County residents
- Learn about key priority issues identified by the health improvement planning collaborative.
- Monitor the implementation of the plan by its various leading participants.

Community-based Organizations

- Invite members of this plan steering committee to present the plan at your congregation.
- Talk with your members regularly about the importance of practicing healthy lifestyles
- Identify specific strategies or tactics in the plan that your organization can help advance.

Government Officials

- Understand how health issues are changing and prioritized in your community.
- Mobilize leaders in Ingham County and the region to take actions
- Invest in programs, policy and environmental changes to help residents lead a healthier lifestyle.

Monitoring

Health For All Begins Here

Everyone has a stake in the health of our children, adults and seniors in Ingham County. This is a living document that we invite you to join us in sharing, implementing and improving. The Plan was developed for 2017-2020 and included detailed steps that we can all help advance and monitor.

The CHIP project coordinator will follow up with the organizations or coalitions that are taking a lead role for various objectives and will develop a matrix with partners' updates by objective every six months; The Power of We Consortium will also host guests from partnering entities to present updates on objectives they are leading once a year.

You can find this document and updates for your review at the following Ingham County website: http://hd.ingham.org/Records,DataReporting/Publications.aspx

For more information, to schedule a representative to speak at your organization, or to participate in any of the Plan initiatives, please contact:

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