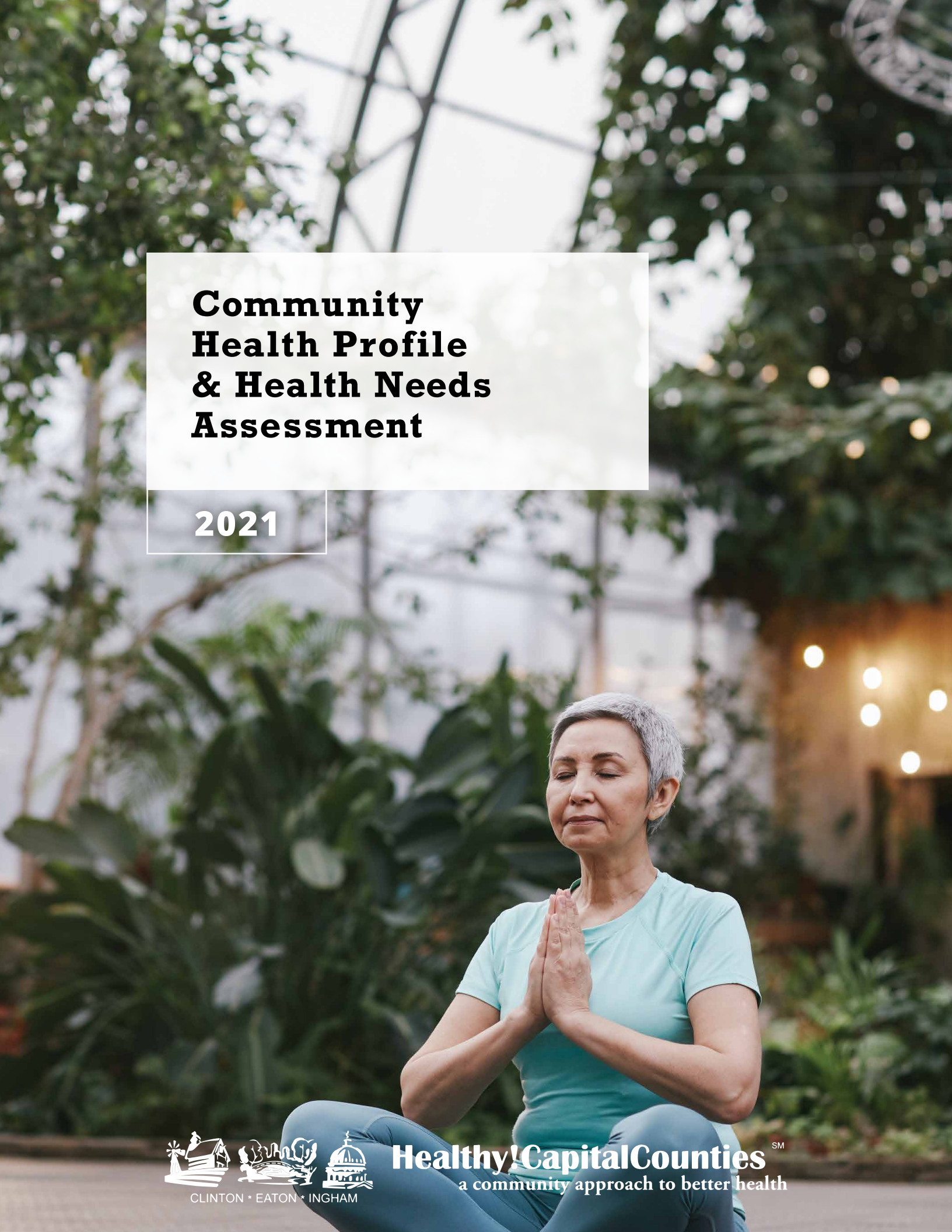

Community Health Profile & Health Needs Assessment

2021

CLINTON • EATON • INGHAM

Healthy Capital Counties℠
a community approach to better health

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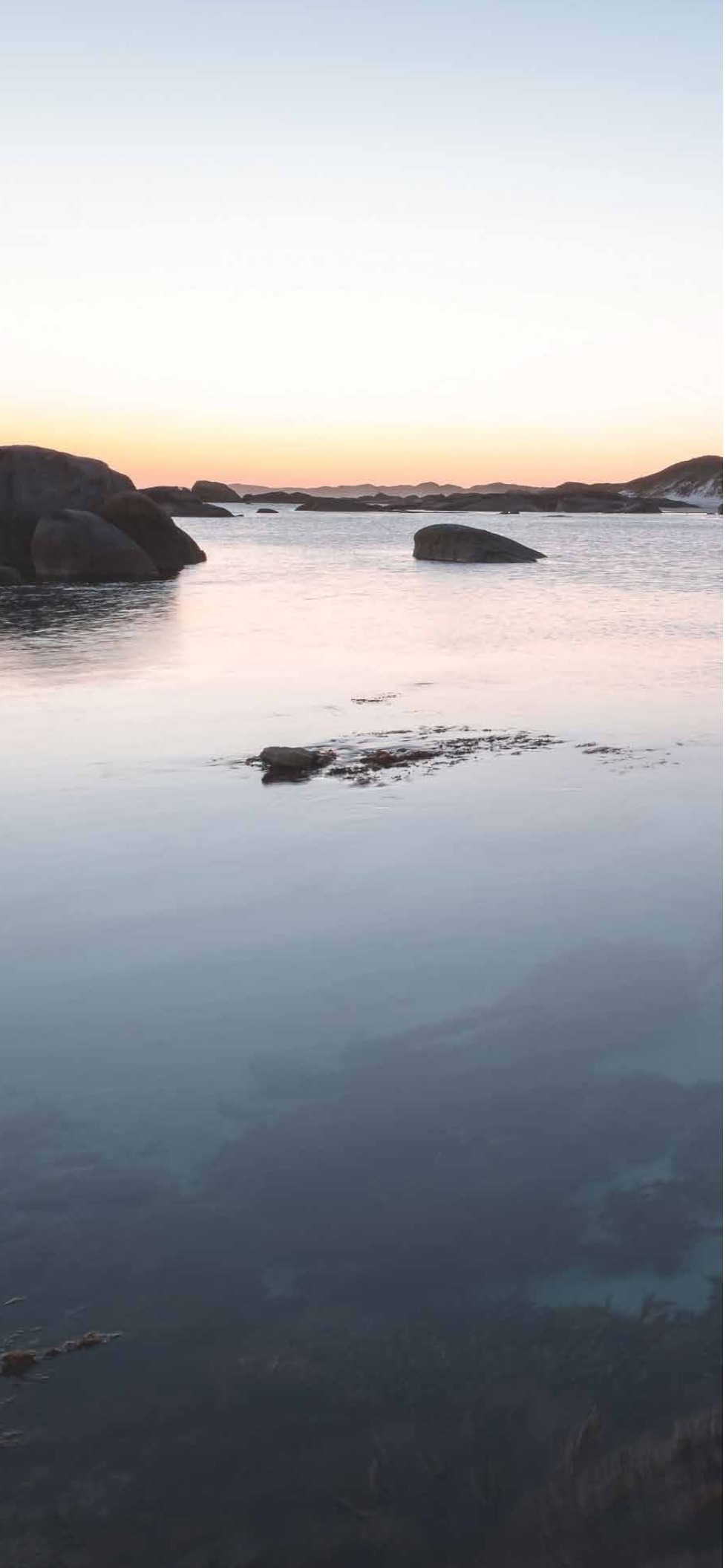

Vision

The vision of the Healthy! Capital Counties Community Health Improvement Process is that all people in Clinton, Eaton, and Ingham counties live:

- In a physical, social, and cultural environment that supports and encourages 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

Purpose

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

About The Project

ACKNOWLEDGMENTS

A large-scale project such as this assessment, conducted during a global pandemic, could not have been possible without the support and meaningful participation of many people and organizations across Clinton, Eaton, and Ingham counties. Our most sincere thanks go to the members of the Healthy! Capital Counties Workgroup — representing the hospital systems and local health departments across our three counties. Your continued support is welcomed as we transition from the assessment to the planning stage of this project. Additional thanks go to those throughout the community who gave their input via participation in focus groups, stakeholder meetings, and surveys.

PROJECT SUPPORT

Support for this project was provided by:

HOSPITALS

- Eaton Rapids Medical Center
- McLaren Greater Lansing
- Sparrow Health System

LOCAL HEALTH DEPARTMENTS

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

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PUBLICATION DESIGN

Redhead Creative Consultancy

PUBLICATION DATE

November 19, 2021

DEFINITIONS

COMMUNITY HEALTH IMPROVEMENT PROCESS

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

COMMUNITY HEALTH ASSESSMENT (CHA)

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

COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP)

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

PROCESS

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

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

In June of 2012, the Healthy! Capital Counties project published the first Community Health Profile and Needs Assessment, with a key findings section added in August 2012. The second round of the community health improvement process was started in October 2014 and resulted in the 2015 Profile and Needs Assessment, published in October of 2015. The third cycle of the Healthy! Capital Counties project started in August of 2017 and was published in November 2018. This cycle began in December 2020 and has led to publication of this document.

COMMUNITY ENGAGEMENT

The Healthy! Capital Counties project is unique in its multi-agency, collaborative structure that reflects the lived experiences of residents. Many view the area as one region rather than three separate counties. This collaboration also promises to integrate and apply a health equity perspective to its processes and data interpretations. Health equity is defined as the economic and social conditions that influence the health of individuals, communities, and jurisdictions as a whole.[1]

The project included one main workgroup, which is made of hospital system and health department representatives, to provide guidance to the project staff, as well as to assist with project visioning, indicator selection, identification of key focus group populations, promotion, communications, and media.

Input from the community was sought through several mechanisms. First, suggestions and comments on the proposed indicator table for the quantitative data were solicited through the Healthy! Capital Counties workgroup. Second, five focus groups were held in various locations (including one held virtually) across the Eaton and Ingham counties to gather input from traditionally underserved populations. Traditionally, a focus group specific to Clinton County was also held. Unfortunately, due to difficulty recruiting and other complicating factors related to COVID-19, a focus group was not held for this cycle. Several attempts were made to recruit participants but none were successful. Online surveys were also distributed to both the community at large and the health care providers of the participating hospital systems to obtain perspective on the health issues and needs currently existing in the tri-county area.

Three stakeholder meetings were held in December 2020, March 2021, and August 2021 to provide community organizations, partners, stakeholders, and the public the opportunity to give feedback on many aspects of the project, including the quantitative indicator table, asset mapping, questions for the focus group participants, the community survey, and a preview of quantitative and qualitative results. These meetings were critical to engaging the community in the community health assessment process.

The next task for the project includes promotion and participation in an event to determine the community health priorities, consisting of numerous representatives, such as: community members, elected officials, cross-sector agency representatives, and leaders from each of the three counties, in addition to members of the workgroup. Development of the Community Health Improvement Plan will then be based on the priorities selected.

JURISDICTION

Many persons living in Clinton, Eaton, and Ingham counties view themselves as residents of a greater “Capital Area”, which is centered on the urban core of the cities of Lansing and 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 a small community hospital to large tertiary care centers. The need to establish a process that would look broadly at the region as a whole and at the county level, while also viewing smaller geographies more closely, was essential. The jurisdiction covered by this Community Health Profile includes all of the residents living in Clinton, Eaton, and Ingham counties.

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

MODEL

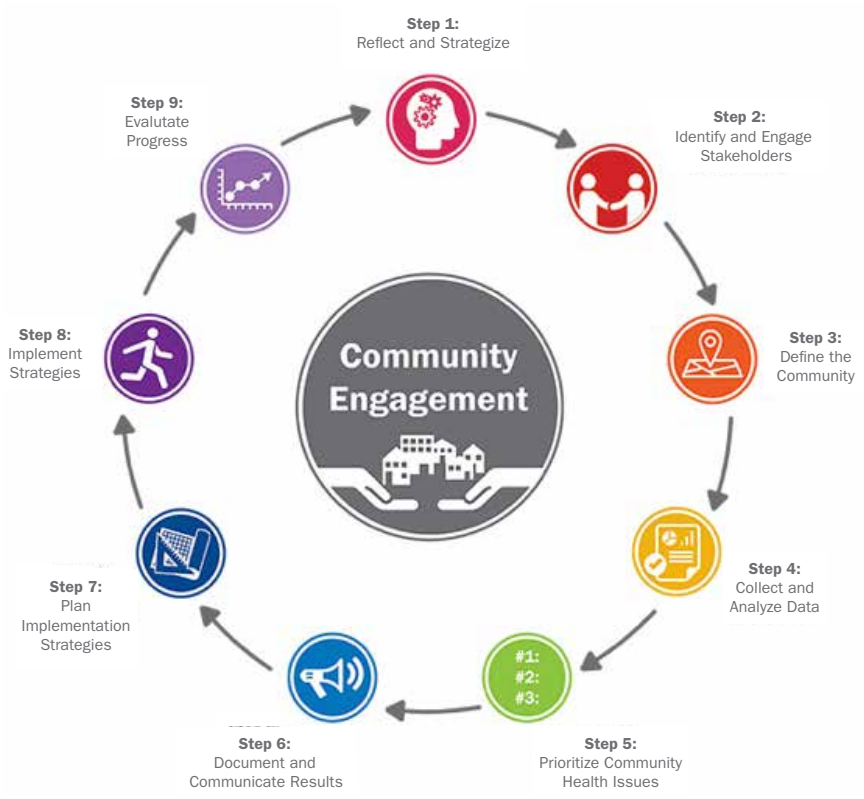
We used the Association for Community Health Improvement's model for our Community Health Assessment and Improvement Planning project. Constructed by a team of professionals working in both hospital and public health settings, this model fit both the nature of our project as well as the timeframe. The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

Steps in this model were modified in order to meet PHAB accreditation standards and to enhance community engagement.

Health equity principles were also applied in the framing of the project. 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; and
- the participation of communities that are traditionally marginalized; and
- community engagement activities.

THE ASSOCIATION FOR COMMUNITY HEALTH IMPROVEMENT MODEL



DATA COLLECTION

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

PRIMARY DATA SOURCES

Several primary data sources were used in the development of this report: the Healthy! Capital Counties focus groups, the Healthy! Capital Counties community and health care provider surveys, and the Capital Area Behavioral Risk Factor and Social Capital survey.

Healthy! Capital Counties Focus Groups: In order to gather information from traditionally hard to survey populations and to document the experiences, thoughts, beliefs, and stories of the community, a series of focus groups were conducted for the project. Six focus groups were held between June and July 2021 and were conducted virtually as well as in various locations throughout the three counties. Groups that were actively solicited for input were:

- Persons with disabilities
- Persons in recovery from substance addiction
- Persons who did not have health insurance
- Persons who had low incomes or were unemployed
- Persons who identified as Spanish-speaking Hispanic or Latino/a
- Persons who identified as a person of color.

Capital Area Behavioral Risk Factor & Social Capital Survey: Since 2000, the Capital Area United Way, Barry-Eaton District Health Department, Ingham County Health Department, and Mid-Michigan Health Department have conducted a population-based landline/mobile phone health survey of adults in their jurisdictions (Barry, Eaton, Ingham, Clinton, Gratiot, and Montcalm counties) on various behaviors, medical conditions, and preventive health care practices. The survey was conducted using the Capital Area Behavioral Risk Factor & Social Capital survey instrument, which is based on the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System questionnaire, as well as questions developed by the health departments to collect information of interest to the local community. During the 2017-2019 sampling period, a total of 2,634 adults in Clinton, Eaton, and Ingham counties responded to the landline/mobile phone survey.

Community and Health Care Provider Surveys: In order to gather input about the community's health needs from stakeholders and the general public, two online surveys were administered during February-May 2021. One survey was for any community resident who lived and/or worked in the tri-county area, and the second survey was for health care providers associated with the project's hospital system partners.

SECONDARY DATA SOURCES

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

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

Michigan Care Improvement Registry (MCIR): MCIR was created in 1998 to collect reliable immunization information for children and make it accessible to authorized users. A 2006 change to the Michigan Public Health Code enabled the MCIR to transition from a childhood immunization registry to a lifespan registry which includes citizens of all ages. MCIR benefits health care organizations, schools, licensed childcare programs, pharmacies, and Michigan's citizens by consolidating immunization information from multiple providers into a comprehensive immunization record.

Michigan Department of Health and Human Services (MDHHS): The Michigan Department of Health and Human Services is responsible for the collection of information on a range of health-related issues, including monitoring Michigan's general health and well-being, health program development, targeting and evaluation of program progress, and identification of emerging health issues and trends.

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

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

United States Department of Agriculture (USDA): The USDA measures many aspects of the food environment, including store/restaurant proximity, food prices, food and nutrition assistance programs, and community characteristics, as well at the interaction between these aspects, in

order to identify causal relationships of food choice, diet quality, and access to healthy food.

Michigan Association of United Ways: Since 2014, the United Ways of Michigan have authored the ALICE report, which provides a comprehensive look at Michigan residents who are at risk of financial deprivation. ALICE stands for Asset Limited, Income Constrained, Employed, and comprises households with income above the Federal Poverty Level but below the basic cost of living for their area. These households typically do not have enough financial resources to cover unforeseen expenses which, when they occur, send them spiraling into poverty.

GEOGRAPHIC AREA GROUPS METHODOLOGY

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

Sub-county statistics are usually not reported by health professionals due to population size. A city/township with a population of 150,000 has sufficient persons experiencing health events (births, deaths, diabetes, heart attacks, etc.) to calculate statistics that are both stable and maintain confidentiality — but a city or township with a population of 15,000 does not. To overcome this problem, some cities and townships in the tri-county area were re-sorted into geographic groupings of similar municipalities with sufficient population sizes for reporting health statistics. For the purposes of this project, sub-county geographic areas were grouped by City. Where possible, City information was combined to form an "Urban" geography. Other sub-county groupings were not analyzed for this report.

TRI-COUNTY GROUP

Clinton, Eaton and Ingham Counties were analyzed individually and as an aggregate group based on county boundaries.

URBAN GROUPS

The City of Lansing, the City of East Lansing, and Lansing Charter Township were analyzed individually and as an aggregate grouping based on existing municipal boundaries.

CITATIONS

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

How does health happen?

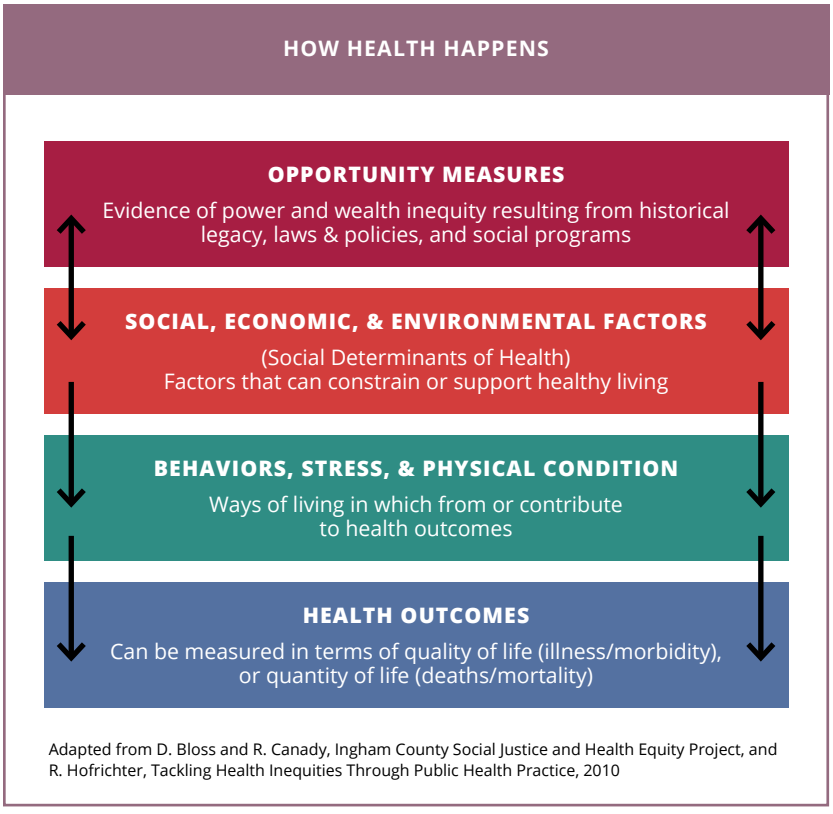
Health can seem like a very fragile thing; one minute you have it, the next minute it is gone. Some people look to their genetics to explain their health, others their behaviors. Some even feel that their neighborhood affects their well-being. In truth, they are all correct. As our knowledge of health evolves, we are realizing that a person's health is based on the interaction between their genes, their behaviors, their environment and their experiences. Some of these factors (*i.e.* our genes) can't be changed, while others, such as behavior, can.

This report is concerned with the changeable aspects of health, and therefore does not address genetics or heritable diseases. While personal responsibility plays a role in each person's individual health, it's important to also consider other factors of social and collective responsibility to improve health. In other words, the choices people make depend on the choices available to them. This report, using information about health outcomes, behaviors, environmental, and societal factors, is designed to reveal the patterns of ill health across populations or groups of people in the tri-county area.

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

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

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



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

2021 Indicators

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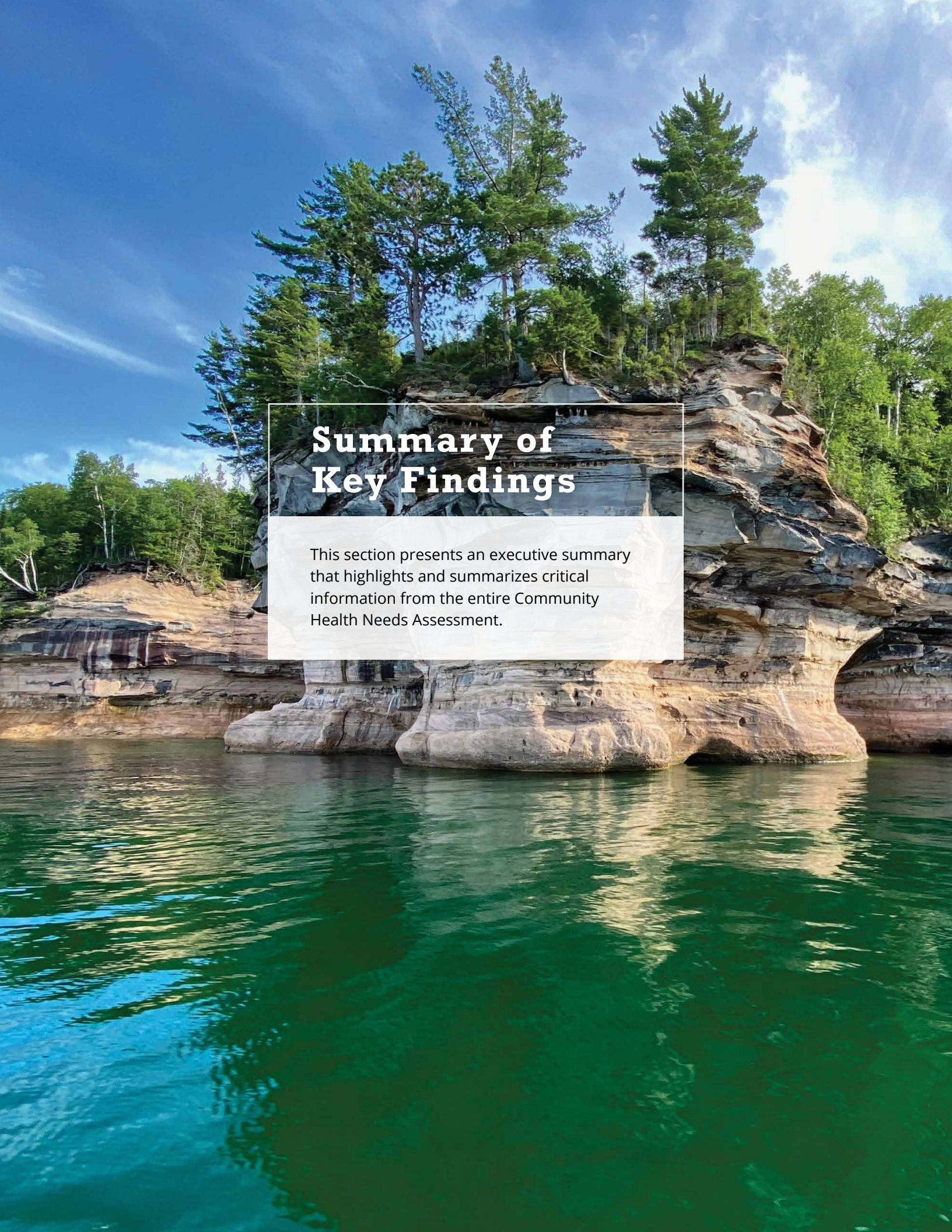
DOMAIN	INDICATOR GROUP	INDICATOR	MEASURES	SOURCE
OPPORTUNITY MEASURES	Income	Income Distribution	Gini coefficient of income inequality	ACS
SOCIAL, ECONOMIC, & ENVIRONMENTAL FACTORS	Social & Economic Factors	Income	Percent of households below ALICE threshold	United Way
		Education	Percent of adults ≥ 25 years old with a Bachelor's degree or higher	ACS
		Social Connection & Social Capital	Percent of adolescents who know adults in the neighborhood they could talk to about something important	MiPHY
		Community Safety	Rate of violent crimes	MSP
		Affordable Housing	Percent of households who spend more than 30% of their income on housing	ACS
	Environmental Factors	Environmental Quality (Indoor)	Rate of elevated blood lead levels among children < 6 years old	MDHHS
		Built Environment	Percent of the population living in a food desert	USDA
BEHAVIORS, STRESS, & PHYSICAL CONDITION	Health Behaviors & Physical Condition	Obesity	Percent of adults who are obese	BRFS
			Percent of adolescents who are obese	MiPHY
		Tobacco Use	Percent of adults who currently smoke	BRFS
			Percent of adolescents who smoked cigarettes during the past 30 days	MiPHY
		Alcohol Use	Percent of adults who binge drank during the past 30 days	BRFS
			Percent of adolescents who binge drank during the past 30 days	MiPHY
		Cannabis Use	Percentage of students who used marijuana in the past 30 days	MiPHY
			Percentage of students who tried marijuana prior to 13 years of age	MiPHY
		Physical Activity	Percent of adults who participated in leisure time physical activity	BRFS
		Nutrition	Percent of adults who consume recommended fruits and vegetables	BRFS
	Clinical Care	Access to Care	Percent of adults with no primary care provider	BRFS
			Percent of adults 18-64 years old with no health insurance	ACS
		Communicable Disease Prevention	Percent of non-medical immunization waivers granted	MCIR
	Stress	Mental Health	Percent of adults with poor mental health	BRFS
			Percent of adolescents with symptoms of depression in past year	MiPHY
HEALTH OUTCOMES	Illness (Morbidity)	Child Health	Rate of preventable asthma hospitalization among youths < 18 years old	MDHHS
		Chronic Disease	Rate of preventable diabetes hospitalization in adults >18	MDHHS
		Communicable Disease	Rate of chlamydia cases	MDHHS
		Adult Health	Rate of preventable CHF hospitalization among adults ≥ 65 years old	MDHHS
	Deaths (Mortality)	Overall Mortality	Mortality rate per 100,000	MDHHS/ACS
		Maternal & Child Health	Infant Mortality Rate	MDHHS
		Chronic Disease	Rate of deaths due to cardiovascular disease	MDHHS
		Safety Policies and Practices	Rate of deaths due to accidental injury	MDHHS

ACS: American Community Survey, conducted by the U.S. Census Bureau
BRFS: Behavorial Risk Factor Survey, conducted by local health departments
MCIR: Michigan Care Improvement Registry
MDHHS: Michigan Department of Health and Human Services
MiPHY: Michigan Profile for Healthy Youth Survey
MSP: Michigan State Police Tracking Network
USDA: United States Department of Agriculture



Summary of Key Findings

This section presents an executive summary that highlights and summarizes critical information from the entire Community Health Needs Assessment.

Findings

From the Healthy! Capital Counties 2021 Community Health Profile & Health Needs Assessment Report

The goal of this document is to summarize data from the report to arrive at a set of major Community Health Assessment findings. Given the length of the Community Health Profile and Health Needs Assessment Report, it is impossible to include all of the concepts, data, and needs discussed throughout the entire report. This document aims to provide a summary of findings only.

OPPORTUNITY MEASURES

(P. 19-21)

Opportunity measures do not impact health directly. They generally influence the physical, economic, and social environment of a community (the social determinants of health which influence health behaviors and outcomes). Opportunity measures are represented in this report by income inequality, which is the level at which income is distributed among a given community – whether that is a City, County, Region, State or Country. High levels of income inequality are associated with numerous adverse outcomes, such as higher crime, low levels of representative democracy, poor economic growth, and poor health. While those who are in poor health and have low income are disproportionally affected by income inequality, the health of other members of society is also adversely impacted by income inequality.

FINDINGS

- Income inequality was largely comparable throughout the majority of the tri-county area.
- The City of East Lansing had the most income inequality in the region, while Lansing Charter Township had the least.
- Among individual counties in the region, Ingham had the highest level of income inequality. Eaton County had the lowest level of income inequality.

SOCIAL, ECONOMIC, AND ENVIRONMENTAL FACTORS

(P. 22-39)

The indicators and measures in the 'Social, Economic and Environmental Factors' section are indicators and measures of the social determinants of health (SDoH). SDoH are factors that cannot be controlled by an individual, but affect the individual's environment and thus provide the context in which health behaviors, either harmful or helpful, and health outcomes arise. Examples of SDoH or 'Social, Economic, and Environmental Factors' are income, education, affordable housing, and built environment.

FINDINGS

- Among the county and sub-county geographic groups, there were substantial differences in the rates of household income, affordable housing, educational achievement, and the percentage of people living in a USDA defined 'food desert'.
- Approximately one third of adults age 25 and over have a bachelor's degree or higher in the Capital Area. Most areas in the tri-county region range from roughly 28% to 40%. The main outlier is the City of East Lansing with 72%, largely due to the presence of the university.
- Racial and ethnic disparities exist across the tri-county region with White residents at nearly 35%, Black residents at 31% and Hispanic residents at 22% who have attained a bachelor's degree or higher.
- Urban areas had the highest rates of residents living in unaffordable housing and were more likely to live in a 'food desert'.
- The percentage of households spending more than 30% of their income on housing costs decreased across all county and sub-county geographies from 2018 to 2019. Despite this decrease, almost 47% of households in the City of East Lansing still spend more than 30% of their income on housing related costs.
- Approximately 40% of adolescents in the tri-county area knew adults in their neighborhood that they could talk to about something important.

BEHAVIORS, STRESS, AND PHYSICAL CONDITION

(P. 40-86)

Behaviors, Stress, and Physical Conditions are different factors that contribute to the way people live. They may also protect or contribute to certain health outcomes. Good behaviors, low levels of stress, and good physical conditions can lead to good health, and vice versa. Examples of 'Behaviors, Stress and Physical Conditions' are obesity, substance use, access to care, and mental health.

FINDINGS

- The tri-county area fared worse than the state of Michigan on several indicators, including adult obesity, having a personal doctor or healthcare provider, adult mental health and adolescent mental health.
- Adult obesity increased at a substantial rate in all three counties; for the tri-county area, it rose from 33.6% in 2014-2016 to 35.1% in 2017-2019. Racial and ethnic disparities were found as well.
- At the county level, there were sizable differences for a few measures:
  - Adult smoking prevalence ranged from 18.3% for Ingham County to 21.8% for Clinton County. All county rates decreased compared to 2014-2016, except Clinton County.
  - The percentage of adolescents who experience symptoms of depression was higher in the tri-county area compared to Michigan with several notable disparities in race and ethnicity.
  - The percentage of adults who reported not having a personal doctor or health care provider ranged from 13.6% for Clinton County to 24.4% for Ingham County.
- There is an overall decreasing trend for current tobacco use in adolescents*. The prevalence ranged from 1.6% for Ingham County to 3.4% for Eaton County, which was much lower than the state rate of 15.3%.
- The percentage of adults 18-64 years with no health insurance has declined or remained relatively steady in all counties and sub-county geographies. However, in sub-county groupings there were differences noted. The prevalence ranged from 5.5% for the City of East Lansing to 10.2% for the City of Lansing.
- In 2019, all three counties had the lowest number of granted non-medical immunization waivers in the reported three year period.

HEALTH OUTCOMES

(P. 87-106)

Health Outcomes are the end results from the combination of opportunity measures, SDoH, behaviors, stress, and physical conditions. These are often measured in quality of life (illness/morbidity) or quantity of life (deaths/mortality). Example indicators of 'Health Outcomes' are Child/Adult Health, Life Expectancy, Chronic Disease, and Accidental Injury.

FINDINGS

- Adult preventable hospitalizations due to diabetes were lower for all three counties compared to Michigan; however, Ingham County's rate was higher than in Clinton or Eaton County.
- Preventable asthma hospitalizations among children under 18 rose considerably in Ingham County from 8.3 to 10.8 hospitalizations per 10,000 patients under 18. Eaton County showed a decrease in childhood asthma hospitalizations. Clinton County data has not been updated since 2014.
- The tri-county area rate of chlamydia cases continues to be slightly higher than Michigan's; Ingham County had the highest rate, which was just shy of double the rate seen in Clinton County. The rate of chlamydia cases decreased slightly in all three counties in 2019 compared to 2018.
- The rolling 3 year average all-cause mortality rate varied by county but was lower than the rate for Michigan. Ingham County's rate increased after two years of slightly decline. The rate in Eaton County continued to rise sharply. Clinton County saw the rate decrease as it has over the last 3 years.
- Infant mortality rates in Ingham County increased after 3 years of minor decreases. A substantial racial disparity exists in Ingham County where the infant mortality rate for Black infants was three times that of White infants. Eaton County continues to show a steady decline overall.
- The rate of cardiovascular disease deaths varied considerably, from 116.5 per 100,000 residents in East Lansing to 175.2 in Eaton County.
- Accidental injury death rates varied by County. Clinton had the lowest rate of 39.5 per 100,000 residents while Ingham had the highest at 62.0 per 100,000. Eaton and Ingham had rates higher than Michigan.

**Note – this measure does not include use of vape products or e-cigarettes.*

HEALTH INEQUITY BY RACE/ETHNICITY

Beyond the differences by geographic area, where possible, measures were analyzed by racial and ethnic groups. An estimated 9.3% of the population of the region identifies themselves as Black or African American, and an additional 7.0% identify themselves as Hispanic or Latino, of any race. While additional racial and ethnic disparities were identified, particularly noteworthy or consistent findings included:

- In the tri-county area, Arab children were the least likely to have a trusted adult that they could talk to. In all three counties, White children were most likely to have a trusted adult to talk to compared to Black, Hispanic and Arab children.
- Hispanic adults were least likely to have a bachelor's degree across all geographic groupings, except in the City of East Lansing.
- Hispanic adolescents, and to a lesser extent white adolescents, had higher rates of binge drinking across all three counties.
- In the tri-county area, Hispanic and Black high school students were more likely to report symptoms of depression in the past year. The difference was most evident in Clinton County.
- Hispanic high school students had higher rates of current marijuana use in all three counties.
- Arab adolescents had the highest consumption of fruits and vegetables in Eaton and Ingham Counties, by a considerable margin.
- Obesity rates were higher for Black, Hispanic and Arab adolescents across the tri-county region.
- Adult obesity rates were higher for minorities. Especially for Blacks in the tri-county area, Eaton County, and Ingham County which mirrors the State of Michigan.

FOCUS GROUP FINDINGS

We conducted several focus groups with persons who may be medically underserved. These groups include uninsured or underinsured, low-income, Spanish speakers, those in recovery, those with disabilities or those utilizing social services such as WIC, housing services, or food banks/pantries. The following issues were commonly identified by the participants:

- Access to and education about health living
- Affording prescriptions and medications, health care and health insurance
- Difficulty accessing medical specialties in the Capital Area
- Disparities in treatment between types of health insurance (i.e. Medicaid compared to private insurance)
- Accessing mental health services
- Importance of psychosocial support and material support for families – especially children and adolescent activities and spaces
- Improving access to community resources such as parks and recreation areas, and strengthening community bonds
- Gun violence and unsafe neighborhoods/ parks as barriers to improving health

HOW DID WE ARRIVE AT THESE FINDINGS?

The above findings were drafted by project staff to summarize the 2021 Community Health Profile and Health Needs Assessment Document.

For the following summary table (Indicators of Concern for Each Geographic Area) each indicator measure was evaluated in three ways: comparison, disparity, and trend.

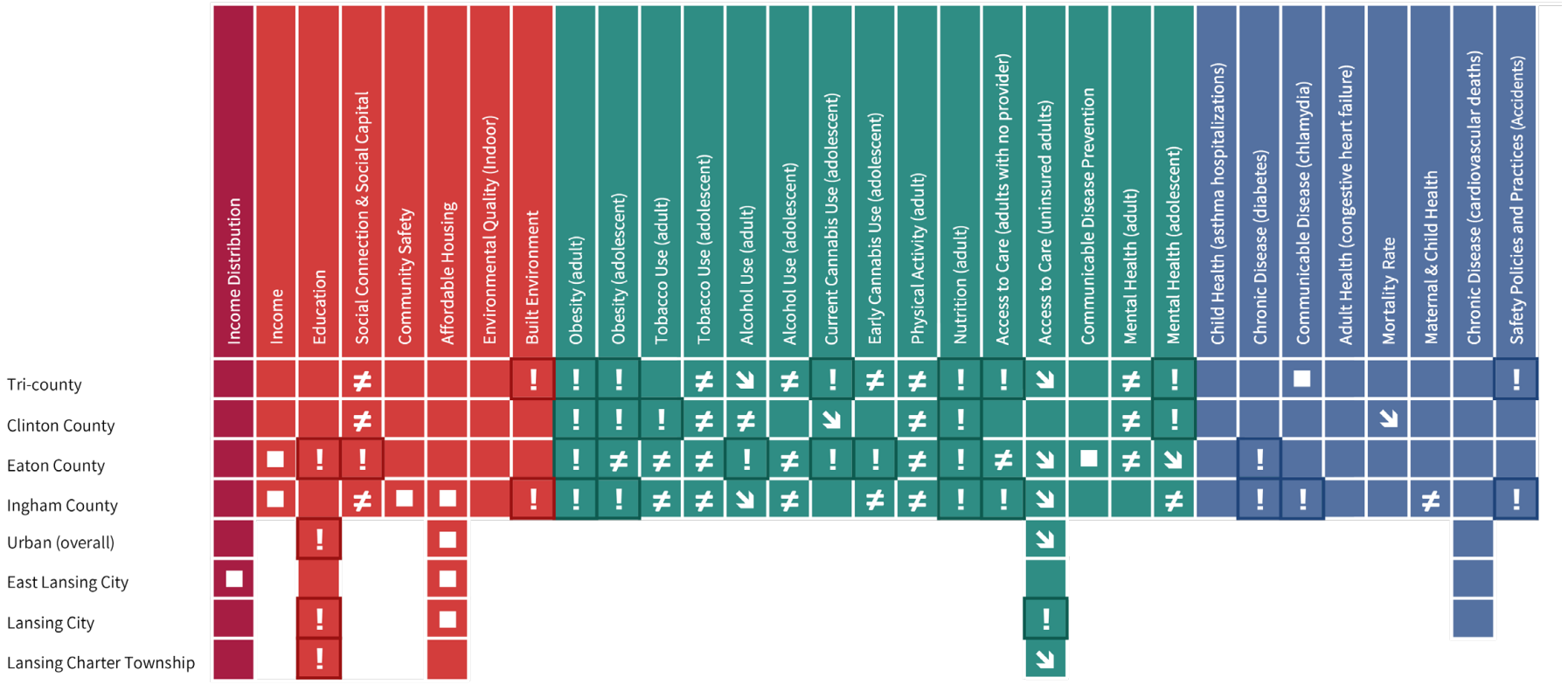
For the purposes of this report, a comparison means that for each measure, the various geographies within the Capital Area were compared to each other, and, if available, to the tri-county area as a whole and to the state of Michigan for one point in time. When a considerable negative (or worse) difference was found for a particular geographic area, this was noted as an area of concern on the table. As an example, Eaton and Ingham Counties had more asset limited residents compared to Clinton County and the State of Michigan.

Disparity refers to a noticeable difference between specific groups for a particular measure for one point in time within the same geographic area; these groups could be different racial, ethnic, gender, or age groups. For instance, for the years 2017-2019, the infant death rate for Black infants in Ingham County was over twice as high as the infant death rate for White infants. Not all measures had available data for group breakouts, and some measures with breakouts required suppression of data for certain geographies due to small sample sizes or as a substantial outlier.

In this report, trend refers to data points for one geographic area that were moving in a negative or worsening direction for at least three points in time (all in the same direction). By using at least three data points, consistency in the direction of the trend can be confirmed. An example is preventable diabetes hospitalizations in Ingham County which has seen an increase in rates in 2013, 2016, 2018 and 2019.

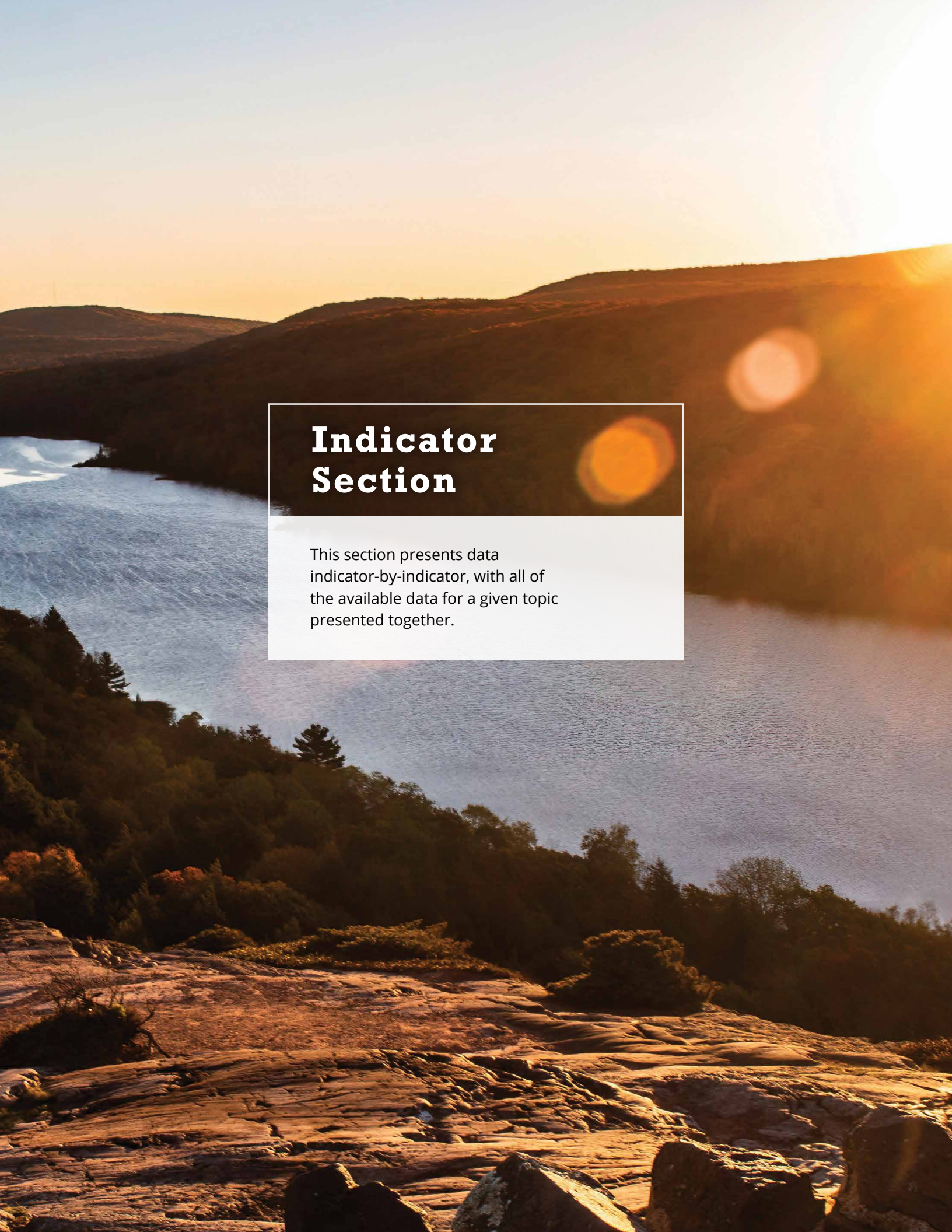
For any one particular measure, if a geographic area had at least two out of three concerns for comparison, disparity, and trend, then it received a “2 or more” rating and may indicate an area of considerable concern. One example is adult obesity for Eaton County, which had a higher rate than Michigan, racial disparities and a worsening trend over the previous assessment cycles.

INDICATORS OF CONCERN FOR EACH GEOGRAPHIC AREA



KEY

■	Comparison	Comparison: In comparison to statewide or Tri-county data, a considerable negative difference was found.
≠	Disparity	Disparity: The data indicated racial, ethnic, gender, or age disparities within a geographic area.
↘	Trend	Trend: Data for this indicator were trending in a negative direction (at least three data points in the same direction).
!	2 or more	2 or more: The data met the criteria for two or more of the above indicators (disparity, comparison, trend).



Indicator Section

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

Opportunity Measures

Income Distribution

MEASURE
Gini coefficent for income inequality

This measure ranges from 0.0 to 1.0. When the index is at 0, total income is shared equally between all people; when it is at 1.0, one person or group owns all income and all others have none. Here, income is defined as new revenues and economic resources received by individuals and families during the course of a year.

DATA SOURCE
American Community Survey

YEARS
2017-2019

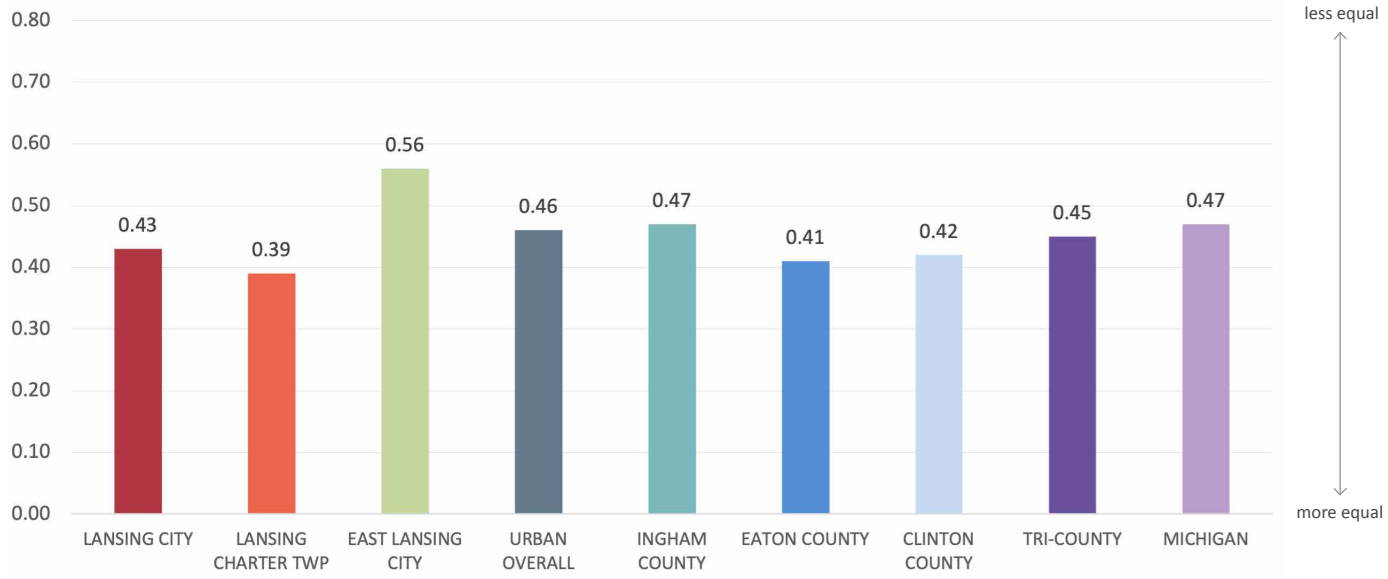
REASON FOR MEASURE
In general, this measure is used to examine the extent of inequality, and the number itself does not imply value — neither 0 nor 1 would be "ideal". However, places with high-income inequality (Gini coefficients ranging from 0.5 and above), such as countries in sub-Saharan Africa and many South American countries, generally have poorer health outcomes and greater societal instability than places with relatively low-income inequality (Gini coefficients less than 0.35), such as Europe, Australia, Canada, and Scandinavia.

Across a region or community, high levels of income inequality may lead to a sense of relative deprivation (being continually reminded of your 'poverty'; feeling like you cannot get ahead; or that you are not financially secure compared to those around you).

Relative deprivation is associated with variety of adverse outcomes, including poor mental health, poor physical health, and social discontent. In addition to relative deprivation, income inequity may also be an indication of absolute deprivation, which can lead to reduced tax revenue for an area, charitable and cultural investment, and business investment. Diversity in incomes among neighbors can enhance the social environment by improving distribution of role models and providing positive social networking opportunities.

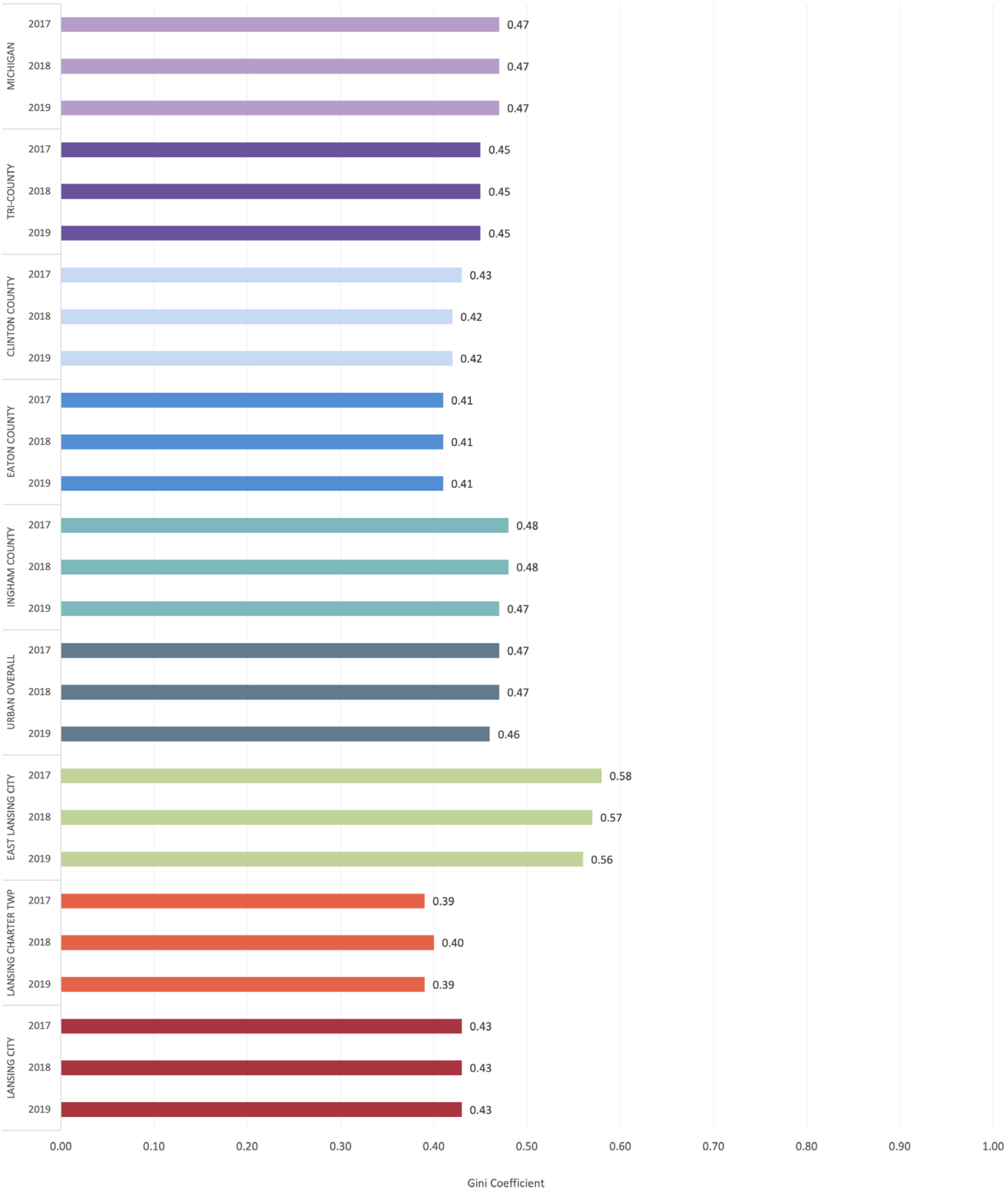
GINI COEFFICIENT FOR INCOME INEQUALITY, 2019

Income inequality is similar throughout the majority of the tri-county area, ranging from 0.39 to 0.47 for most geographic areas. However, there are some exceptions, as Lansing Charter Township has more income equity that the surrounding areas. The highest level of income inequality is seen in the City of East Lansing. The unusually high number for East Lansing, compared to the rest of the region, is due in large part to the presence of students attending Michigan State University.



TREND IN GINI COEFFICIENT FOR INCOME INEQUALITY, 2017-2019

Income inequity is typically stable in our region. Over the previous three years, most areas did not experience a considerable change in income inequity at all. Interestingly, income inequality in the City of East Lansing has decreased in each of the last two years despite still being the area with the highest level of income inequality.



Social, Economic, & Environmental Factors

Income

MEASURE
Percent of households below the ALICE Threshold

DATA SOURCE
2017 Michigan United Way ALICE Report

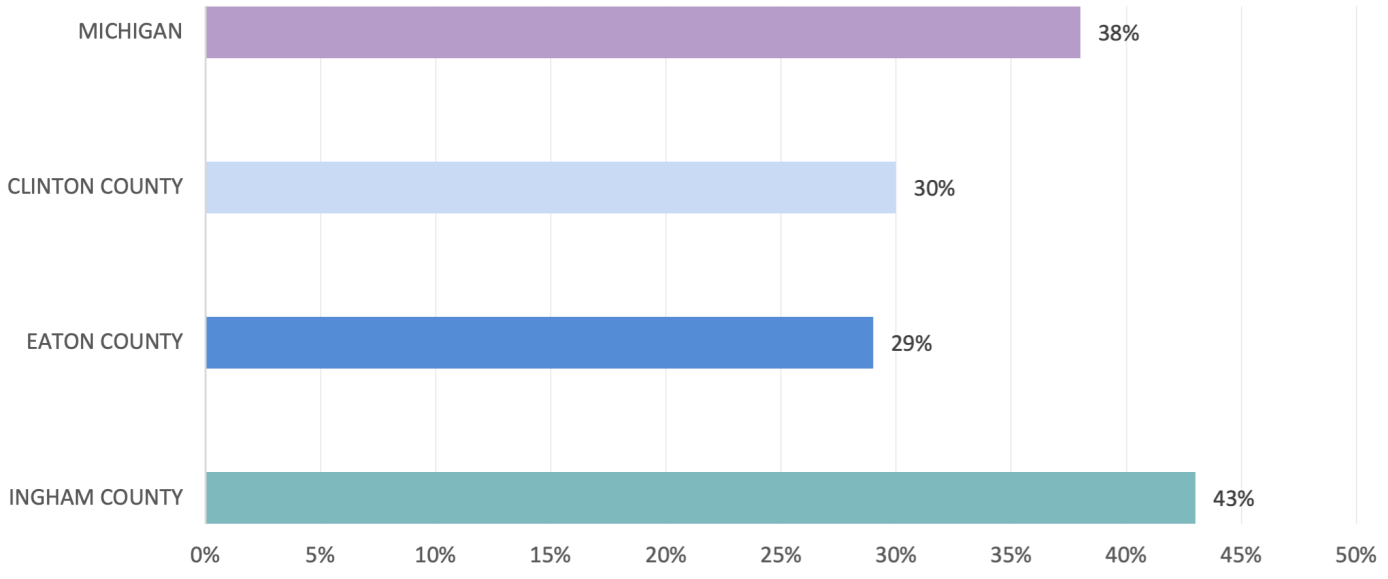
YEARS
2010-2019

REASON FOR MEASURE
ALICE stands for Asset Limited, Income Constrained, and Employed. ALICE households have incomes above the Federal Poverty Level, but below the basic cost of living for their area. The basic cost of living includes necessities like housing, childcare, food, healthcare, and transportation. It does not include savings, entertainment, dining out, or leisure activities. ALICE households may appear to be middle-class and have members who have a college education and are steadily employed. However, because they are making just enough to meet their expenses, they are at risk of financial difficulties and poverty if they experience an unforeseen financial expense (e.g. a major car repair). Calculating the percent of households that are below the ALICE Threshold is an attempt to more accurately capture the proportion of households that are at risk of financial ruin or are already impoverished.

What usually surprises many people about the ALICE Threshold is learning the basic cost of living. For example, in Eaton County in 2019, the household survival budget (includes childcare, taxes, and healthcare, but no luxuries or savings) was $64,704 annually or $5,392 each month for a family of four including a two children in child care. In Ingham County, that same family of four would have to make $72,228 a year ($6,019 monthly) to meet their basic expenses. Without savings or an adequate social safety net, this family, who may not appear impoverished, could be at high risk of becoming financially unstable as a result of unexpected expenses.

PERCENT OF HOUSEHOLDS BELOW THE ALICE THRESHOLD (2019)

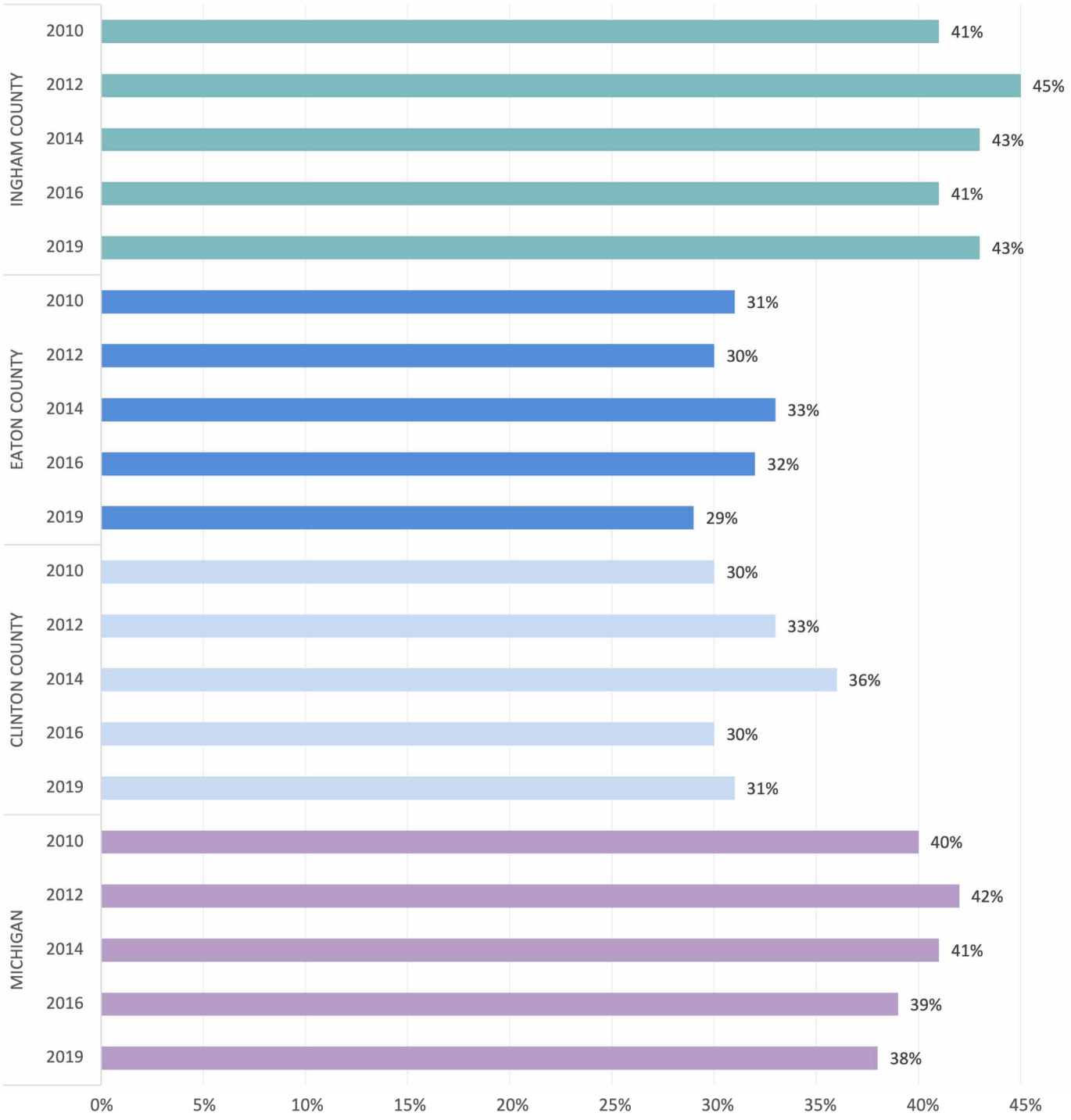
In many areas in our region, about one-third of households are either impoverished or at risk of financial instability because their household income is below the ALICE Threshold. In Ingham County, more than 40% of households are either impoverished or at risk of becoming impoverished, especially for people of color.



Income

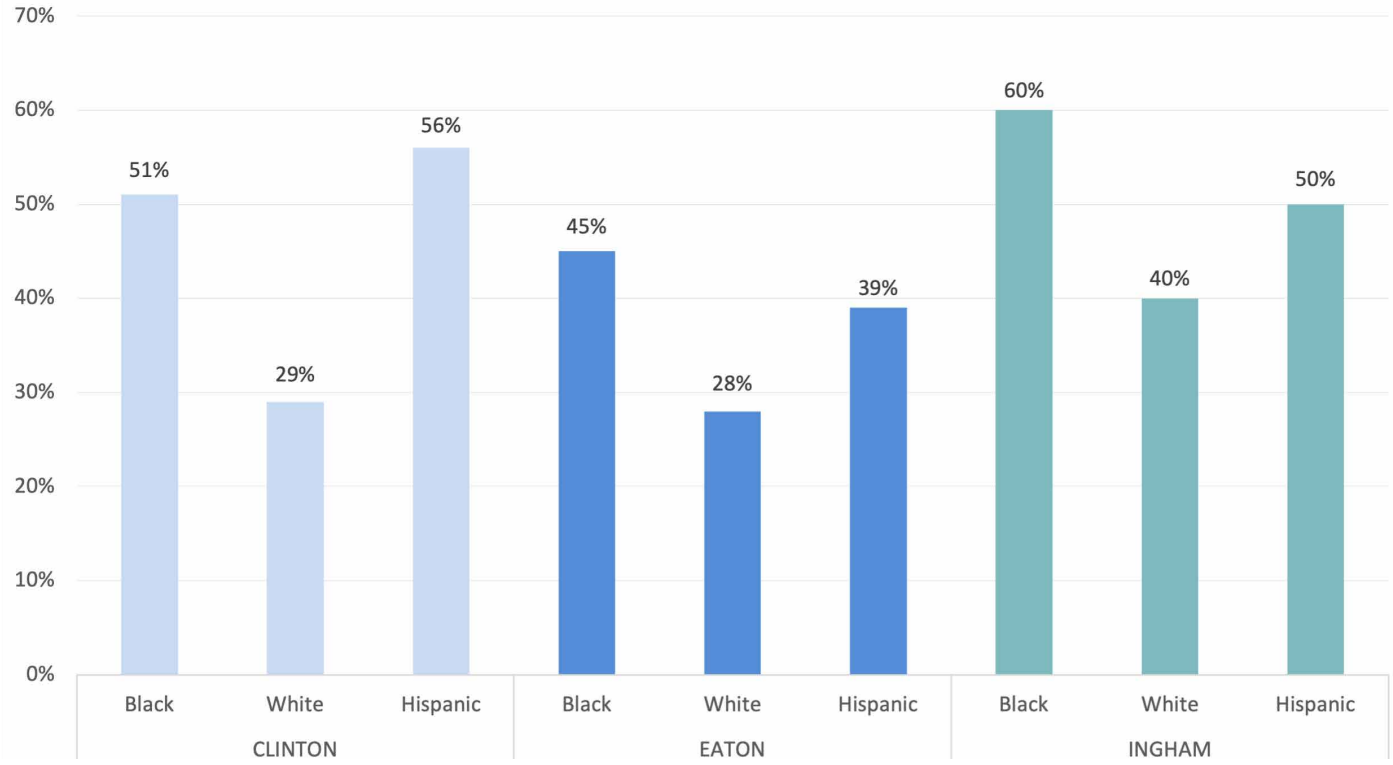
TREND IN PERCENT OF HOUSEHOLD BELOW THE ALICE THRESHOLD (2013-2019)

In Michigan there has been a trend in since 2012 in a decreasing number of households below the ALICE threshold. For the Tri-County area, the percentage of households below the ALICE threshold has remained fairly steady since 2010 with Ingham County generally having more households below the ALICE threshold compared to Eaton and Clinton Counties.



PERCENT OF HOUSEHOLDS BELOW ALICE THRESHOLD BY RACE/ETHNICITY, 2019

When examining the ALICE data by race and ethnicity, there are clear disparities present. In all three counties, White households are least likely to be below the ALICE threshold than Black and Hispanic households with the biggest disparity present in Clinton County. Approximately half of Hispanic households and 60% of Black households in Ingham County fall under the ALICE threshold, while in Eaton County those numbers are 39% and 45%, respectively.



Education

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

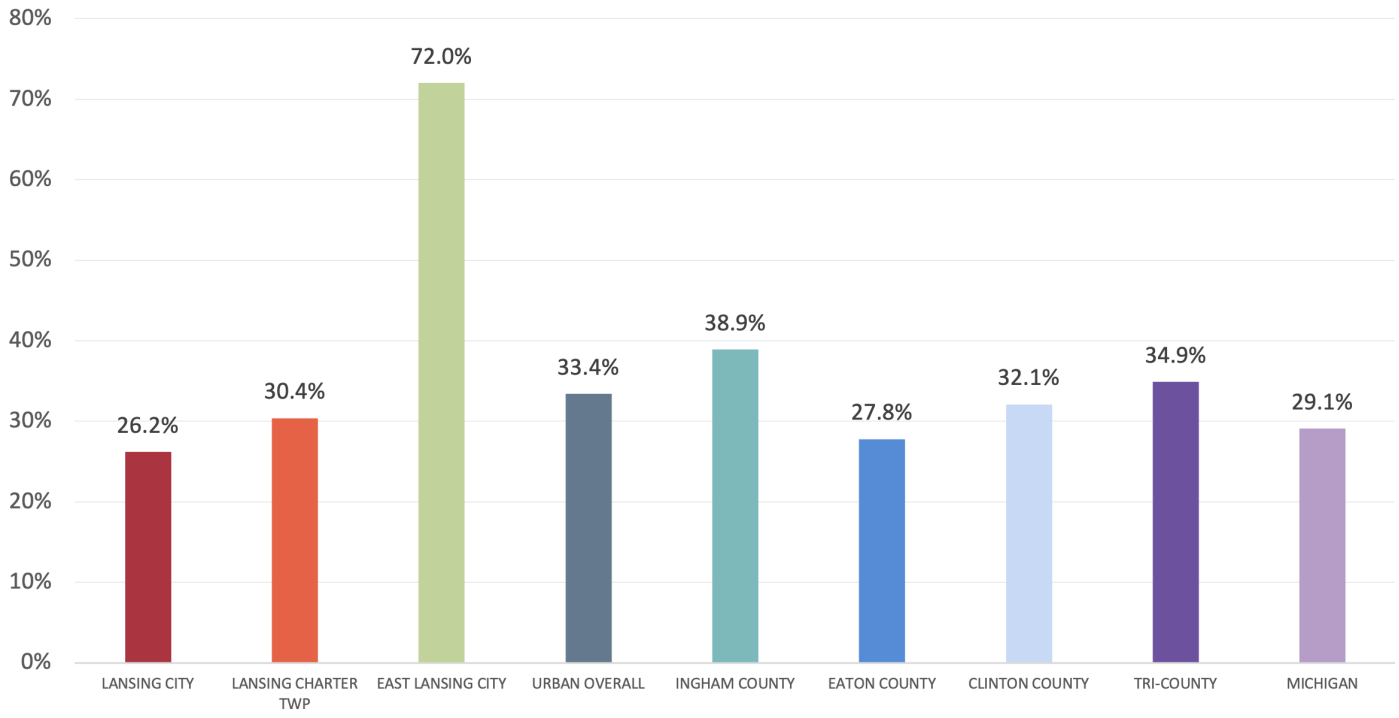
DATA SOURCE
American Community Survey

YEARS
2013-2019

REASON FOR MEASURE
The relationship between higher education and improved health outcomes is well known, with years of formal education correlating strongly with improved work and economic opportunities, reduced psychosocial stress, and healthier lifestyles[CHR]. In other words, persons with more education, in general, have healthier lives than those with less education.

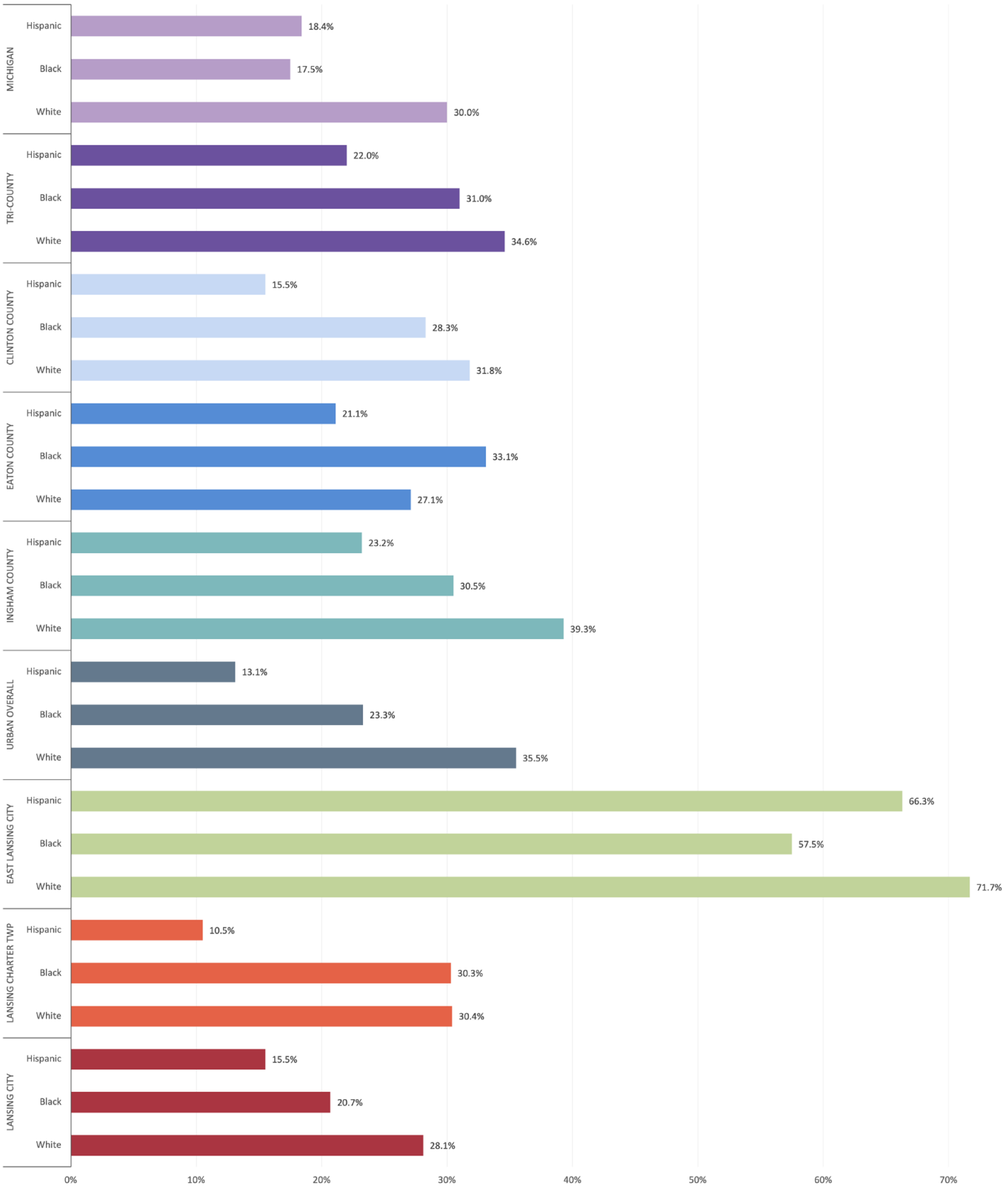
PERCENT OF ADULTS 25 YEARS AND OLDER WITH A BACHELOR'S DEGREE OR HIGHER, 2019

Over one in three adults in the Capital Area have a bachelor's degree or higher. Most areas within the three counties have proportions ranging from approximately 26% to 39%. The most marked outlier in the region is the City of East Lansing (where, because of the university community, almost three-quarters of adults have bachelor's degree or higher).



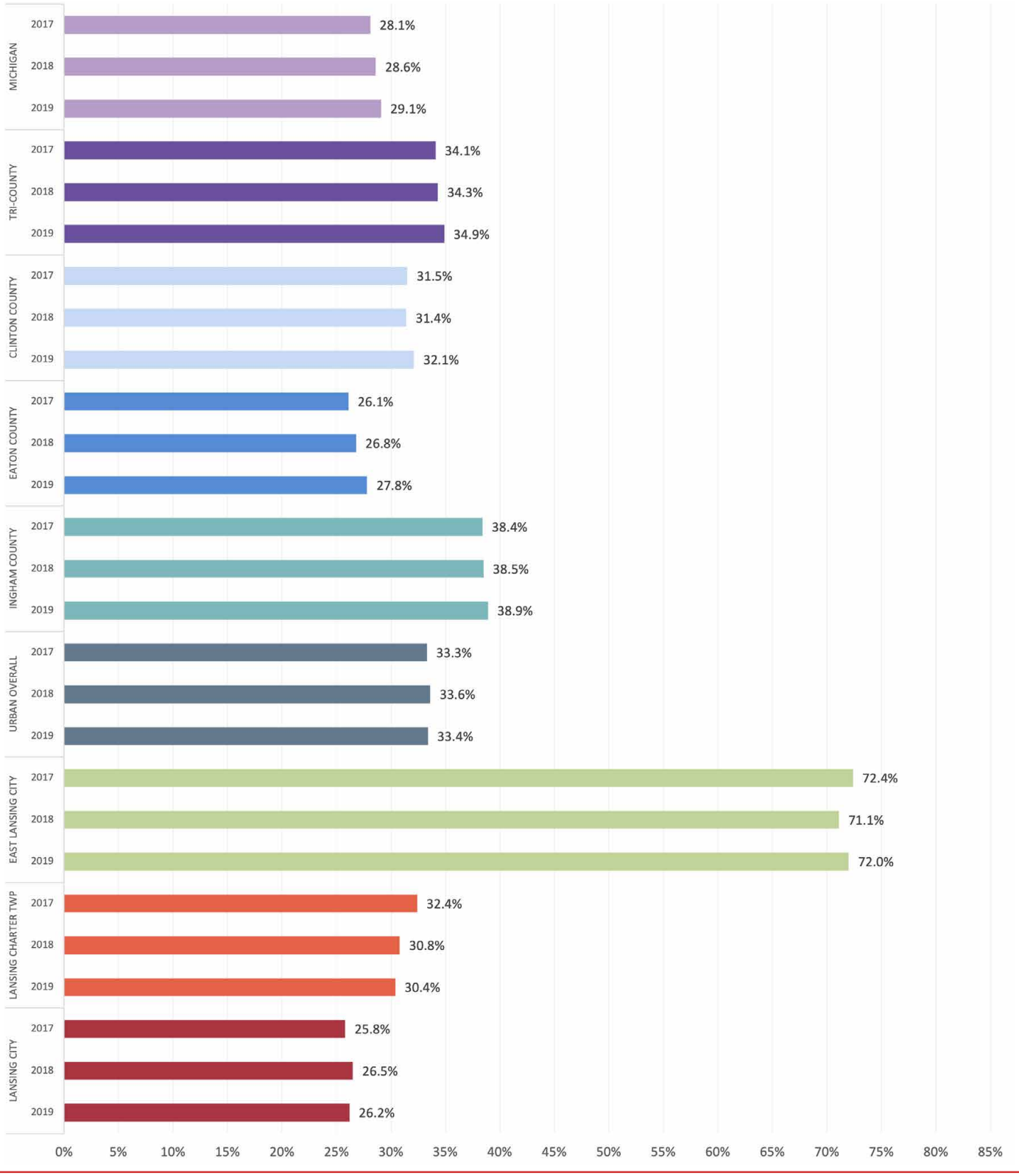
ADULTS 25 YEARS AND OLDER WITH A BACHELOR'S DEGREE OR HIGHER (BY RACE/ETHNICITY), 2019

Across the region, in most geographies, Hispanic adults are less likely to have a Bachelor's degree compared to their White and Black peers except in the City of East Lansing. In Eaton County, Black residents were more likely to have a Bachelor's degree or higher compared to White or Hispanic residents (33.1% compared to 27.1% and 21.1%, respectively).



TREND IN PERCENT OF ADULTS 25 YEARS AND OLDER WITH A BACHELOR'S DEGREEE OR HIGHER, 2015-2019

In most areas, the educational attainment of adults 25 years old or older has either been stable or increased between 2017 and 2019 with the exception of Lansing Charter Township which has declined from 32.4% in 2017 to 30.4% in 2019.



Social Capital

MEASURE
Percent of adolescents (9th and 11th grade students) that reported knowing an adult in their neighborhood they could talk to about something important

DATA SOURCE
Michigan Profile for Healthy Youth Survey (MiPHY)

YEARS
2013-2014, 2015-2016, 2017-2018, 2019-2020

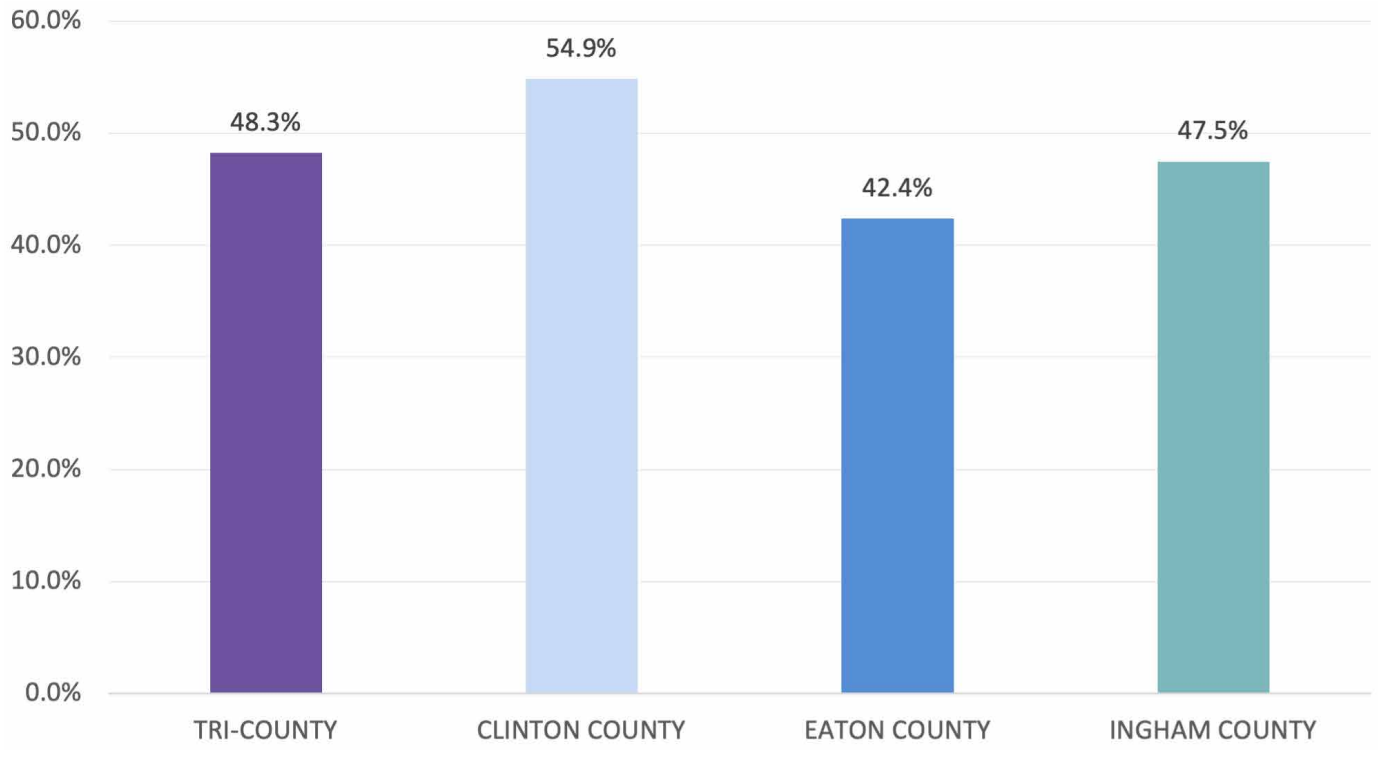
REASON FOR MEASURE
The network involved in the social-emotional development of children is wide and encompasses family, peers, and non-family adults. A growing body of evidence suggests that non-parent adults have a large influence, either positive or negative, in adolescent development. Adolescents whose social network includes a non-parent adult mentor who is involved in illegal activity have an increased probability of becoming involved in illegal activity. Non-parent adults who are positive and supportive can contribute to an adolescent's self-esteem, problem-solving behavior, and overall resilience. Childhood resilience is an important component in developing adults who are capable and equipped to handle life's challenges, which in turn, contributes to a community's well-being.

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

Statistics for this measure were not available for the state of Michigan, as this question was not asked on the Michigan Youth Risk Behavior Survey.

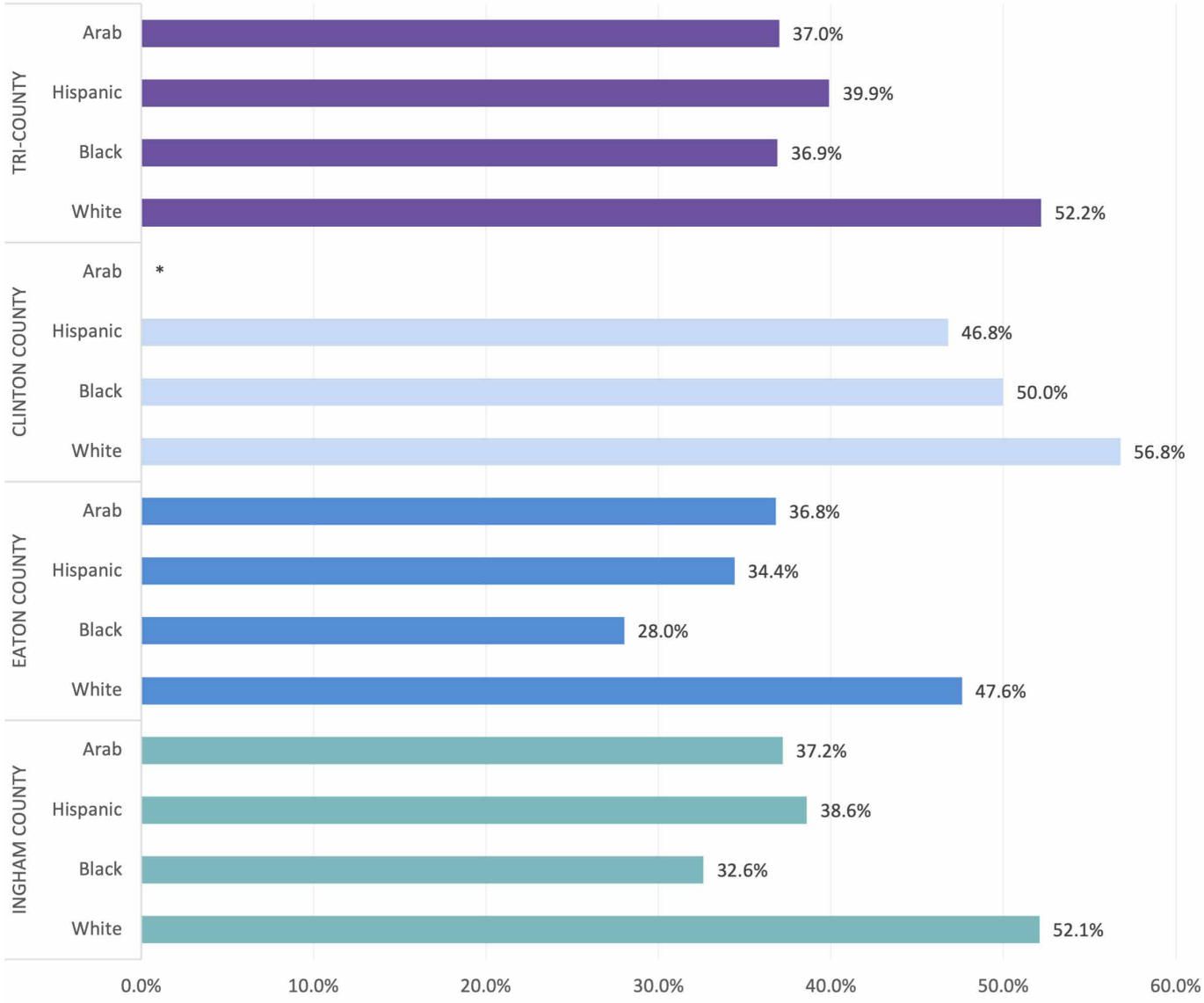
PERCENT OF ADOLESCENTS WHO KNOW ADULTAS IN THE NEIGHBORHOOD THEY COULD TALK TO ABOUT SOMETHING IMPORTANT, BY GEOGRAPHY, 2019-2020

Just under half (48.3%) of adolescents in the Capital Area indicated that they had a non-parent adult who they could talk to about important things. Within individual counties, Clinton County had the highest proportion of adolescents (54.9%) who reported having a non-parent adult they could speak to, compared to Eaton (42.4%) or Ingham (47.5%) counties.



TREND IN THE PERCENT OF ADOLESCENTS WHO KNOW ADULTS IN THE NEIGHBORHOOD THEY COULD TALK TO ABOUT SOMETHING IMPORTANT, BY GEOGRAPHY, 2013-2018

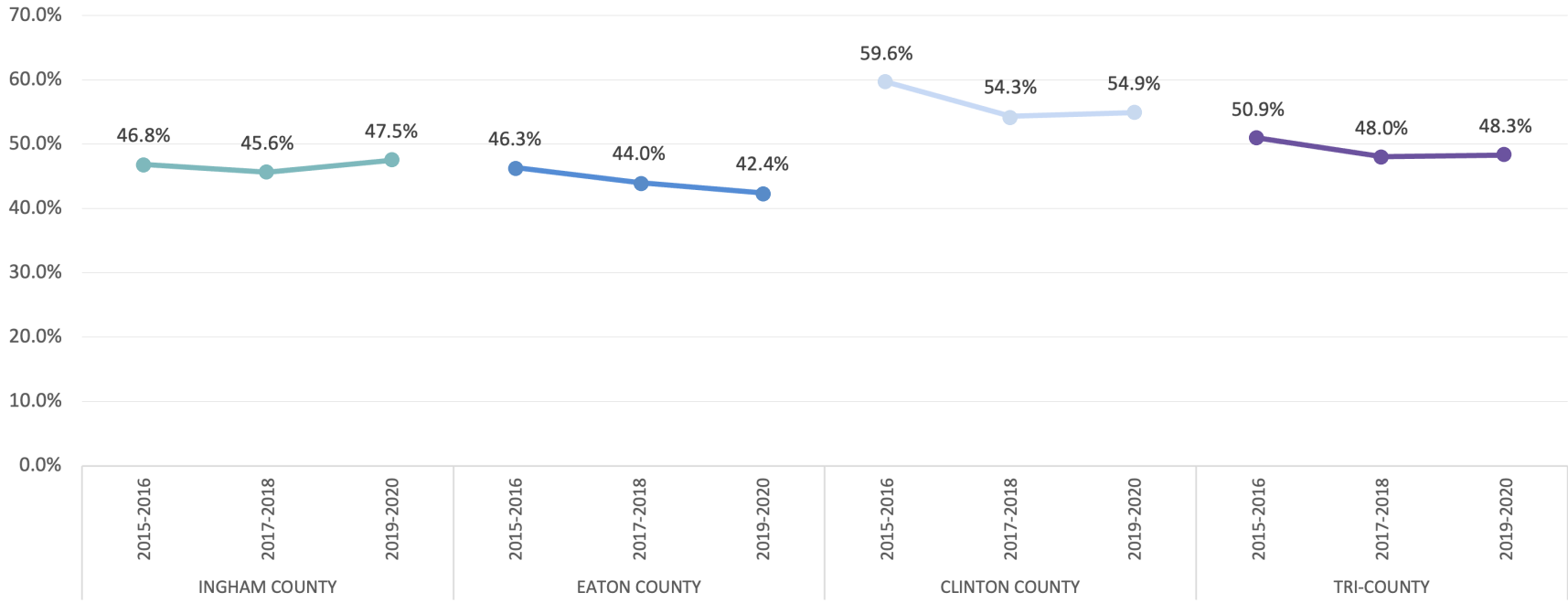
The proportion of adolescents who indicated having an adult in the neighborhood or non-parent adult that they feel they can speak to varied by race/ethnicity. In the tri-county area and within the individual counties, White high school students were far more likely to say they have non-parent adults who they can discuss important issues with. Arab, Hispanic and Black students in the tri-county area all had roughly the same percentage of support, ranging from 37% to 40%. Black students in Eaton County were the least likely to report non-parental support at 28.0%.



*Data for Arab students in Clinton County was suppressed due to low sample size.

TREND IN THE PERCENT OF ADOLESCENTS WHO KNOW ADULTS IN THE NEIGHBORHOOD THEY COULD TALK TO ABOUT SOMETHING IMPORTANT, BY GEOGRAPHY, 2015-2020

The trend of adolescents having a non-parent adult that they can speak to varied slightly between counties but remained relatively flat overall. Eaton County has seen a decrease in non-parental support in each of the last three MiPHY cycles, while Ingham had an increase to 47.5% in 2019-2020 from 45.6% in the previous survey cycle. The rate in Clinton County has remained essentially flat in 2019-2020 after a decrease from 2015-2016 to 2017-2018.



Community Safety (Violent Crime)

MEASURE
The rate of violent crimes per 100,000 people

Violent crimes are defined as offenses that involve face-to-face confrontation between the victim and the perpetrator, including homicide, forcible rape, robbery, and aggravated assault.

DATA SOURCE
Michigan State Police,
Michigan Incident Crime Reporting

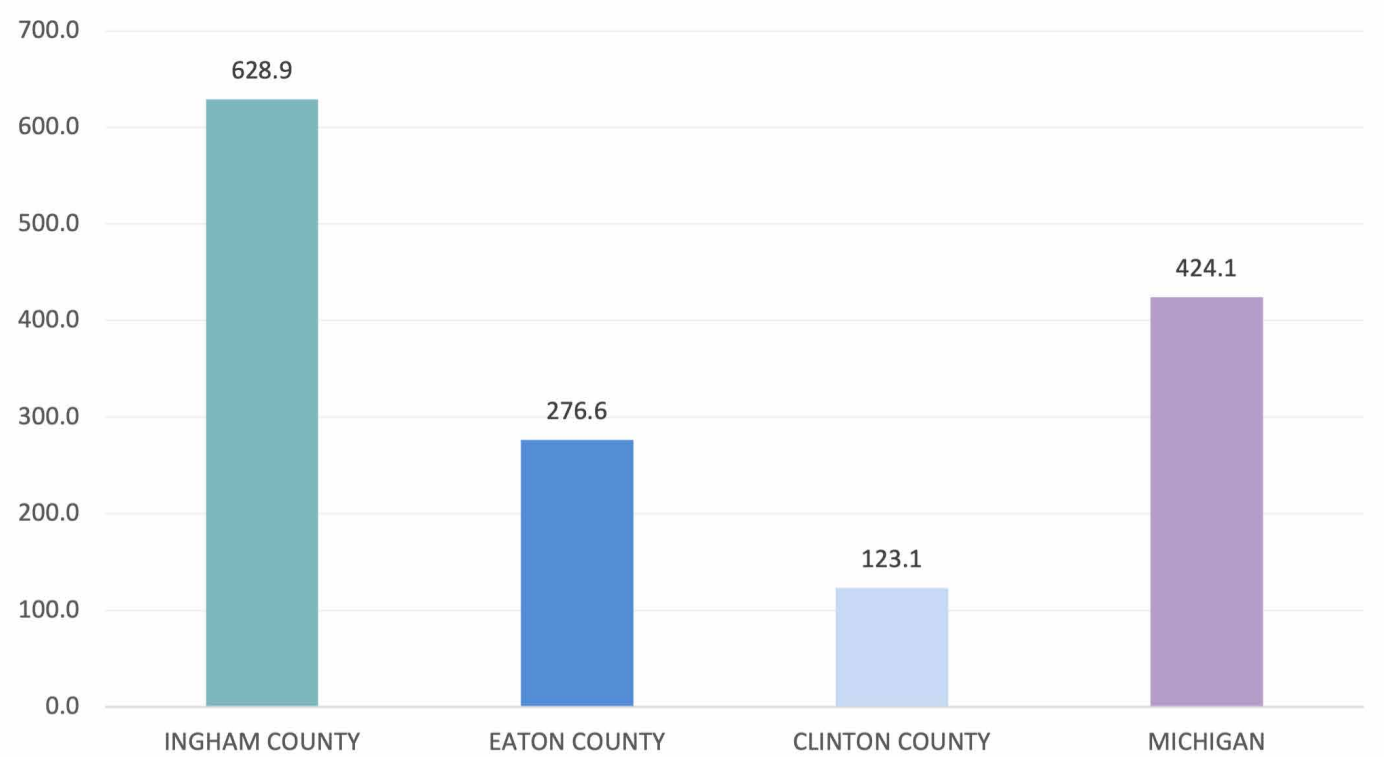
YEARS
2017-2019

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

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

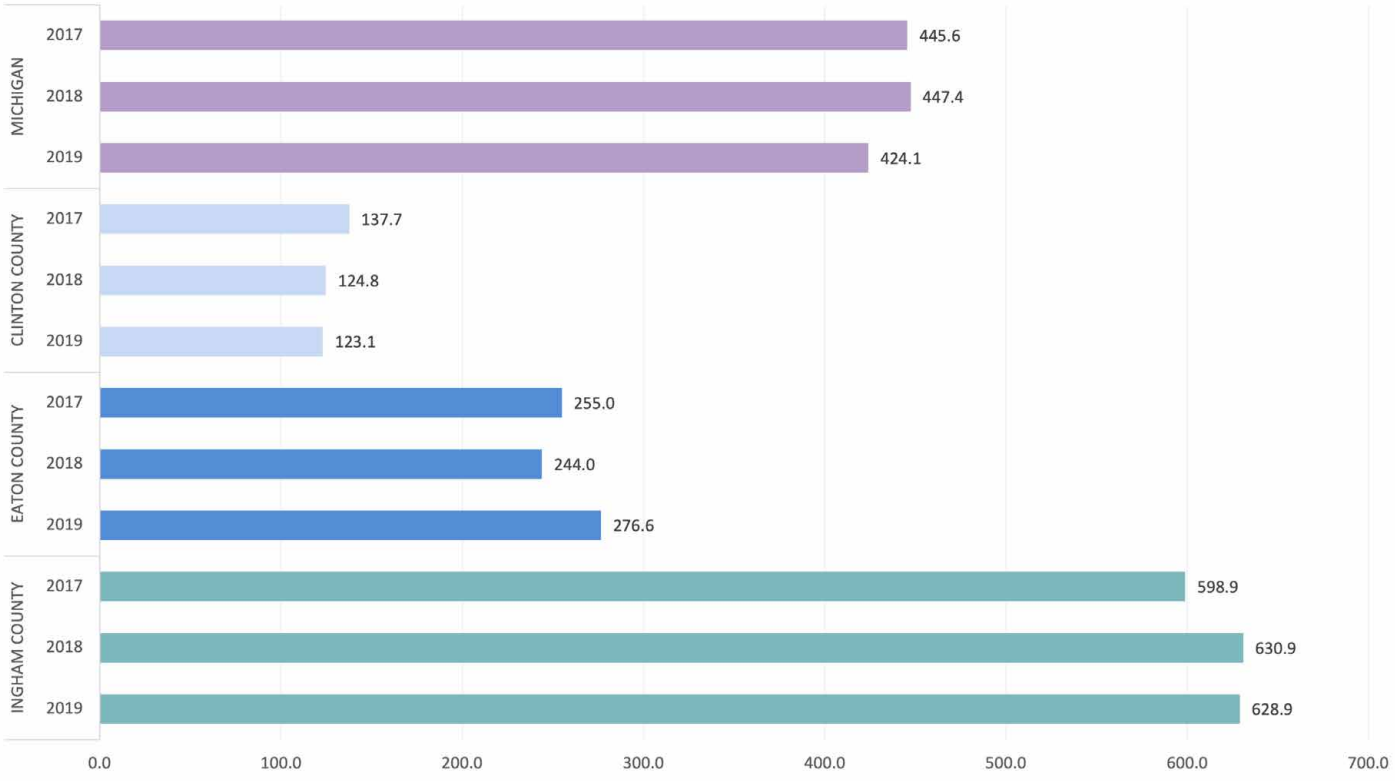
RATE OF VIOLENT CRIMES PER 100,000 PERSONS, BY GEOGRAPHY, 2019

The violent crime rate is highest in Ingham County, which includes the majority of the region's urban core. Ingham County has a rate twice as high as Eaton County and approximately six times that of Clinton County. Eaton and Clinton Counties both have lower rates of violent crime when compared to Michigan.



TREND IN RATE OF VIOLENT CRIMES PER 100,000 PERSONS, BY GEOGRAPHY, 2017-2019

In 2019 the rate of violent crime decreased in Michigan. In the tri-county area, Clinton County and Ingham County had approximately the same rates in 2018 and 2019. The rate in Ingham County continues to be far higher than the rest of the Capital Area. Eaton County saw an increase in the violent crime rate from 2018 to 2019 (244.0 to 276.6 per 100,000 residents).



Affordable Housing

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

DATA SOURCE
American Community Survey

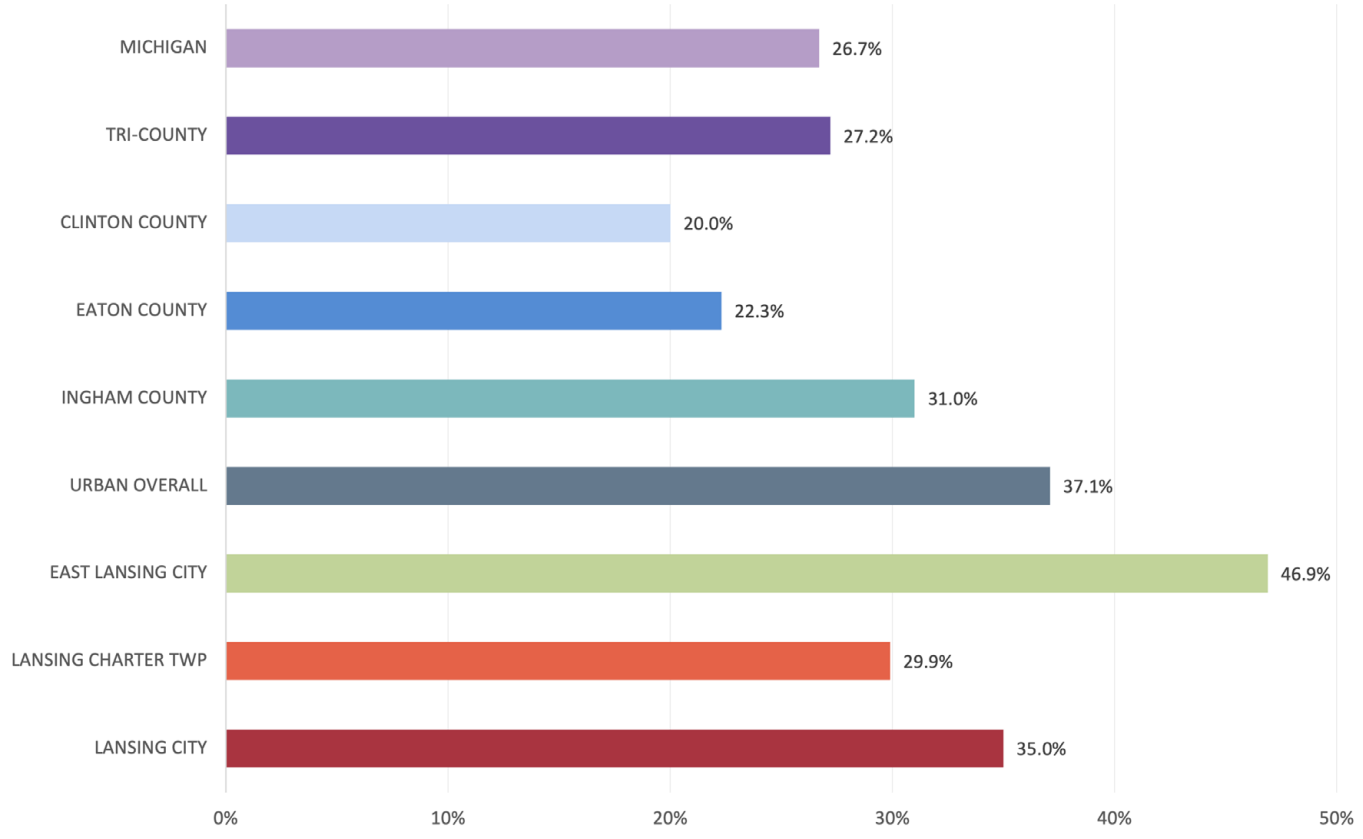
YEARS
2013-2019

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

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

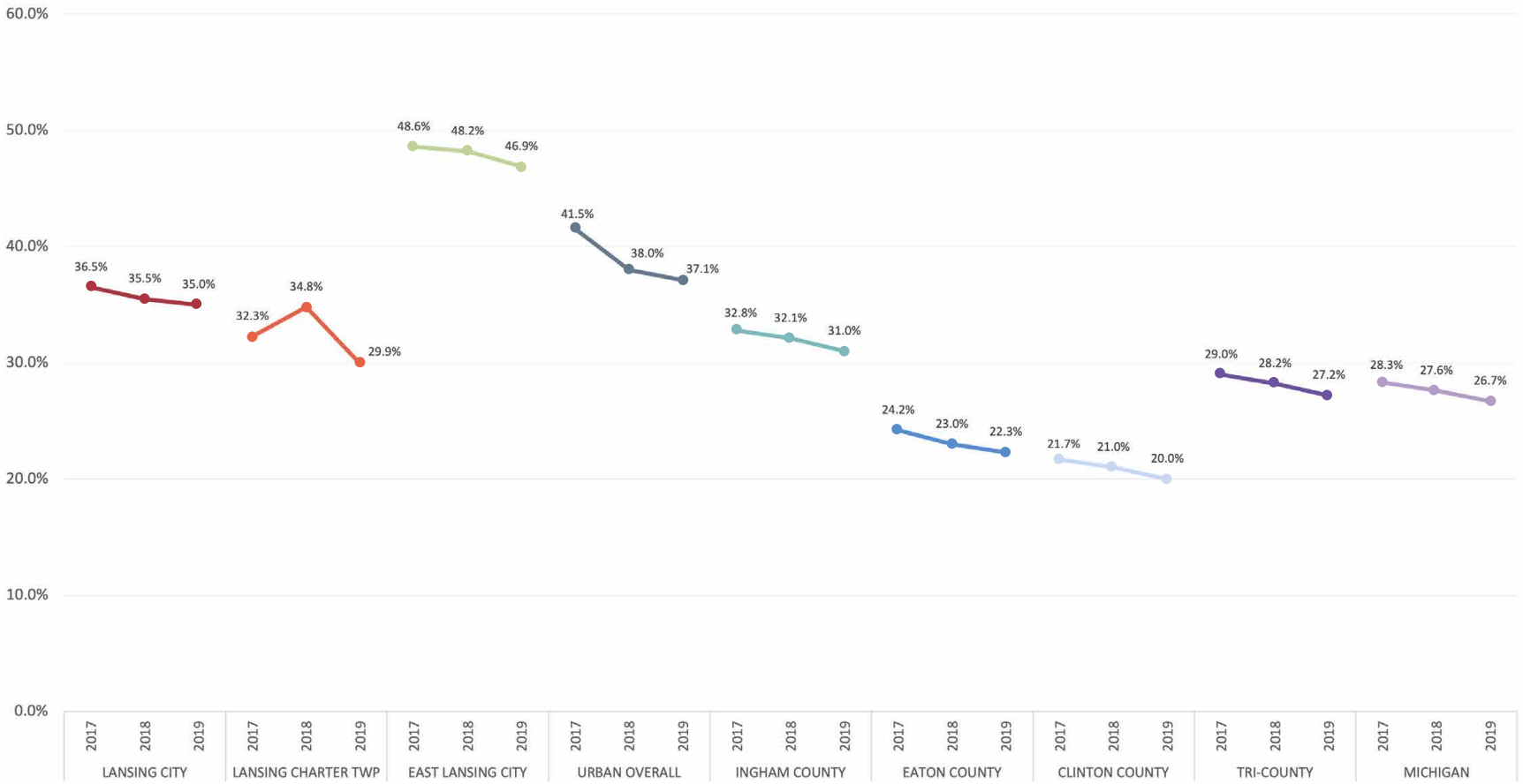
PERCENT OF HOUSEHOLDS SPENDING MORE THAN 30% OF THEIR INCOME ON HOUSING COSTS, 2019

Approximately one-third of households in the state of Michigan, and just over one-quarter in the tri-county area, spend more than 30 percent of their income on housing. Within the region, the percentage of households in unaffordable housing is highest in the urban areas, especially in the City of East Lansing, where 46.9% of households spend more than a third of their income on housing.



TREND IN PERCENTAGE OF RESIDENTS SPENDING MORE THAN 30% OF INCOME ON HOUSEHOLD COSTS

Between 2017 and 2019, there is been a decline in the proportion of persons spending 30% or more of their income on housing costs in Michigan, the tri-county area, the individual counties, and across the sub-county geographic groups. The decline was steepest in Lansing Charter Township and was steady across the rest of the geographies.



Environmental Quality

MEASURE
The percentage of children less than six years of age with elevated blood lead levels (EBLL).

EBLL ≥ 5ug/dL (highest venous or capillary blood lead level). This percentage is calculated by dividing the number of children less than six years of age who have an EBLL ≥ 5ug/dL by the number of children less than six years of age who had their blood tested for lead.

DATA SOURCE
Childhood Lead Poisoning and Prevention Program, Michigan Department of Health and Human Services

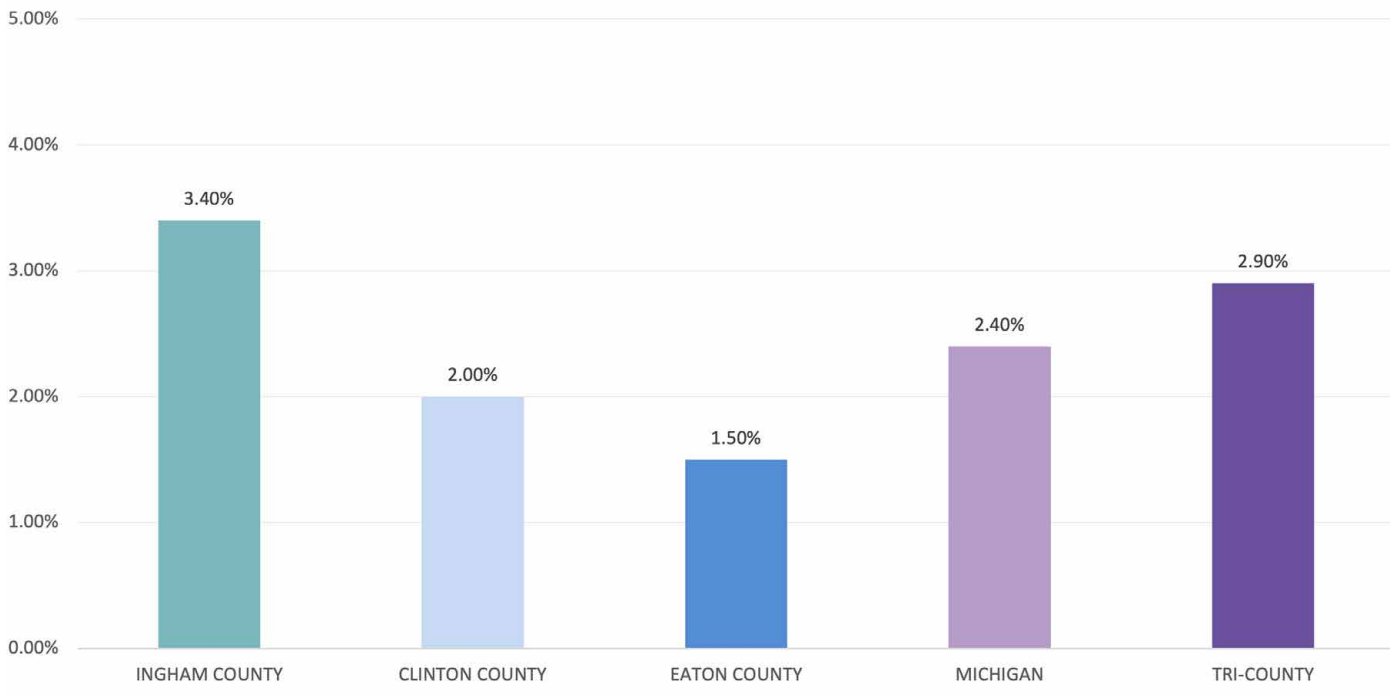
YEARS
2015-2019

REASON FOR MEASURE
Lead exposure among children continues to be an important public health problem. At highest risk are children living in older housing that may still contain lead-based paint. The adverse health effects of lead exposure in children are numerous and well documented, including cognitive impairment, low bone density, and poor childhood growth and development.

***Note: Data for 2020 was suppressed in 2 of 3 counties, and thus not included in this analysis, due to low testing volume and a small number of elevated tests as a result of the COVID-19 pandemic.

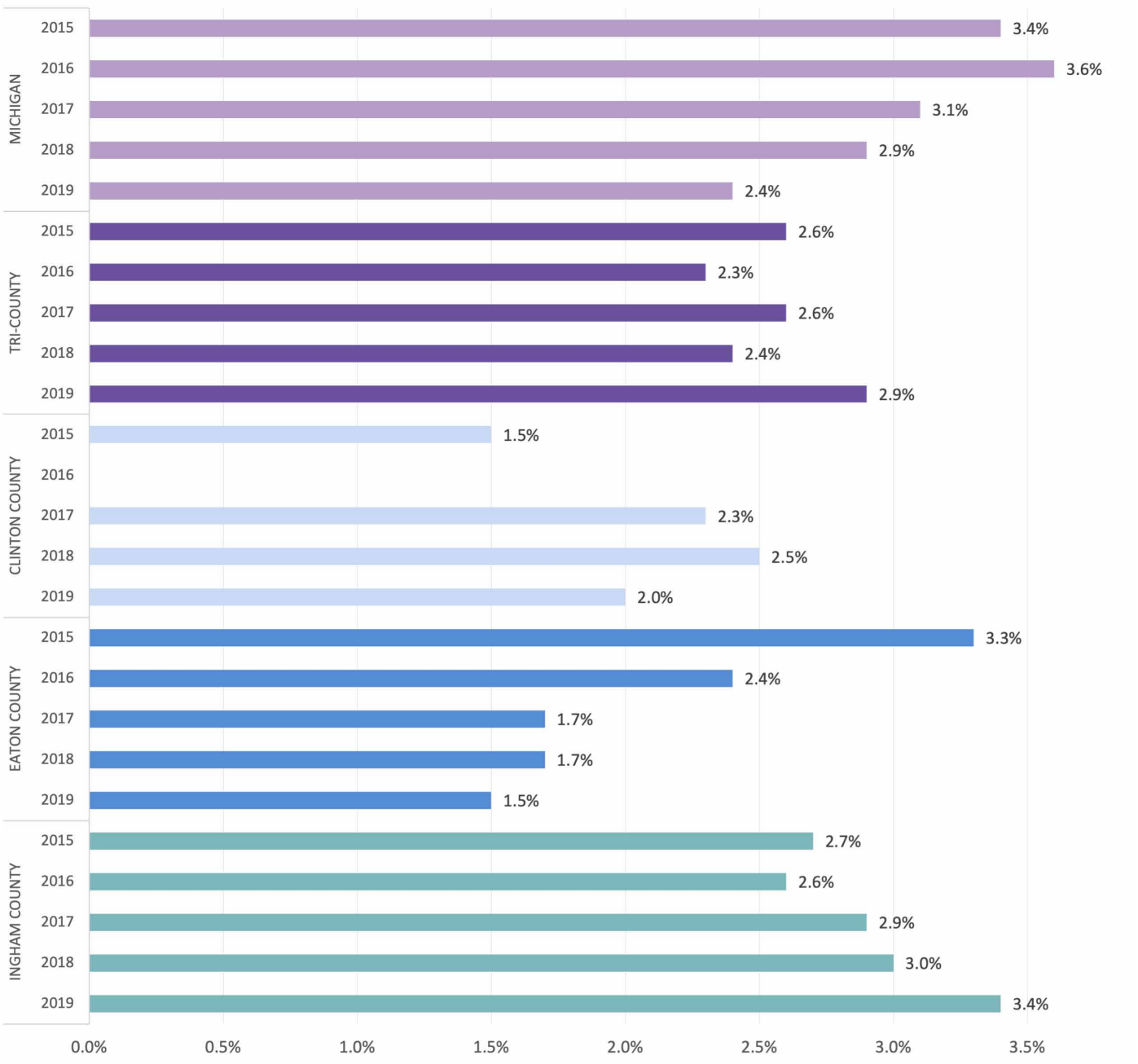
PERCENT OF CHILDREN LESS THAN SIX YEARS OF AGE WITH ELEVATED BLOOD LEAD LEVELS, 2019

Out of the children tested, approximately three percent of children in the Capital Area under the age of six have an EBLL. Ingham County (3.4%) is the only area with a higher EBLL percentage than the State of Michigan (2.4%). The prevalence of children with an EBLL is 1.5% in Eaton County, 2.0% in Clinton County and 3.4% in Ingham County.



TREND IN PERCENT OF CHILDREN LESS THAN SIX YEARS OF AGE WITH ELEVATED BLOOD LEAD LEVELS, 2015-2018

In Eaton County, the percentage of children with an EBLL has continuously declined since 2015; meanwhile, there is an increasing trend in Ingham County, rising from 2.6% in 2016 to 3.4% in 2019. There is no discernable trend in Clinton County as numbers vary by year. This could partially be explained by low testing numbers leading to greater variability. The State of Michigan is in the midst of a decreasing trend since 2016, falling from 3.6% to 2.4% in 2019.



Built Environment

MEASURE
The percent of the population that lives in an USDA-defined 'food desert'

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

DATA SOURCE
United States Department of Agriculture (USDA)

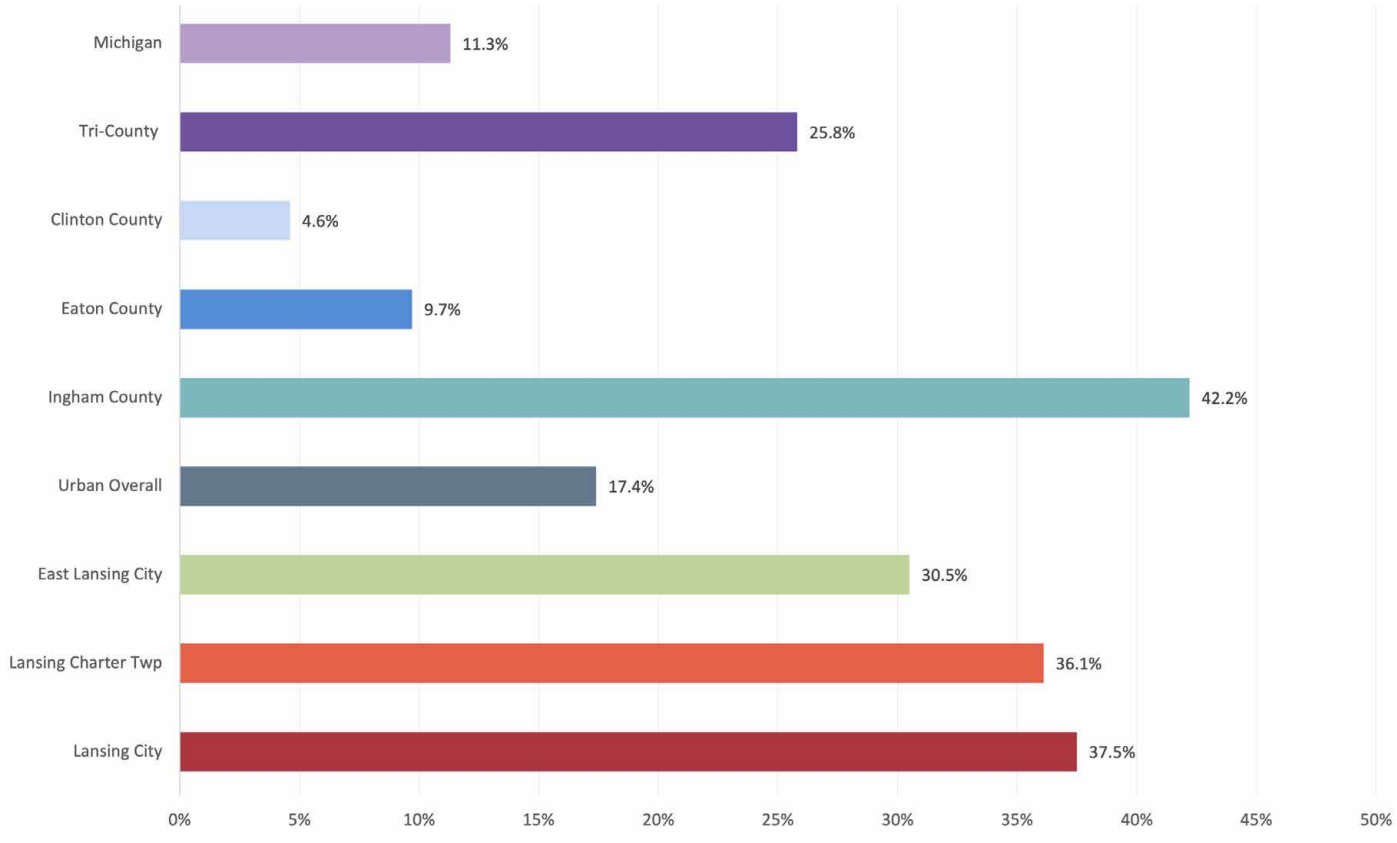
YEARS
2010, 2015, 2019

REASON FOR MEASURE
The majority of studies that have examined the relationship between store access and dietary intake find that better access to a supermarket or large grocery store is associated with eating healthier food. Better access to a supermarket is associated with a reduced risk of obesity, and better access to convenience stores is associated with an increased risk of obesity. Recent research suggests that lack of access to specific nutritious foods may be less important than relatively easy access to all other foods.

'Food swamps' may better explain increases in body mass index (BMI) and obesity than "food deserts." Increasing access to specific foods like fruits and vegetables, whole grains, and low-fat milk alone may not affect the obesity problem, as most stores that carry these nutritious foods at low prices also carry the less healthy foods.

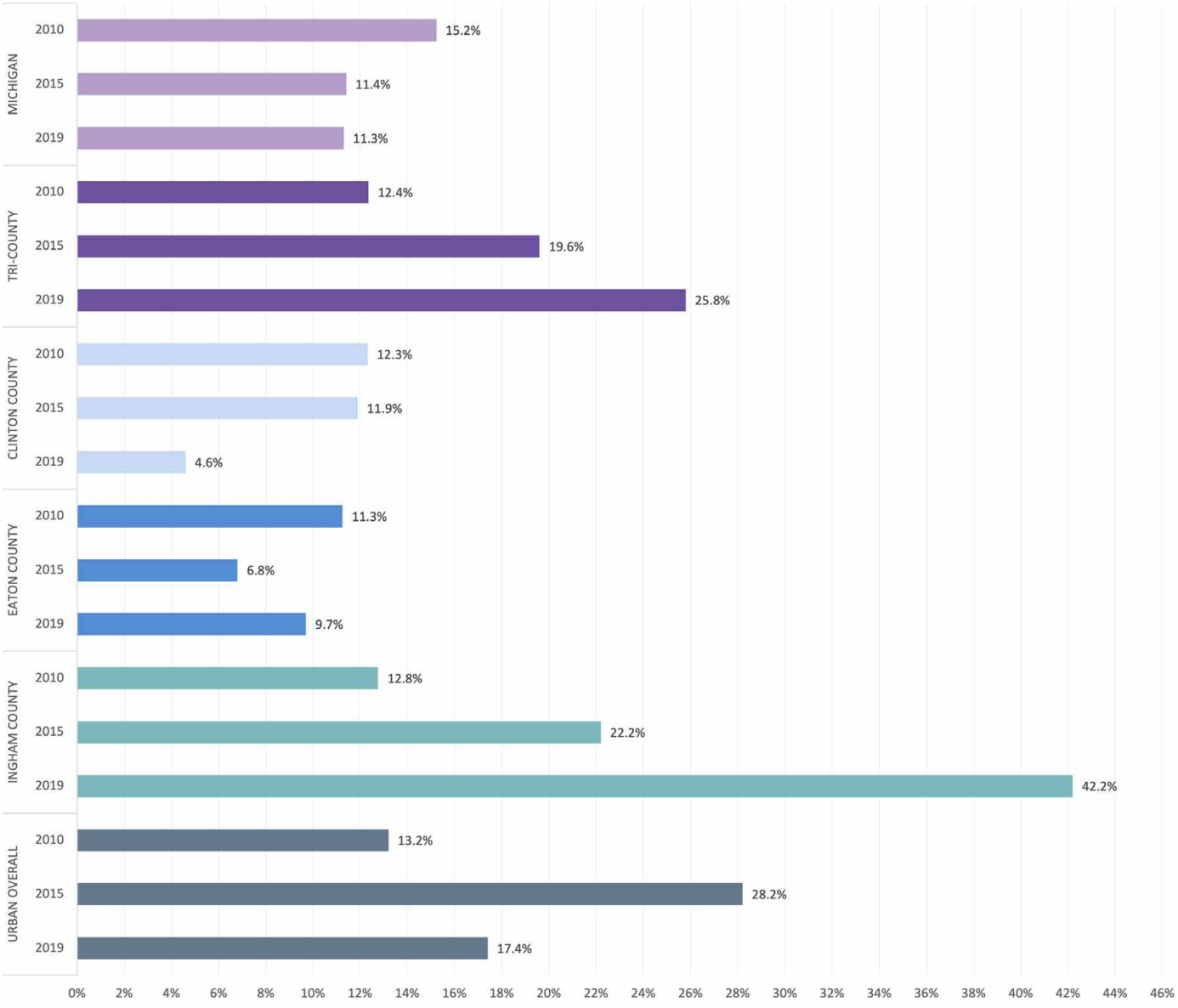
PERCENT OF THE POPULATION THAT LIVES IN A USDA-DEFINED 'FOOD DESERT', 2019

One in four persons in the Tri-County region lived in an area that the USDA would define as being a 'food desert' in 2019; this was considerably higher than the corresponding population for the state of Michigan. The proportion of persons who lived in a 'food desert' was highest among the municipalities that make up the region's urban core, which ranged from 37.5% in the City of Lansing, 36.1% in Lansing Charter Township and 30.5% in the City of East Lansing. Clinton County (4.6%) had the lowest level of people living in a food desert.



PERCENT OF THE POPULATION THAT LIVES IN A USDA-DEFINED 'FOOD DESERT', 2010-2019

In the state of Michigan, the percent of the population who lived in an area defined as a 'food desert' declined between 2010 and 2019, but in the Capital Area, it increased considerably from 12.4% to 25.8%. The increase in the Capital Area was driven primarily by Ingham County which has seen steady and substantial increases in the prevalence of 'food deserts' in its urban area and now sits at 42.4%, up from 22.2% in 2015.



Behaviors, Stress, & Physical Condition

Obesity - Adults

MEASURE

Adult obesity prevalence represents the percentage of the adult population (age 18 and older) with a body mass index (BMI) greater than or equal to 30 kg/m^2.

BMI is calculated from the individual's self-reported height and weight. BMI is defined as weight in kg divided by height in meters, squared.

DATA SOURCES

- Michigan Behavioral Risk Factor Surveillance System
- Capital Area Behavioral Risk Factor Survey

YEARS

MI BRFS and Capital Area BRFS 2008-2010, 2011-2013, 2014-2016, 2017-2019

REASON FOR MEASURE

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

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

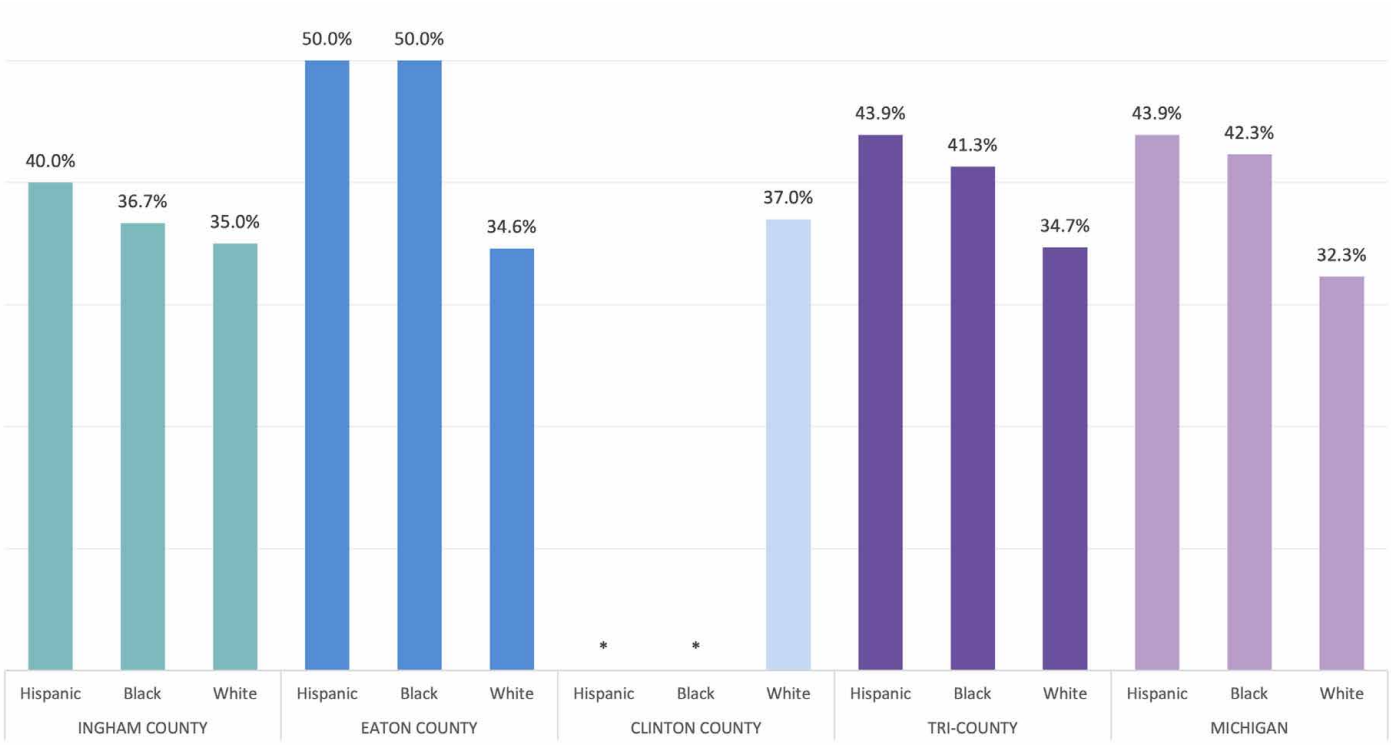
PERCENT OF ADULTS WHO ARE OBESE, BY GEOGRAPHY, 2017-2019

The tri-county region has a marginally higher prevalence of adult obesity than the state of Michigan. Proportions for individual counties within the region range from 34.6% in Ingham County to 37.7% in Clinton County.

Obesity - Adults

PERCENT OF ADULTS WHO ARE OBESE, BY GEOGRAPHY, 2017-2019 (BY RACE/ETHNICITY)

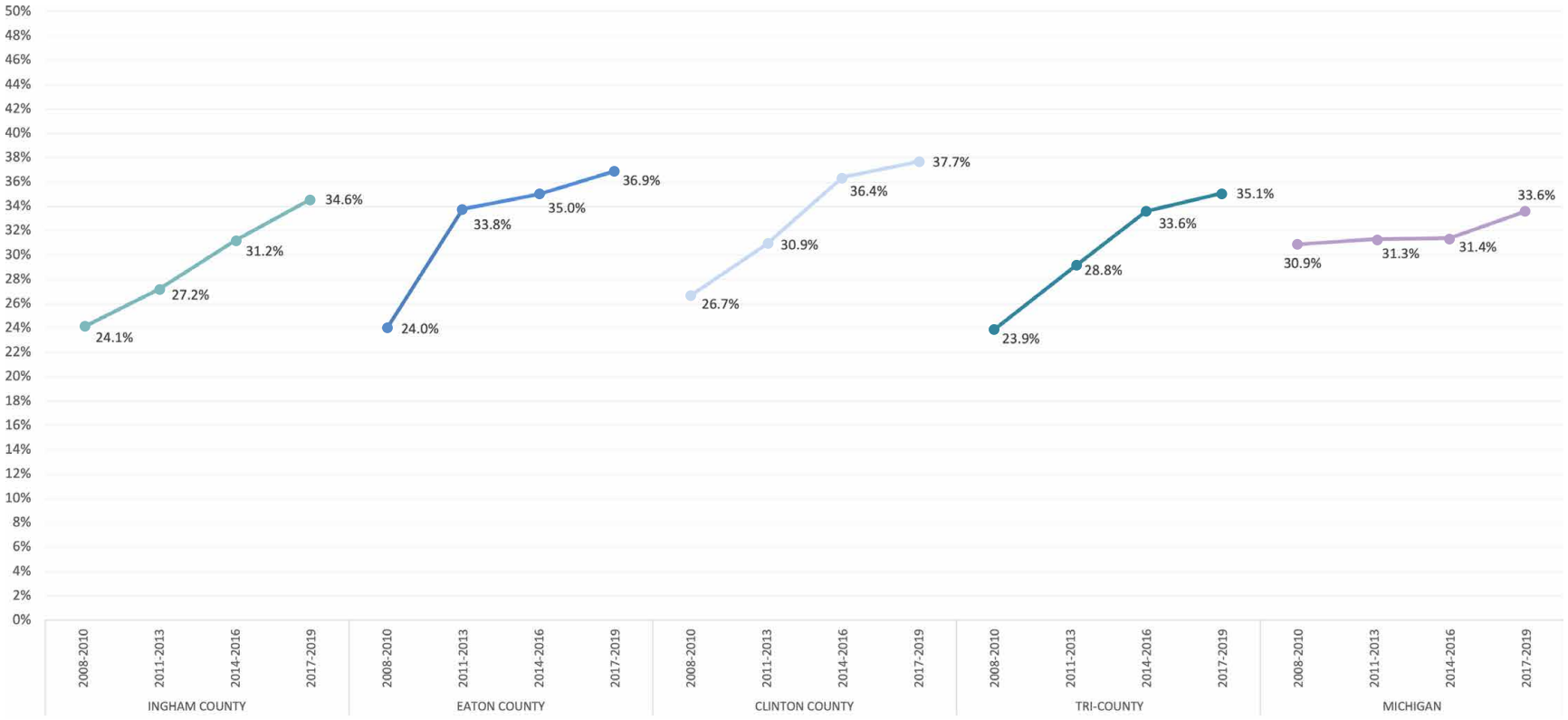
Looking at obesity by race/ethnicity, obesity disproportionately affects minority adults, compared to their White peers. In Eaton County, half of Hispanic and Black adults are obese. In Ingham County, Hispanic adults (40.0%) are most likely to be obese, followed by Black adults (36.7%) and White adults (35.0%). Data for Clinton County could not be included due to low sample sizes and other data that can be considered an outlier.



Obesity - Adults

TREND IN PERCENT OF ADULTS WHO ARE OBESE, BY GEOGRAPHY, 2008-2019

According to the Michigan BRFS, obesity in adults statewide is rising after plateauing for several years. Locally, the percentage of adults who are obese has increased by considerable in all areas from 2008 to 2019. All counties range from 34.6% to 37.7%.



Obesity - Adolescents

MEASURE

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

BMI is calculated from the individual's self-reported height and weight. BMI is defined as weight in kg divided by height in meters, squared.

DATA SOURCES

- Michigan Youth Risk Behavior Survey (MI YRBS)
- Michigan Profile for Healthy Youth (MiPHY)

YEARS

MI YRBS: 2014-2015, 2016-2017, 2018-2019
MiPHY: 2015-2016, 2017-2018, 2019-2020

REASON FOR MEASURE

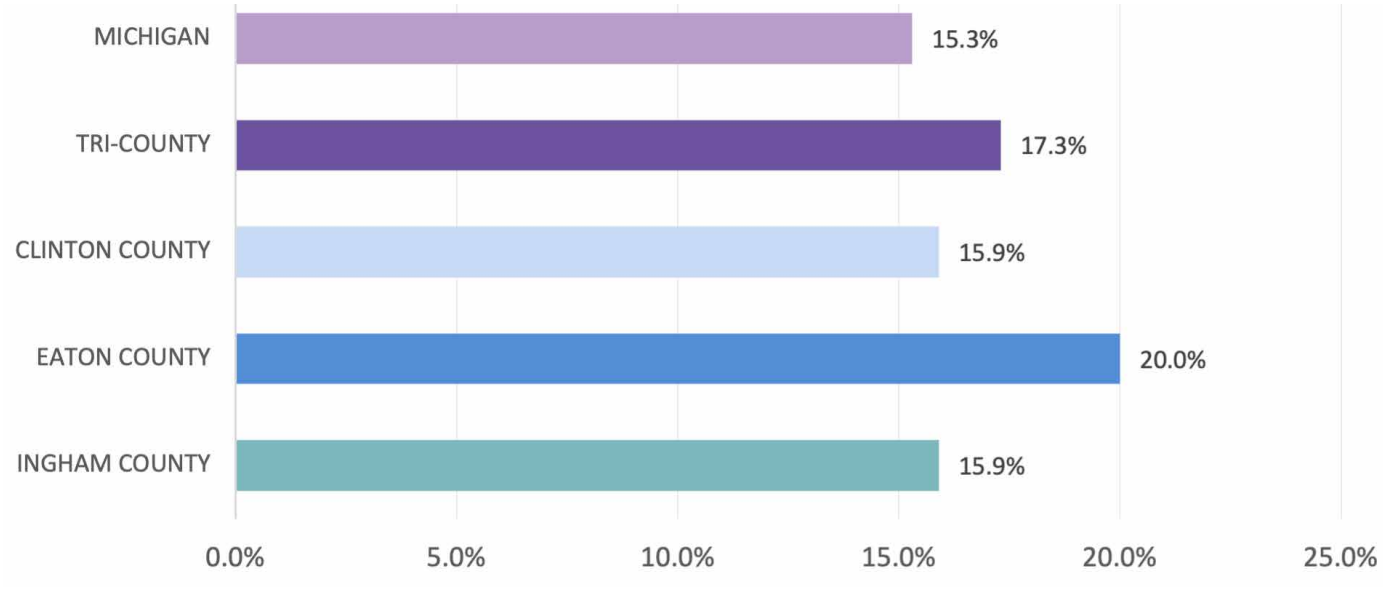
Some of the immediate health effects of obese youth are that they are more likely to have risk factors for cardiovascular disease, such as high cholesterol or high blood pressure. In a population-based sample of 5- to 17-year-olds, 70% of obese youth had at least one risk factor for cardiovascular disease. Obese adolescents are more likely to have pre-diabetes, a condition in which blood glucose levels indicate a high risk for development of diabetes. Children and adolescents who are obese are at greater risk for bone and joint problems, sleep apnea, and social and psychological problems, such as stigmatization and poor self-esteem. Potential long-term health effects for obese children and adolescents include a high probability of adult obesity, heart disease, type 2 diabetes, stroke, several types of cancer, and osteoarthritis.

One study showed that children who became obese as early as age two were more likely to be obese as adults. Being overweight or obese is associated with increased risk for many types of cancer, including cancer of the breast, colon, endometrium, esophagus, kidney, pancreas, gallbladder, thyroid, ovary, cervix, and prostate, as well as multiple myeloma and Hodgkin's lymphoma.

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

PERCENT ADOLESCENTS WHO ARE OBESE 2019-20

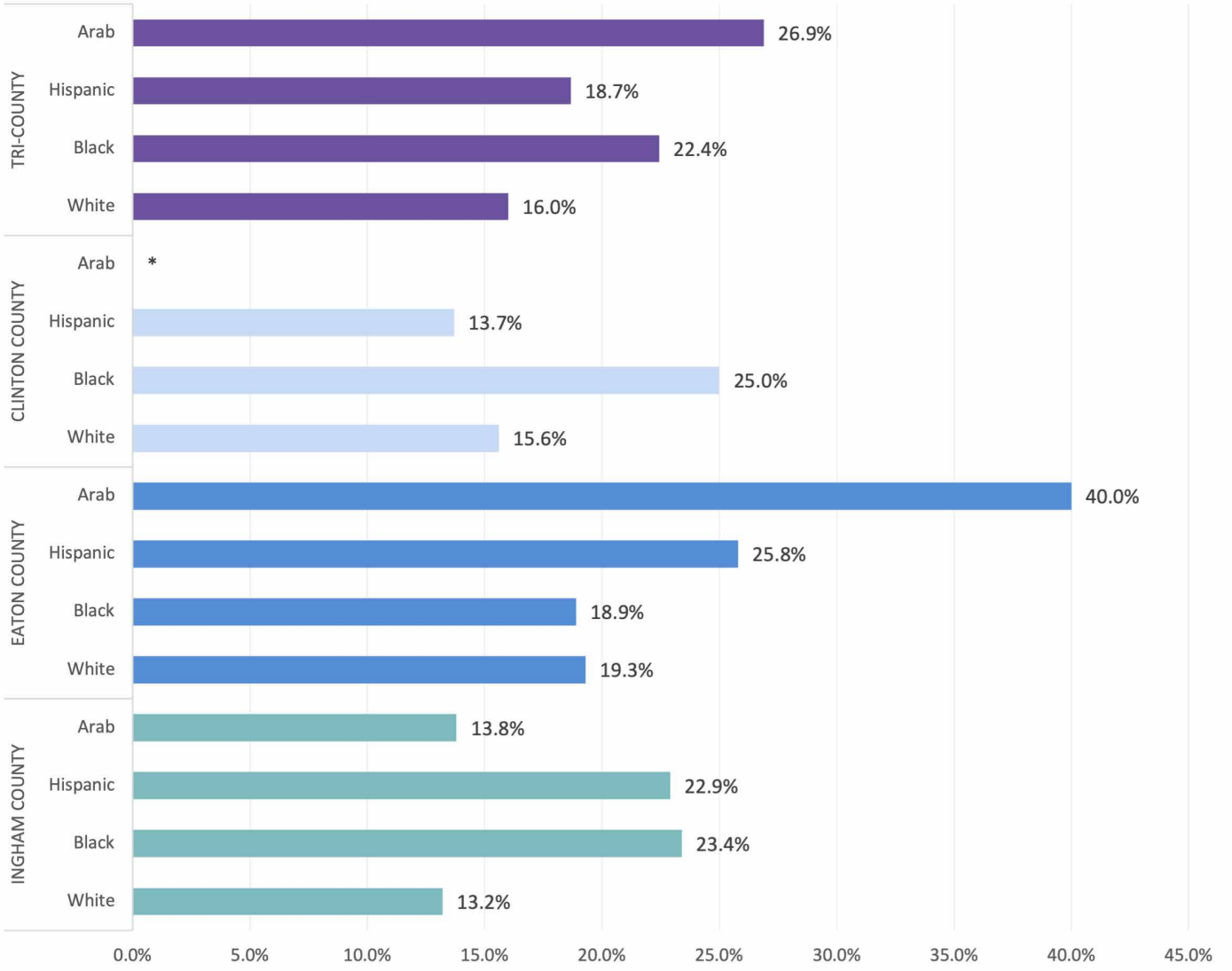
Across the Capital Area region, 17.3% of adolescents were considered obese, which was slightly higher than the prevalence for Michigan (15.3%). Clinton and Ingham counties had a slightly higher prevalence (15.9% for each) while Eaton County had the highest rate of obesity at 20.0%



Obesity - Adolescents

PERCENT OF ADOLESCENTS WHO ARE OBESE, 2018-2020 (BY RACE/ETHNICITY)

When looking at obesity between racial/ethnic groups within the tri-county region, the rate of obesity varied among races and ethnicities. In Eaton County, 40.0% of Arab high school students were obese, while in Ingham County the rate was only 13.8%. In the Tri-County area overall, Arab students had the highest rate of obesity at 26.9%, largely driven by Arab students in Eaton County. Black and Hispanic high school students were also more likely to be obese in the tri-county area (22.4% and 18.7%, respectively) compared to their White peers (16.0%). The exception to this is in Clinton County where White students (15.6%) were slightly more likely than Hispanic students (13.7%) to be obese.

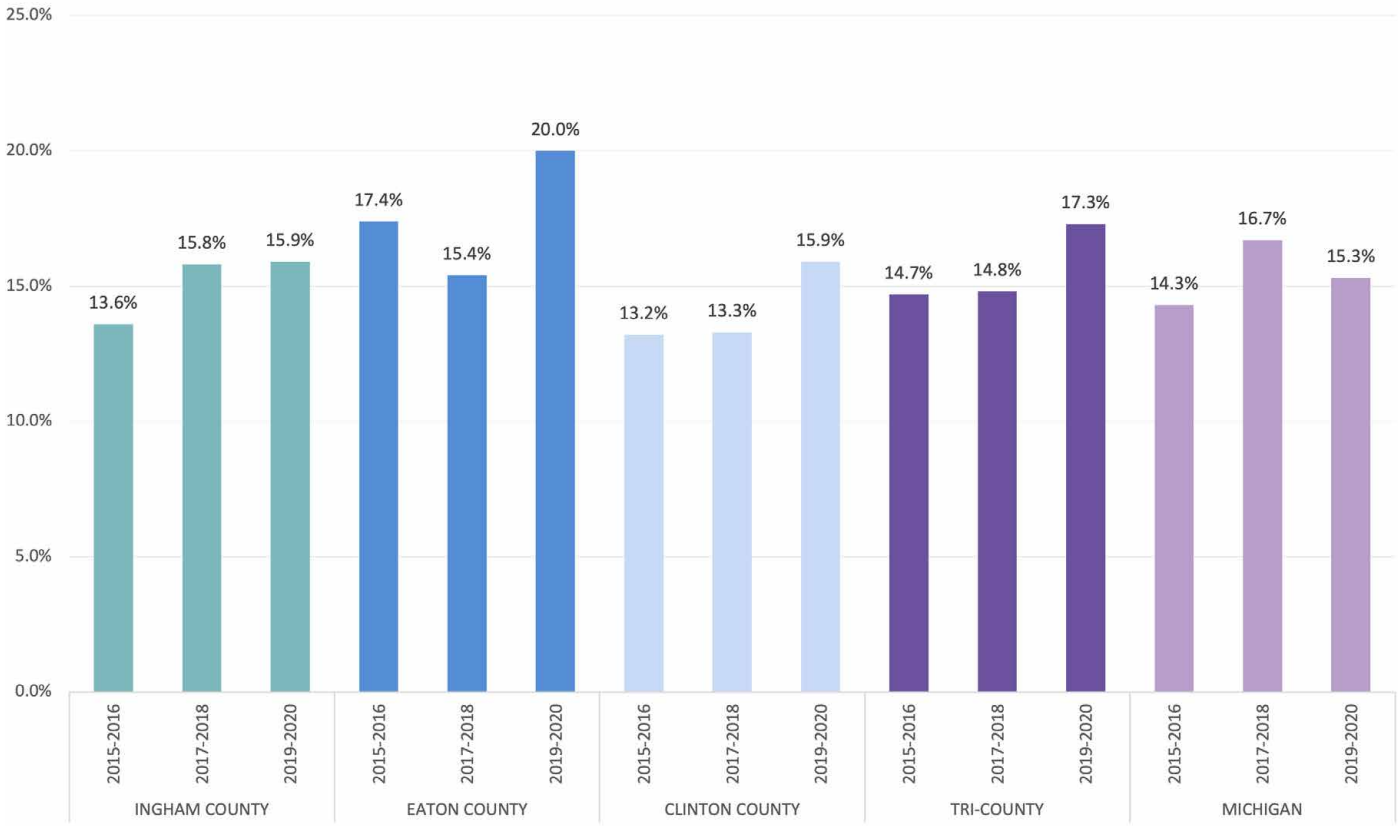


*Data for Arab students in Clinton County was suppressed due to low sample size.

Obesity - Adolescents

TREND IN PERCENT ADOLESCENTS WHO ARE OBESE 2017-2019

The trend for adolescent obesity is mixed in Eaton County and Michigan, but rising in Ingham and Clinton Counties. The rate of obesity fell to 15.4% in Eaton County in 2017-2018, but rose to 20.0% in 2019-2020. Meanwhile, Michigan's rate decreased from 16.7% to 15.3% over a similar timeframe.



Tobacco Use - Adults

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

DATA SOURCES
- Michigan Behavioral Risk Factor Surveillance System
- Capital Area Behavioral Risk Factor Surveillance System

YEARS
2008-2019

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

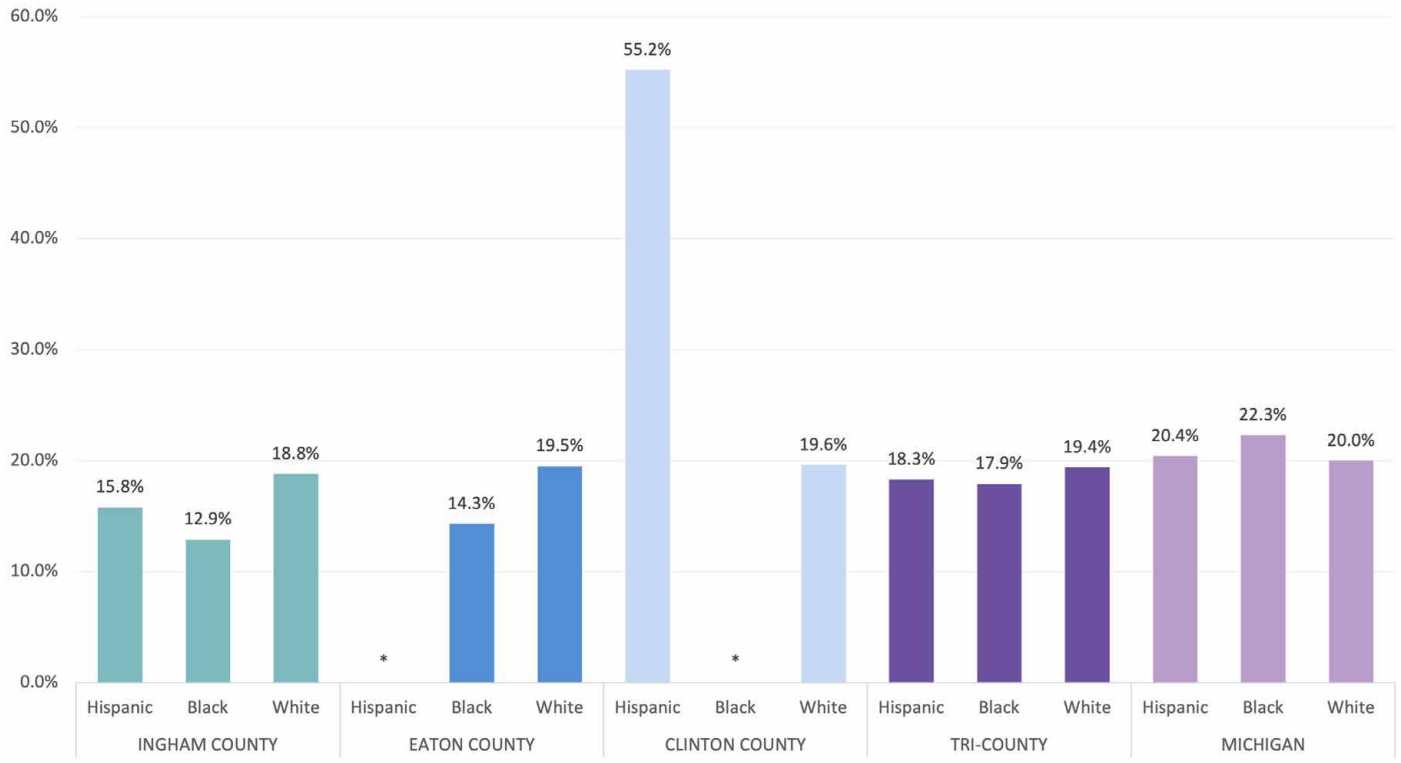
Sub-county level geographic area group breakouts are not available for this indicator.

PERCENT OF ADULTS WHO CURRENTLY SMOKE, 2017-2019

In the state of Michigan, approximately one in five adults currently smokes cigarettes. The tri-county area's prevalence is similar, with 19.6% of adults being current smokers. There are differences in the prevalence of smoking among adults in the individual counties. An estimated 21.8% of Clinton County's adults are cigarette smokers, whereas the prevalence is 20.2% in Eaton County and 18.3% in Ingham County.

PERCENT OF ADULTS WHO CURRENTLY SMOKE, 2014-2019 (BY RACE/ETHNICITY)

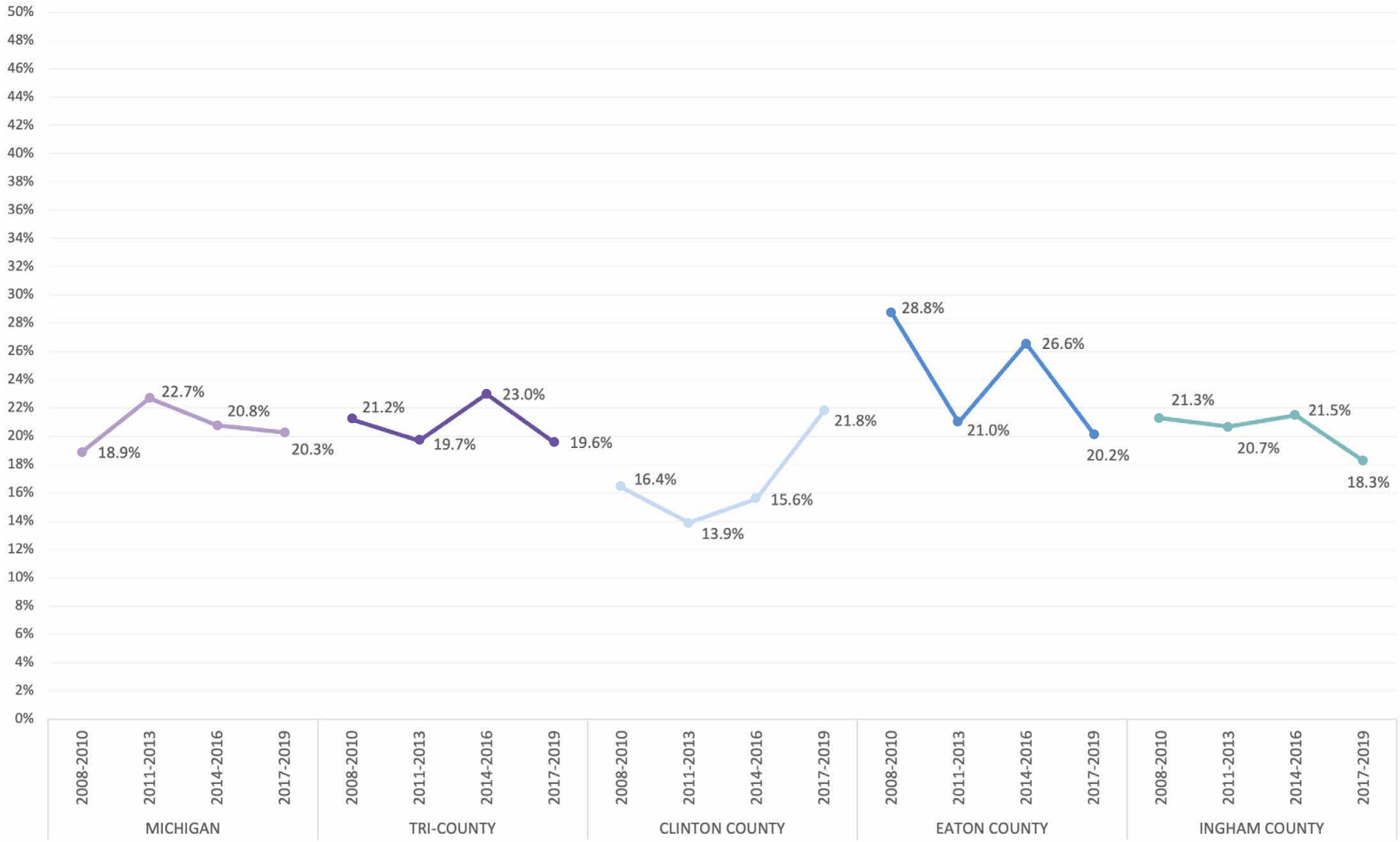
When stratified by race and ethnicity, information about cigarette smoking prevalence could not be reported for Clinton County's or Eaton County's racial/ethnic minority populations because of small sample sizes. In the state of Michigan, racial/ethnic minorities had a slightly higher proportion of smokers in their population compared to White adults. In Ingham County, the opposite occurred, with more smokers among White adults.



Tobacco Use - Adults

TREND IN PERCENT OF ADULTS WHO CURRENTLY SMOKE, 2008-2019

In the State of Michigan, there has been a slight decreasing trend in the prevalence of current cigarette smokers between 2011-2013 and 2017-2019. During this same time period, the tri-county area has had its rate vary from cycle to cycle, between 19.6% and 23.0%. Clinton County has seen a considerable increasing trend in current rates of smoking since 2011-2013 (13.9%) and has reached 21.8% in 2017-2019. The rate in Eaton County has been highly variable from cycle to cycle while Ingham's rate remained mostly flat before decreasing in 2017-2019 to 28.3%.



Tobacco Use - Adolescents

MEASURE
Adolescent smoking prevalence represents the percent of 9th and 11th grade students in who smoked cigarettes during the past 30 days.

DATA SOURCES
- Michigan Youth Risk Behavior Survey (MI YRBS)
- Michigan Profile for Healthy Youth Survey (MiPHY)

YEARS
MI YRBS: 2012-2013, 2014-2015, 2016-2017, 2018-2019
MiPHY: 2013-2014, 2015-2016, 2017-2018, 2019-2020

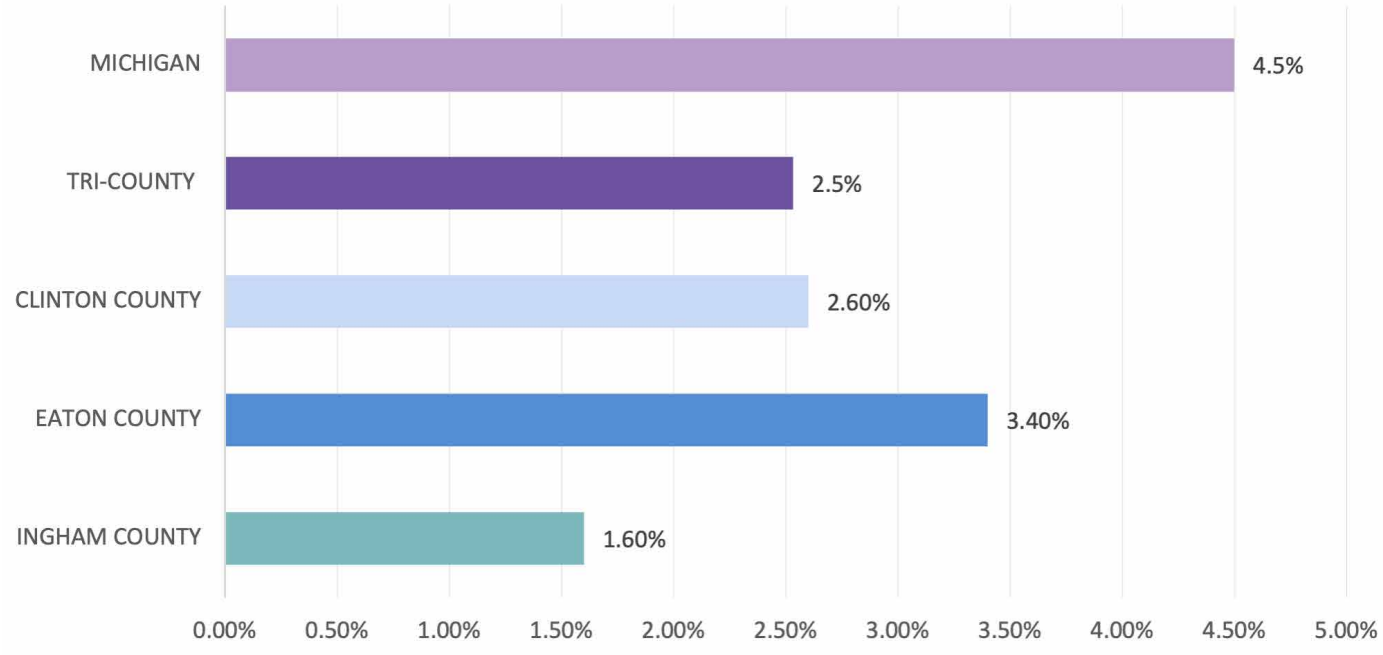
REASON FOR MEASURE
Each year, approximately 443,000 premature deaths occur in the United States primarily due to smoking. Cigarette smoking is a cause of multiple diseases, including various cancers, cardiovascular disease, respiratory conditions, low birth weight, and other adverse health outcomes.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

MEASURE NOTE
This measure only looks at those who smoke tobacco cigarettes and does not include vaping products or e-cigarettes. Due to this factor, trends and overall rates of smoking should be examined with care as vaping products and e-cigarettes are much more common than in previous data cycles.

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

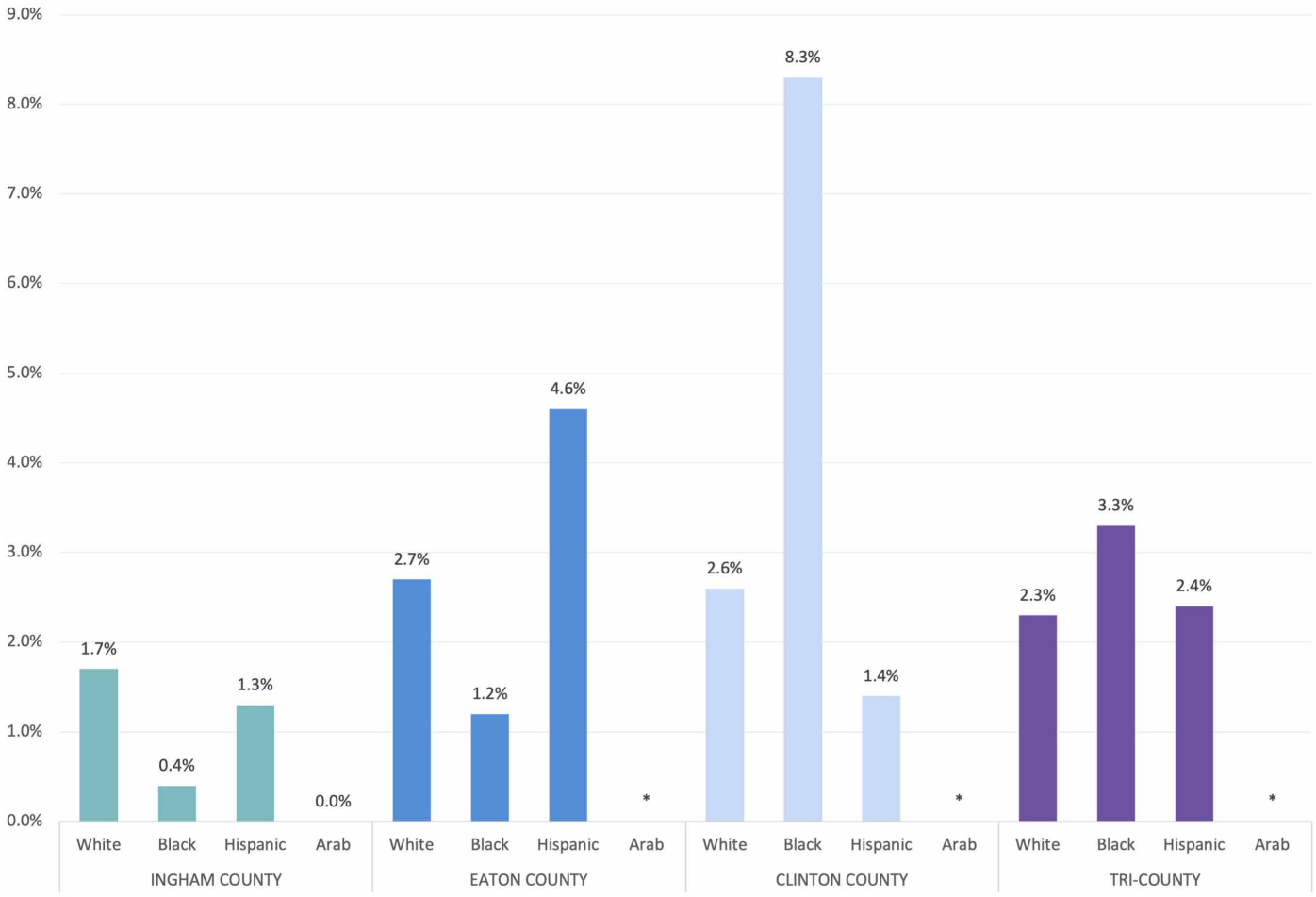
PERCENTAGE OF HS STUDENTS WHO SMOKED CIGARETTES DURING THE PAST 30 DAYS (2019-20)

A very low percentage (2.5%) of adolescents in the Capital Area reported smoking cigarettes recently, which was lower than the Michigan prevalence (4.5%). The proportion of self-reported adolescent recent cigarette smokers was higher in Eaton County (3.4%) than in Clinton or Ingham counties (2.6% and 1.6%, respectively).



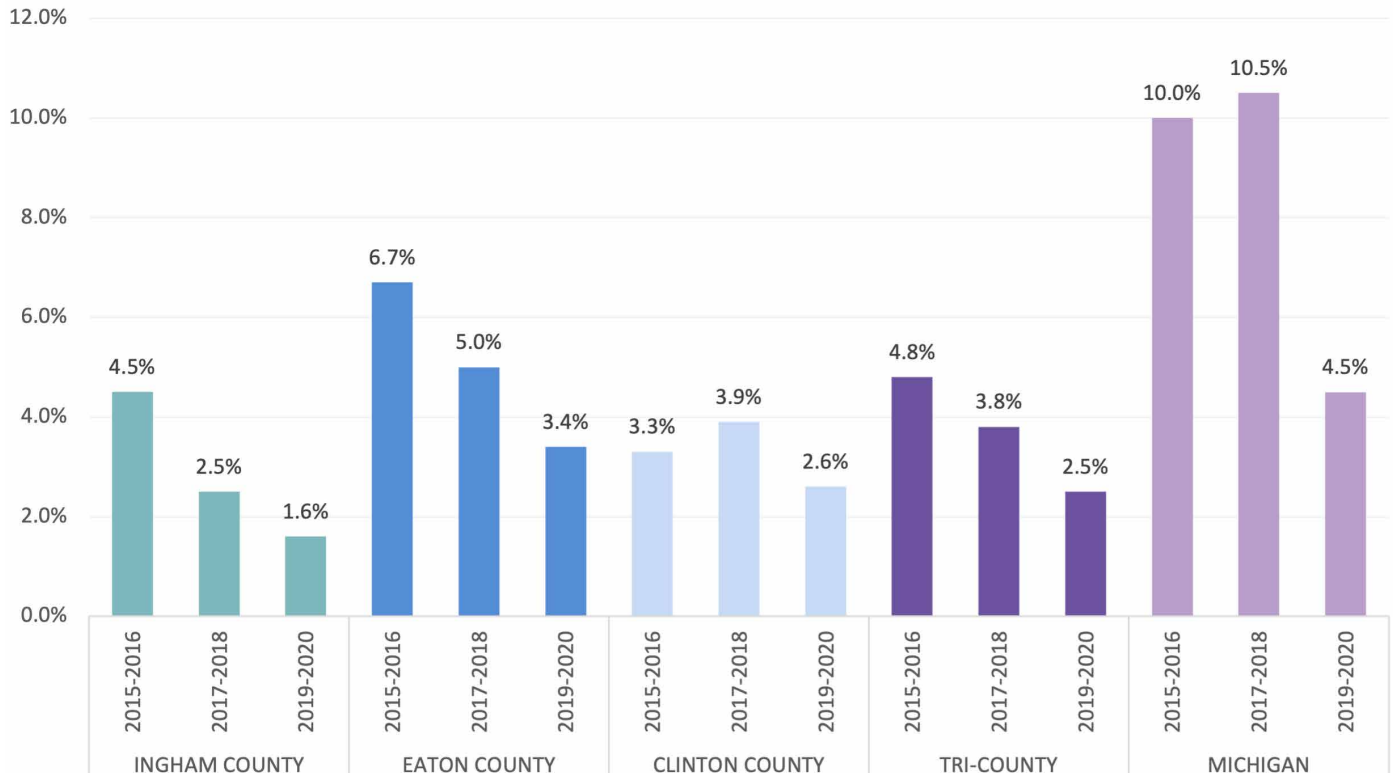
PERCENTAGE OF HS STUDENTS WHO SMOKED CIGARETTES DURING THE PAST 30 DAYS BY RACE/ETHNICITY (2019-20)

The prevalence of recent cigarette smoking was slightly higher among Black adolescents (3.3%), as compared to their White (2.3%), and Hispanic (2.4%) peers in the tri-county area. Prevalence of smoking was highest among Black adolescents in Clinton County (8.3%) while Eaton County showed Hispanic students (4.6%) were more likely to report current smoking habits. There were some notable differences between ethnic groups in Ingham County. Arab (0.0%) and Black students (0.4%) did report the least amount of current cigarette compared to their peers. Statistics for Arab adolescents in the tri-county area could not be calculated due to small sample sizes.



TREND IN PERCENT OF HS STUDENTS WHO SMOKED CIGARETTES DURING THE PAST 30 DAYS (2015-2020)

In Eaton and Ingham counties, there continues to be a trend in decreasing smoking rates. Clinton County's rate of adolescent smoking decreased from 2017-2018 to 2019-2020. The smoking rate in Michigan feel sharply from 10.5% in 2016-2017 to 4.5% in 2018-2019. Sharp declines are likely due to the increasing popularity of vaping products and e-cigarette use in place of traditional tobacco cigarettes.



Alcohol Use - Adults

MEASURE
Binge drinking is defined as consuming more than four (women) or five (men) alcoholic beverages on a single occasion within the past 30 days.

DATA SOURCES
- Michigan Behavioral Risk Factor Surveillance System
- Capital Area Behavioral Risk Factor Surveillance System

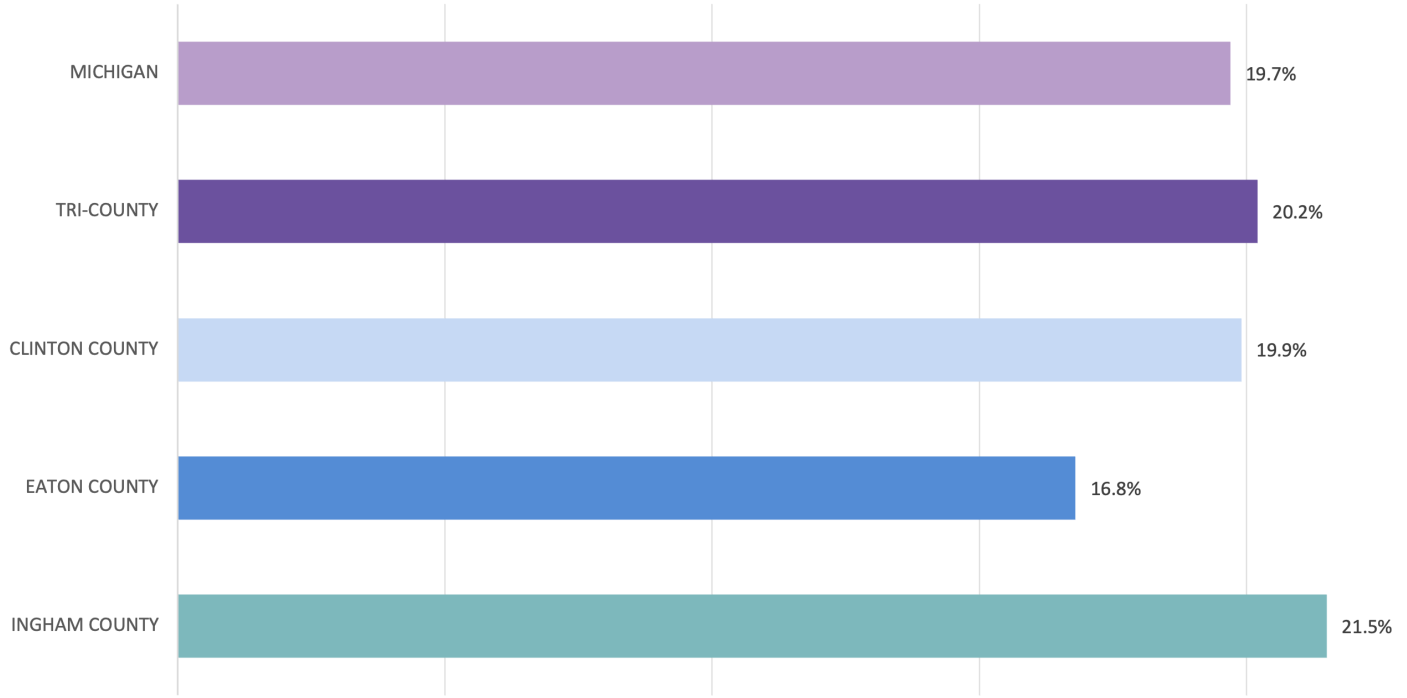
YEARS
2008-2019

REASON FOR MEASURE
Binge drinking is a risk factor for a number of adverse health outcomes, such as alcohol poisoning, hypertension, acute myocardial infarction, sexually-transmitted infections, unintended pregnancy, fetal alcohol syndrome, sudden infant death syndrome, suicide, interpersonal violence, and motor vehicle crashes.

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

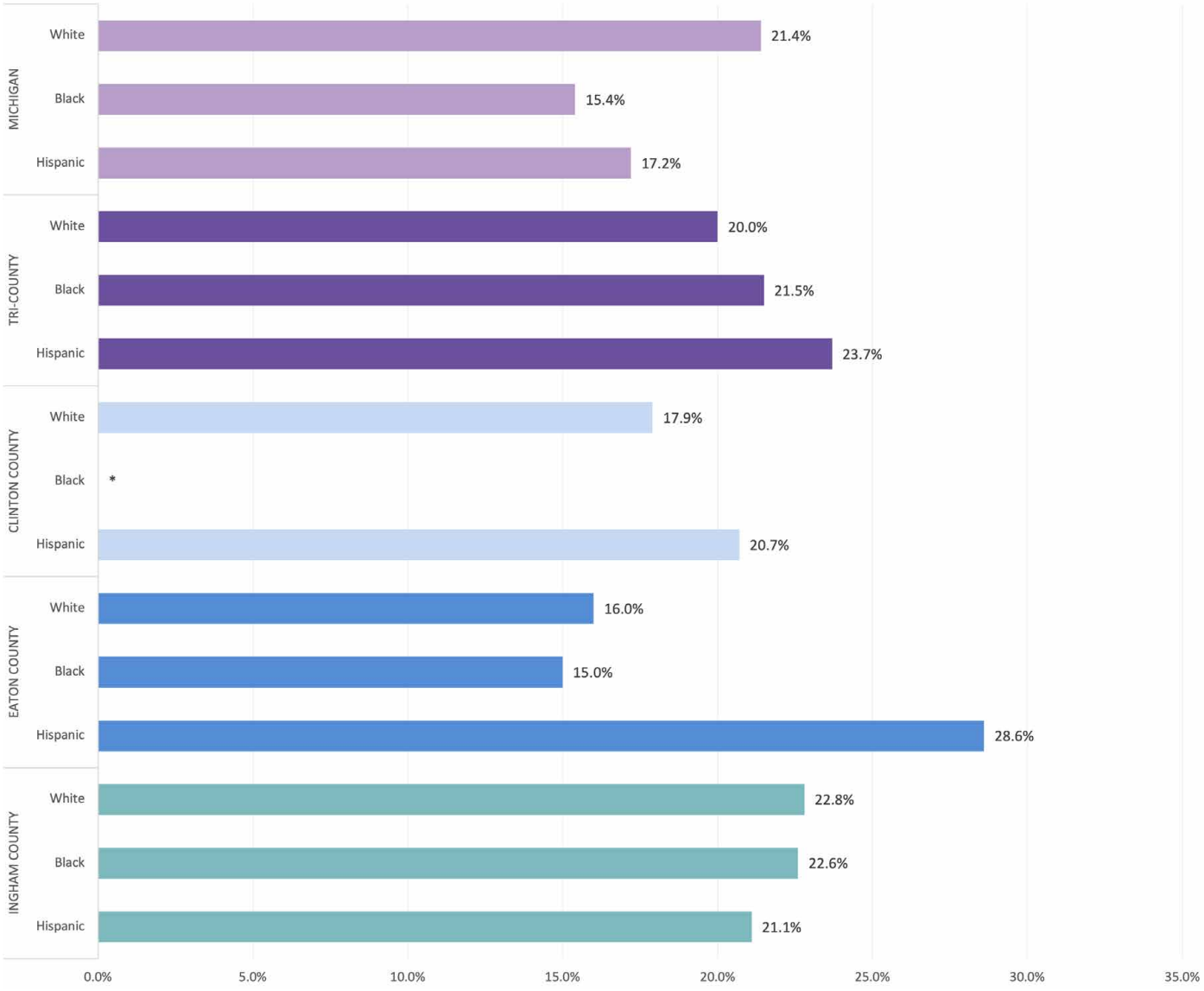
PERCENT OF ADULTS WHO REPORTED BINGE DRINKING IN THE LAST 30 DAYS, 2017-2019

Approximately one in five adults in Michigan and the tri-county region engaged in recent binge drinking. During the reporting period, Ingham and Clinton counties had the highest binge drinking prevalence among adults (21.5% and 19.9%, respectively). Eaton County had the lowest proportion (16.8%) in the region.



PERCENT OF ADULTS WHO HAD FIVE OR MORE DRINKS IN A ROW DURING THE PAST 30 DAYS, BY GEOGRAPHY, 2017-2018 (BY RACE/ETHNICITY)

In Clinton and Eaton County, Hispanic adults reported the highest rates of binge drinking in the tri-county area at 20.7% and 28.6%, respectively. In Ingham County, White adults (22.8%) had the highest rate of binge drinking in the last 30 days, followed by Black adults (22.6%) and Hispanic adults (21.1%). Rates of binge drinking among people of color in the tri-county area are equal to or higher than Michigan.

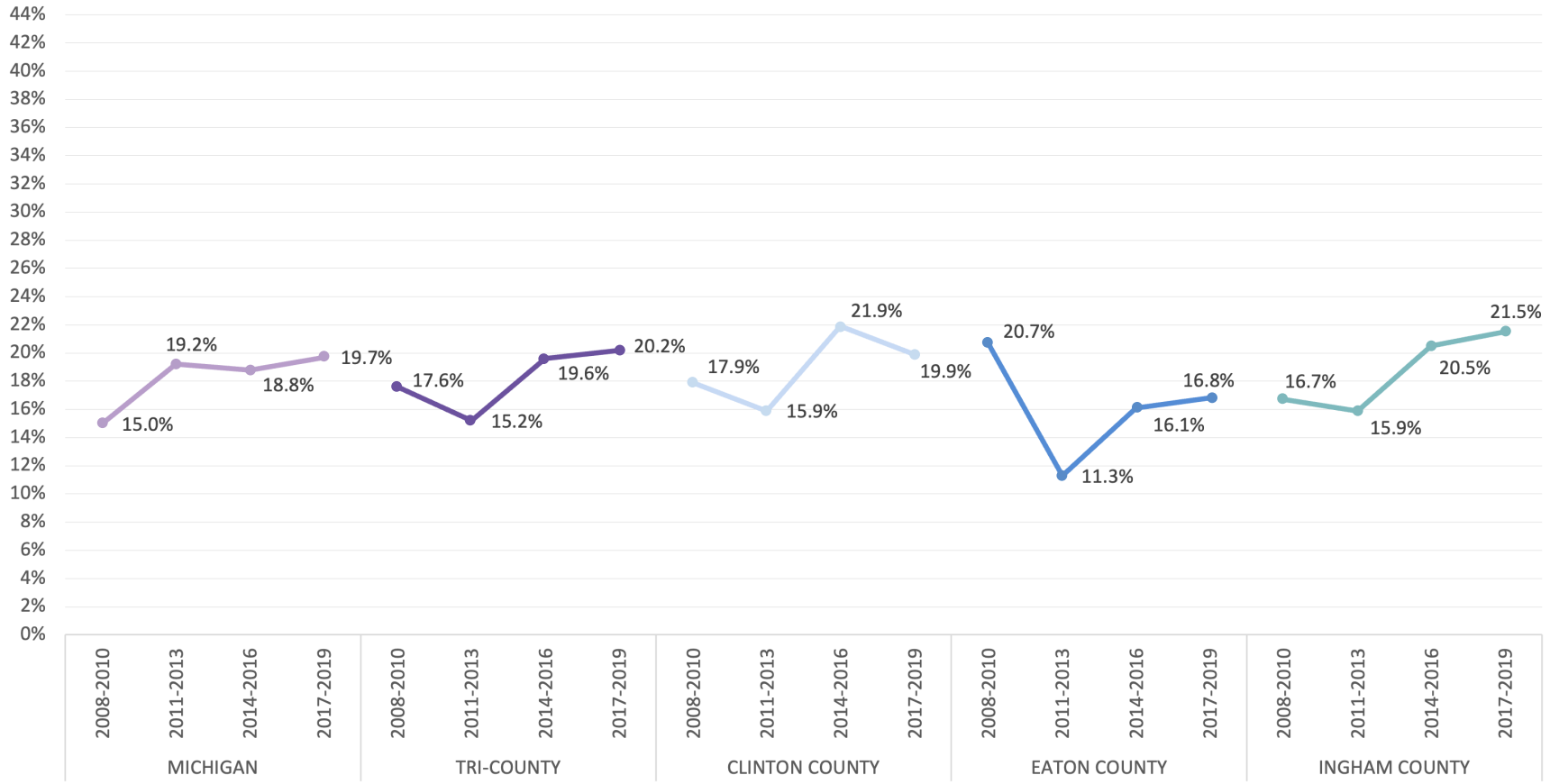


*Data for Black adults in Clinton County was suppressed due to data outlier and low sample size.

Alcohol Use - Adults

TREND IN PERCENT OF ADULTS WHO REPORTED BINGE DRINKING IN THE LAST 30 DAYS, 2008-2019

Ingham and Eaton County have both seen an increasing trend in percent of adults who reported binge drinking over the last 30 days in the past three BRFS cycles – from 2011-2013 to 2017-2019. In Clinton County the rate decreased from 21.9% in 2014-2016 to 19.9% in 2017-2019. Both findings are higher than in the first two cycles of the Capital Area BRFS.



Alcohol Use - Adolescents

MEASURE

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

DATA SOURCES

- Michigan Youth Risk Behavior Survey (MI YRBS)
- Michigan Profile for Healthy Youth Survey (MiPHY)

YEARS

MI YRBS: 2014-2015, 2016-2017, 2018-2019
MiPHY: 2013-2014, 2015-2016, 2017-2018, 2019-2020

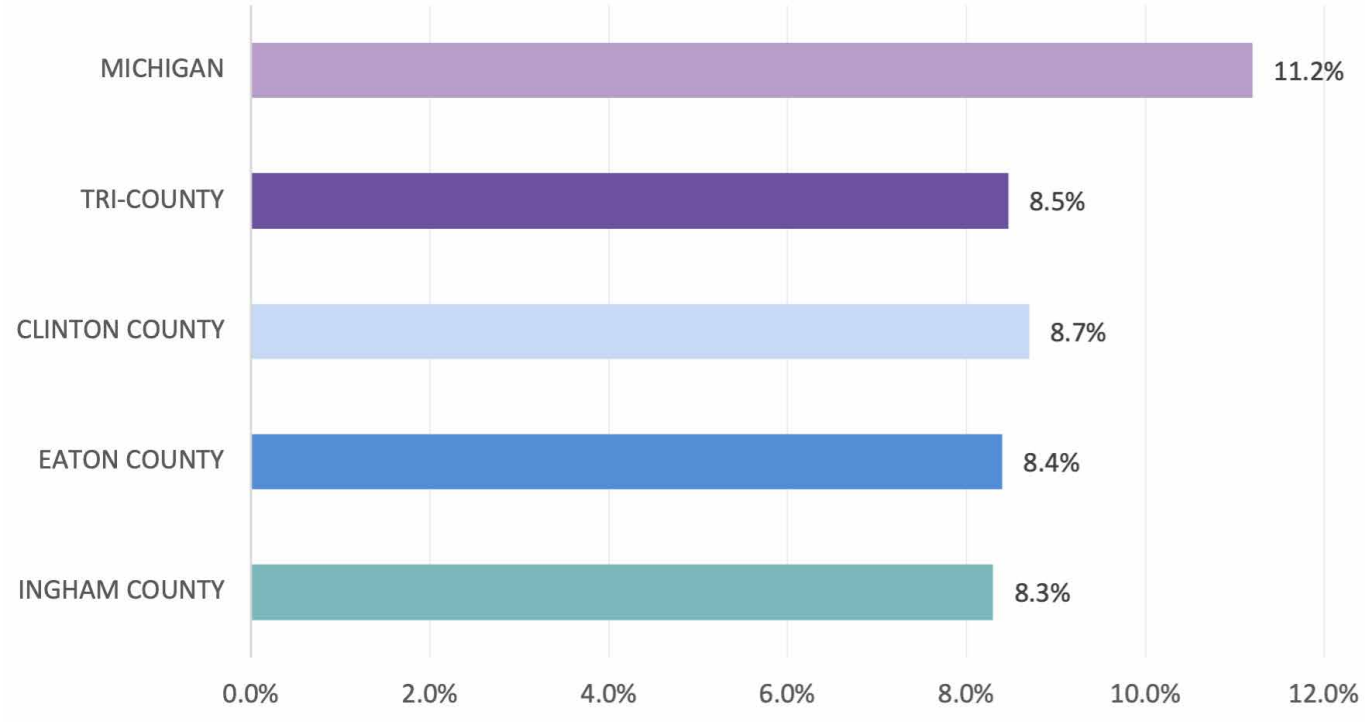
REASON FOR MEASURE

Binge drinking is a risk factor for a number of adverse health outcomes, such as alcohol poisoning, hypertension, acute myocardial infarction, sexually transmitted infections, unintended pregnancy, fetal alcohol syndrome, sudden infant death syndrome, suicide, interpersonal violence, and motor vehicle crashes.

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

PERCENT HIGH SCHOOL BINGE DRINKING (2019-20)

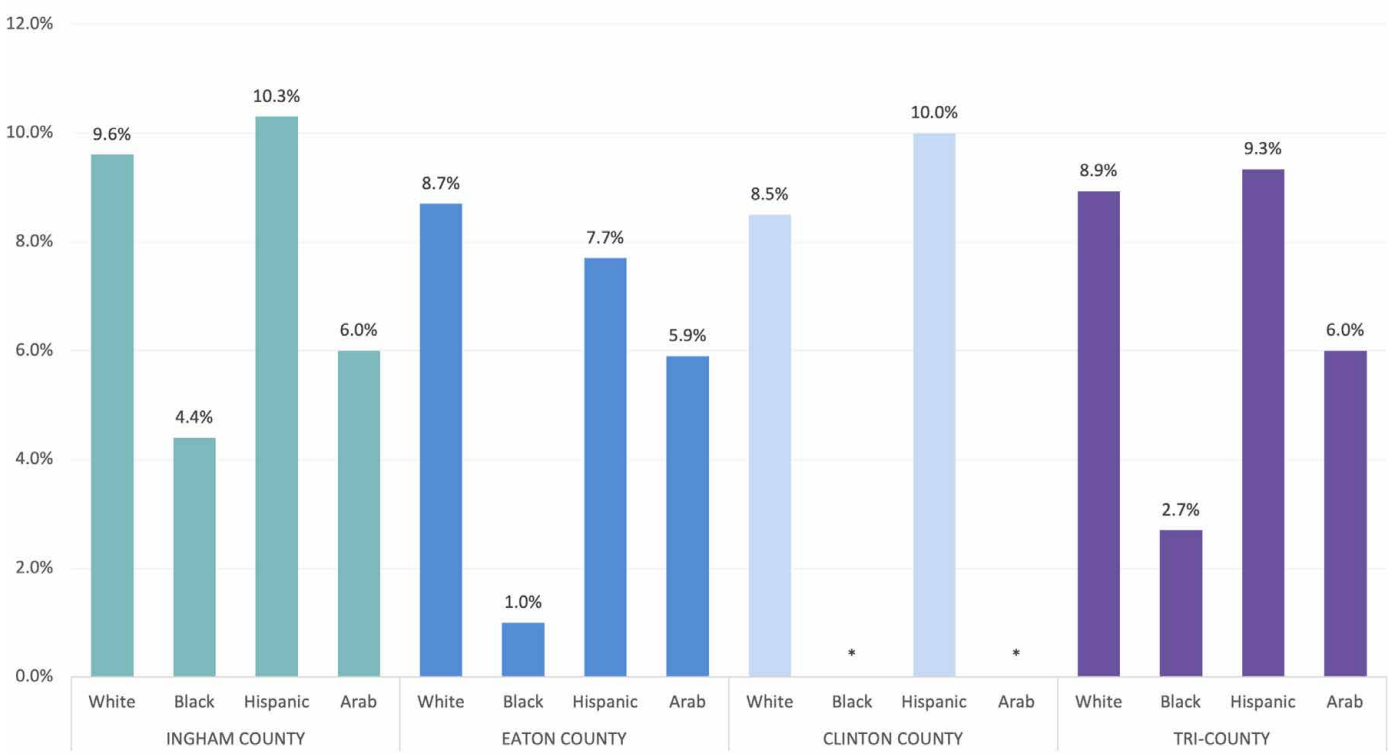
Recent binge drinking among adolescents in the Capital Area was lower than the state (8.5% vs 11.2%, respectively). The percentage of adolescents who reported recent binge drinking ranged from 8.3% in Ingham County to 8.7% in Clinton County. Eaton County was at 8.4%.



Alcohol Use - Adolescents

PERCENT HIGH SCHOOL BINGE DRINKING BY RACE AND ETHNICICTY (2019-20)

In two of three counties, Hispanic high school students reported the highest percentage of binge drinking in the previous 30 days. The exception is Eaton County where White students (8.7%) had a higher percentage of current binge drinking than Hispanic students (7.7%). In the Tri-County area, Black students were the least likely to have recently binge drank at 2.7%. Hispanic and White Students had higher reported rates of binge drinking at 9.3% and 8.9%, respectively. Arab students reported 6.0%.

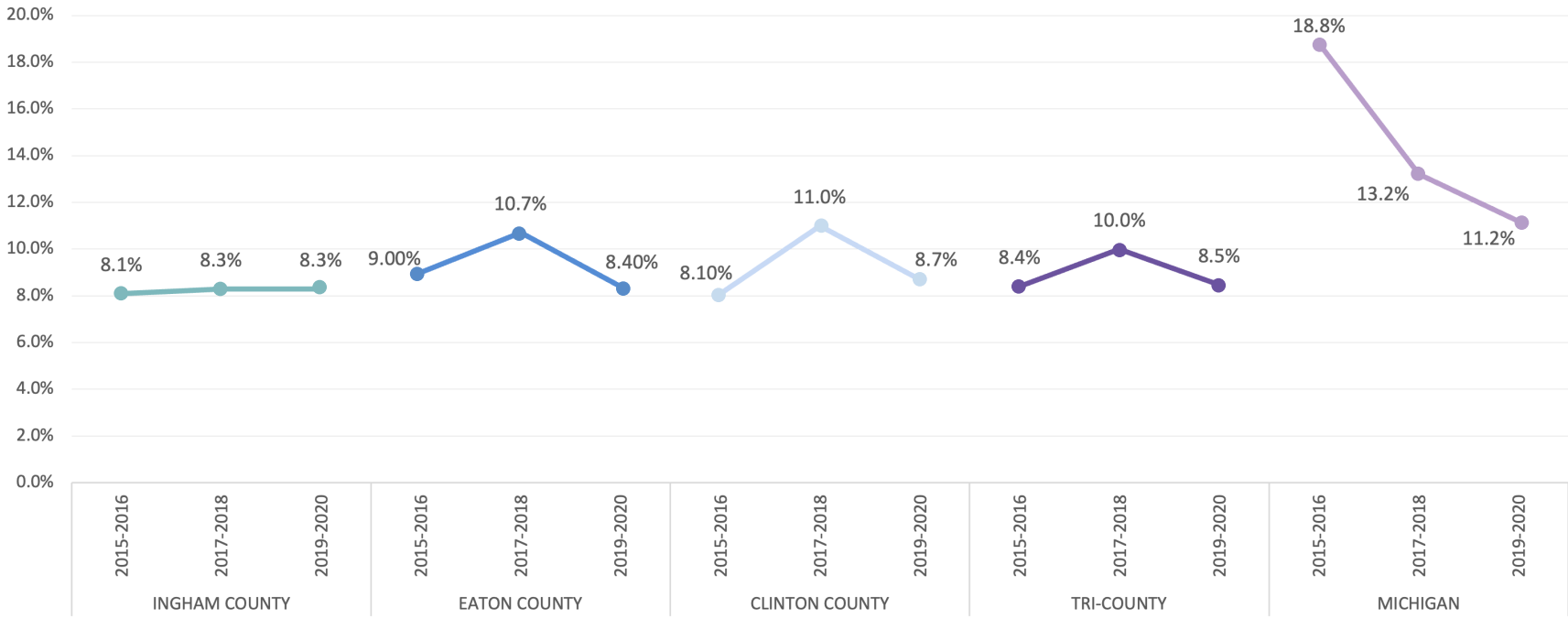


*Data for Clinton County's Black and Arab students was suppressed due to low sample size.

Alcohol Use - Adolescents

TREND IN PERCENT HIGH SCHOOL BINGE DRINKING (2015-2020)

In Ingham County, binge drinking has remained between 8.1% and 8.3% from 2015-2016 to 2019-2020. Eaton and Clinton County declined from roughly 11% to 8.4% in Eaton and 8.7% in Clinton. All counties continue to be lower than the overall rate for Michigan.



Marijuana Use – Adolescents

MEASURE
Percent of high school students who have used marijuana in the past 30 days.

DATA SOURCE
- Michigan Youth Risk Behavior Survey (MI YRBS)
- Michigan Profile for Healthy Youth Survey (MiPHY)

YEARS
MI YRBS: 2014-2015, 2016-2017; 2018-2019
MiPHY: 2015-2016, 2017-2018; 2019-2020

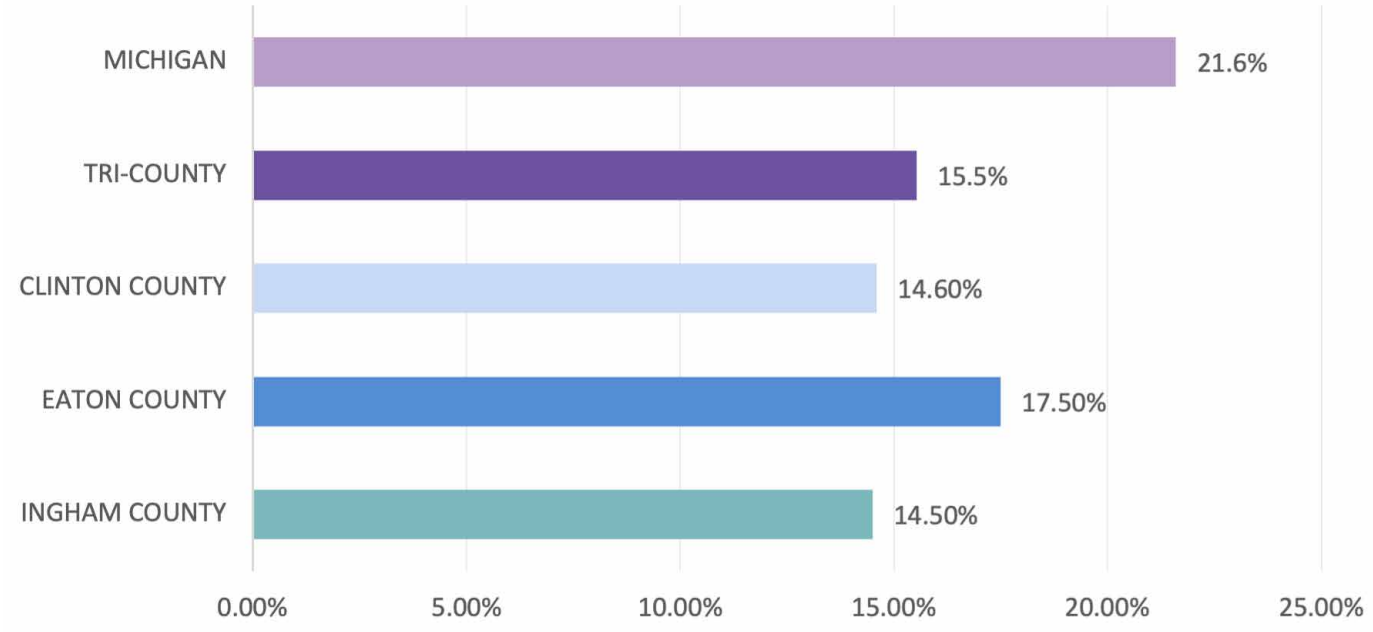
REASON FOR MEASURE
Research shows that marijuana use can have permanent effects on brain function on the developing brain when use begins in adolescence, especially with regular or heavy use.

Frequent or long-term use marijuana graduation rate use is linked to school dropout and lower educational achievement.

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

PERCENTAGE OF STUDENTS WHO USED MARIJUANA DURING THE PAST 30 DAYS (2019-20)

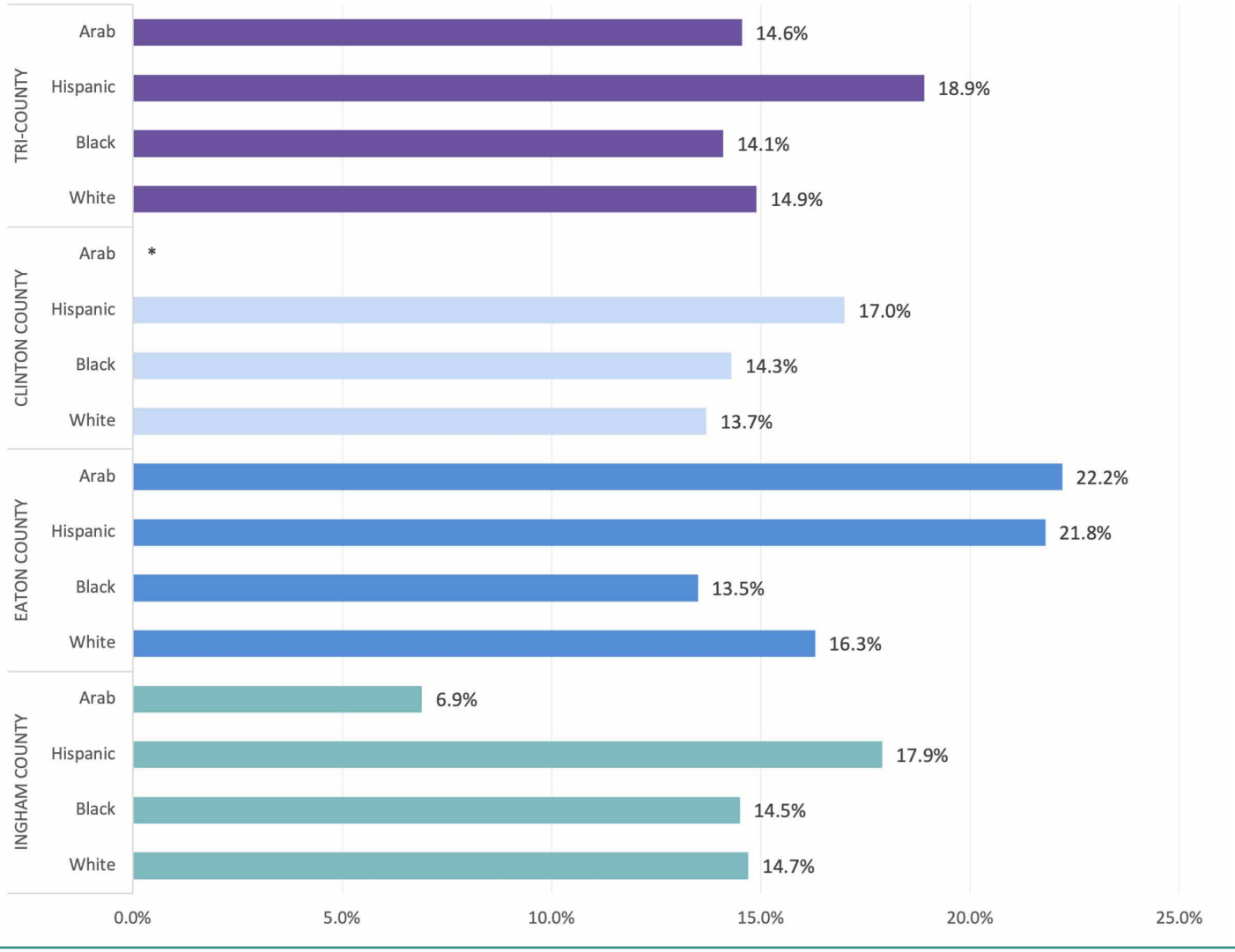
Compared to the state of Michigan, the tri-county area and all individual counties had lower rates of current marijuana use among high school students. Rates ranged from 14.5% in Ingham County to 17.5% in Eaton County.



Marijuana Use – Adolescents

PERCENTAGE OF STUDENTS WHO USED MARIJUANA DURING THE PAST 30 DAYS BY RACE AND ETHNICITY (2019-20)

Current marijuana use was highest among Hispanic high school students in Clinton (17.0%) and Ingham Counties (17.9%). The rate among Hispanic students was also high in Eaton County (21.8%) but slightly less than that for Arab students (22.2%). White and Black adolescents in Ingham County (14.7%, 14.5% respectively) had similar rates of current use, while in Eaton County White students (16.3%) had a slightly higher rate of current use than Black students (13.5%). Current marijuana use was lowest among Arab students in Ingham County (6.9%).

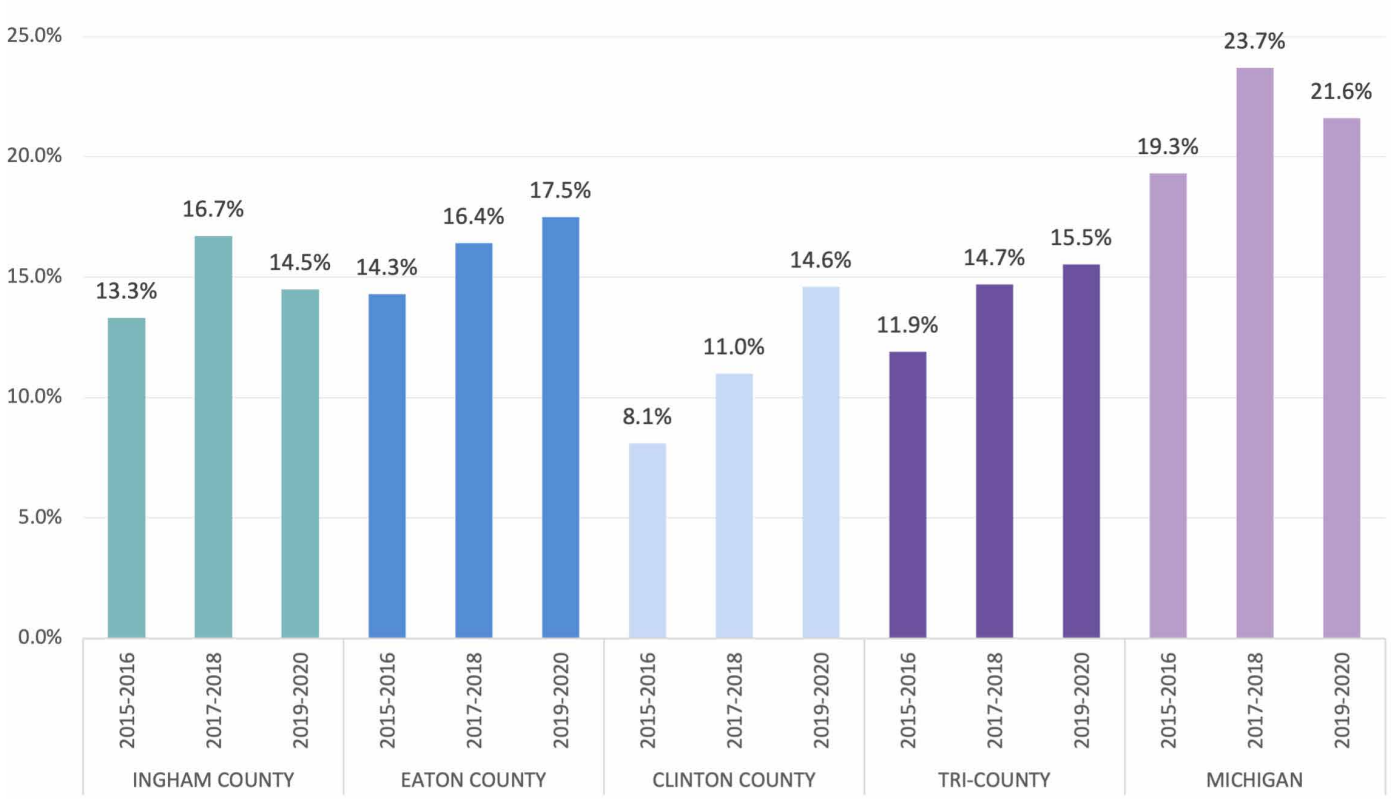


*Data for Arab students in Clinton County has been suppressed due to low sample size.

Marijuana Use – Adolescents

TREND IN PERCENTAGE OF STUDENTS WHO USED MARIJUANA DURING THE PAST 30 DAYS (2015-20)

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



Marijuana Use – Adolescents Prior to 13 Years of Age

MEASURE
Percent of high school students who tried marijuana before 13 years of age.

DATA SOURCE
- Michigan Youth Risk Behavior Survey (MI YRBS)
- Michigan Profile for Healthy Youth Survey (MiPHY)

YEARS
MI YRBS: 2014-2015, 2016-2017; 2018-2019
MiPHY: 2015-2016, 2017-2018; 2019-2020

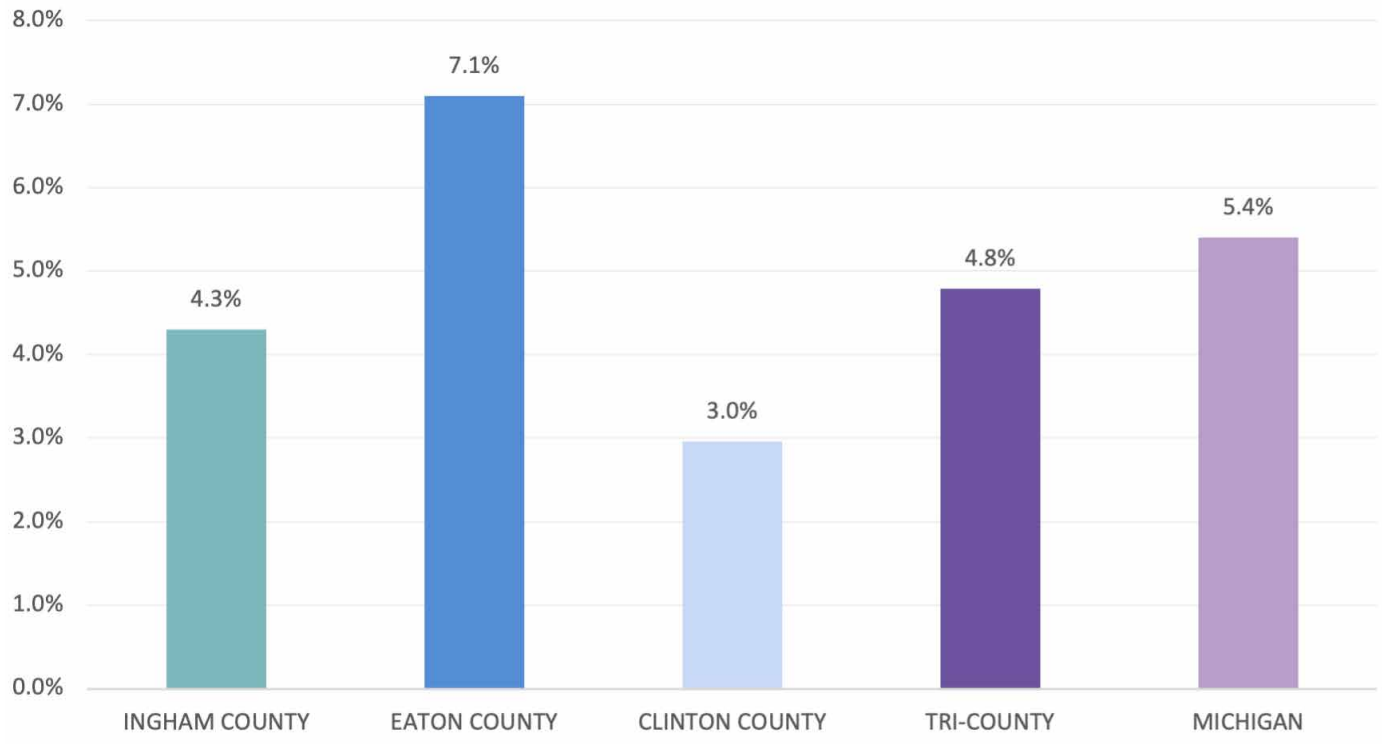
REASON FOR MEASURE
Research shows that marijuana use can have permanent effects on brain function on the developing brain when use begins in adolescence, especially with regular or heavy use.

Frequent or long-term use marijuana graduation rate use is linked to school dropout and lower educational achievement.

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

PERCENT HIGH SCHOOL STUDENTS WHO TRIED MARIJUANA BEFORE 13 YEARS OF AGE

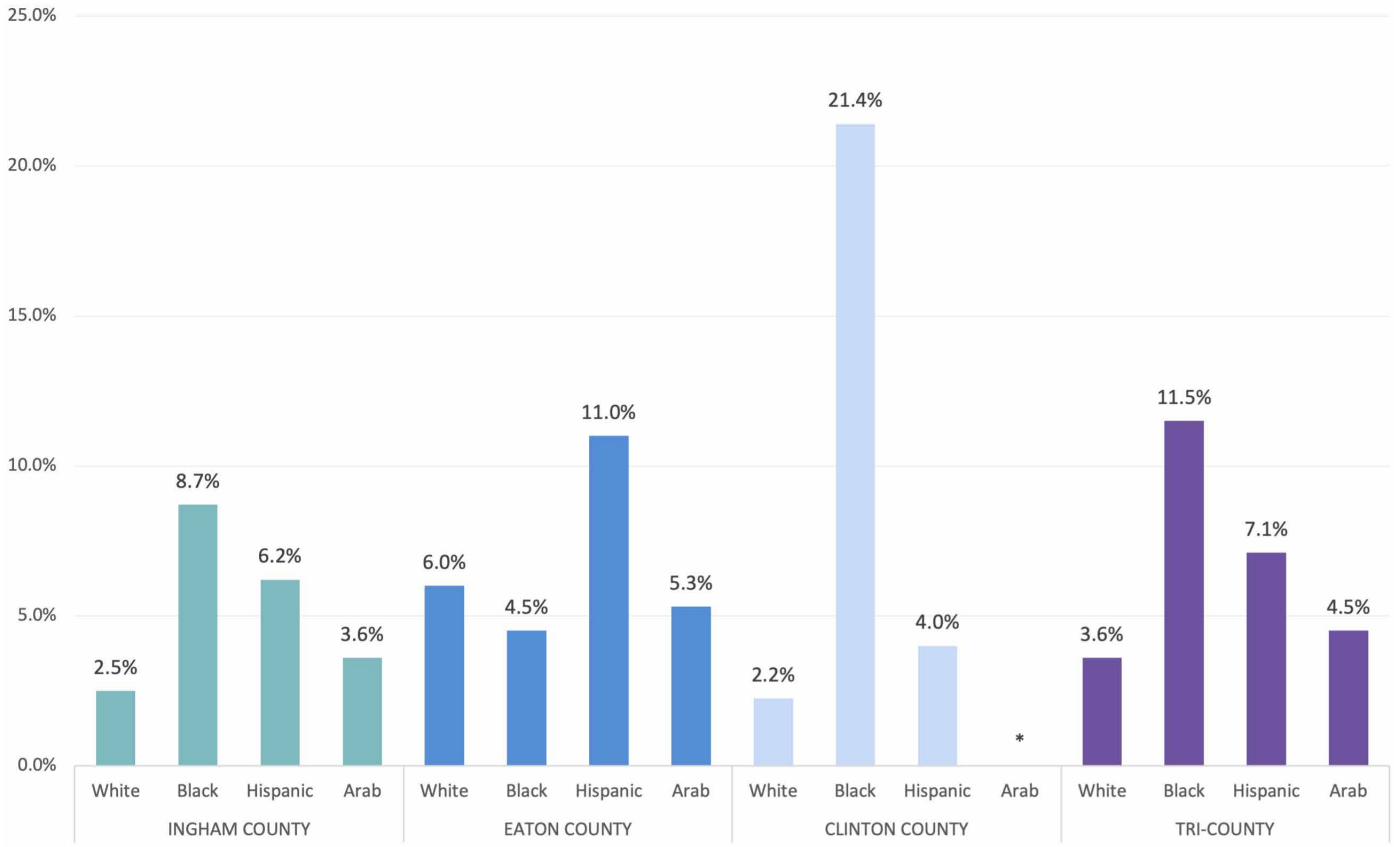
The tri-county area (4.8%) and the state of Michigan (5.4%) have roughly equal rates of adolescents using marijuana prior to 13 years of age. Individual counties had considerably more variation. Eaton County (7.1%) had the highest rate of early marijuana use, followed by Ingham County (4.3%) and Clinton County (3.0%).



Marijuana Use – Adolescents Prior to 13 Years of Age

PERCENT OF HIGH SCHOOL STUDENTS BY RACE/ETHINICTY WHO TRIED MARJIUANA BEFORE 13 YEARS OF AGE

Early use of marijuana was highest among Black adolescents in the tri-county area (11.5%), though this was largely driven by Clinton County's rate (21.4%) among Black high school students saying they tried marijuana before age 13. Hispanic adolescents had the highest percentage of early marijuana use in Eaton County (11.0%) compared to their White (6.0%), Arab (5.3%) and Black (4.5%) peers. Rates Ingham County varied from 2.5% for White adolescents to 8.7% among Black adolescents.

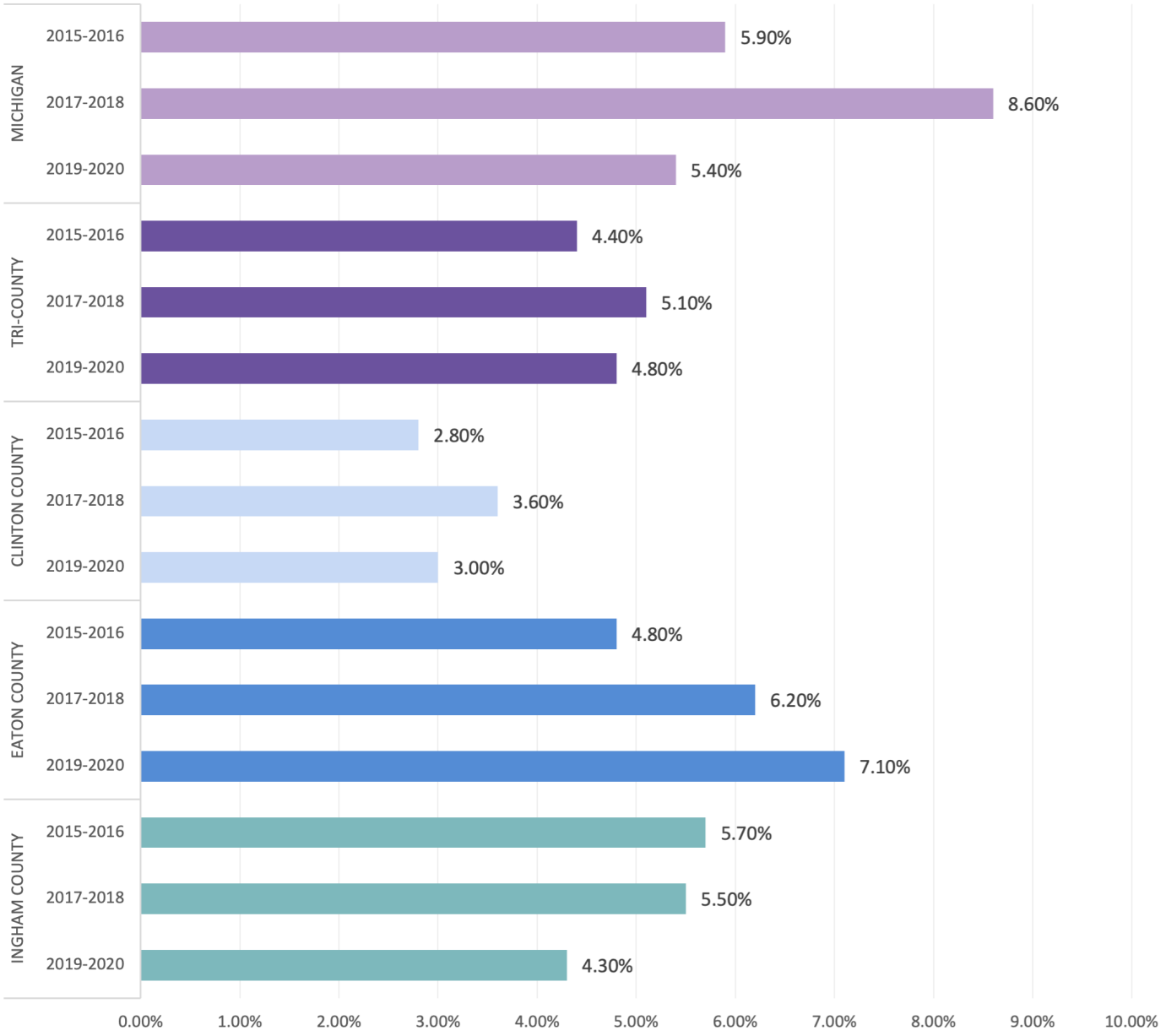


*Data for Arab students in Clinton County has been suppressed due to low sample size.

Marijuana Use – Adolescents Prior to 13 Years of Age

TREND IN PERCENT HIGH SCHOOL STUDENTS WHO TRIED MARIJUANA BEFORE AGE 13 YEARS

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



Physical Activity - Adults

MEASURE
The percent of adults engaging in no leisure time physical activity.

DATA SOURCES
- Michigan Behavioral Risk Factor Surveillance System (MI BRFS)
- Capital Area Behavioral Risk Factor Surveillance System (Capital Area BRFS)

YEARS
2008-2010, 2011-2013, 2014-2016, 2017-2019

REASON FOR MEASURE
Physical activity is any movement produced by the contraction of skeletal muscle that increases energy expenditure above normal levels; therefore, it is not simply exercise. The benefits of physical activity are numerous. Physically active persons have:

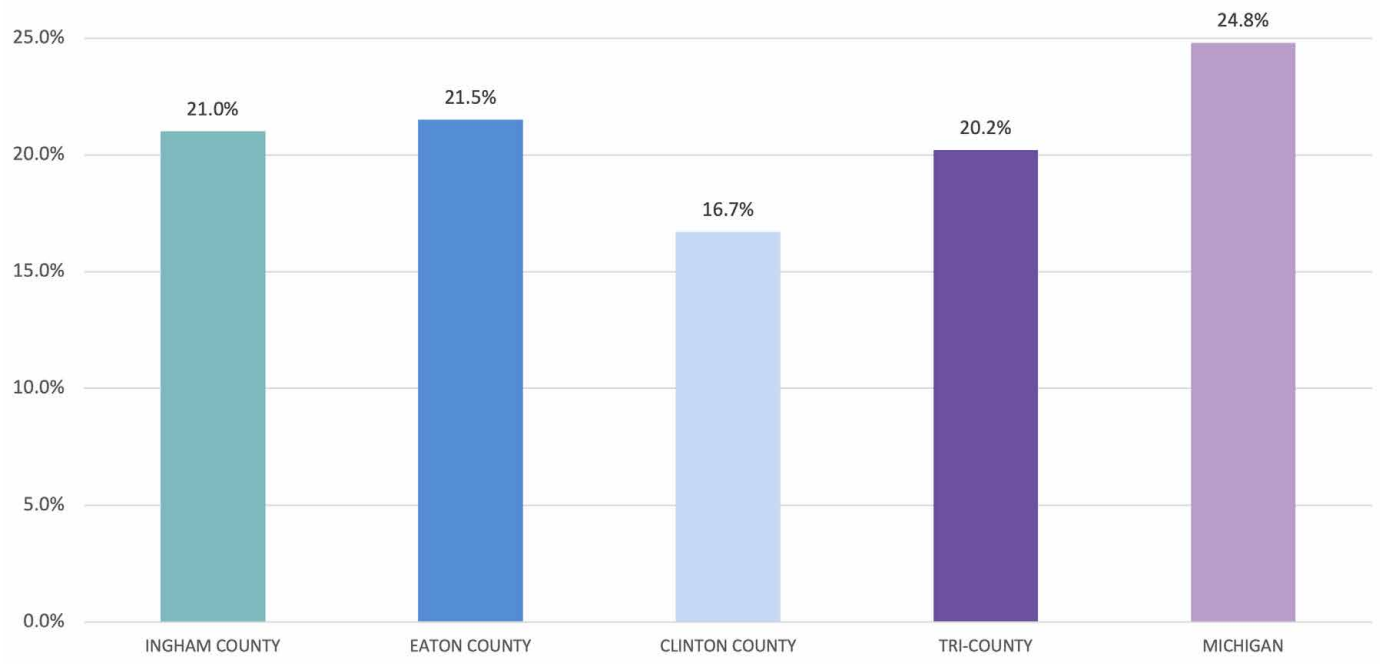
- 20-35% lower risk for cardiovascular disease, coronary artery disease, and stroke;
- 30-40% lower risk for type 2 diabetes and metabolic syndrome;
- 30% lower risk for colon cancer;
- 20% lower risk for breast cancer; and
- 20-30% lower risk for depression, distress/well-being, and dementia.

The questions for physical activity, both in the MI BRFS and the Capital Area BRFS, have changed over time to reflect revisions to the physical activity recommendation. Consequently, comparing the percentage of adults getting the recommended amount of physical activity has become increasingly difficult, since local and state statistics may not be comparable, and older statistics may not be comparable with current statistics. However, the question about leisure time physical activity itself has not changed over time.

NOTES ABOUT MEASURE
In 2010, the methodology of the Capital Area BRFS was changed to incorporate cell phones, as well as landline, telephones. Extreme caution should be used when using the statistics for trends.

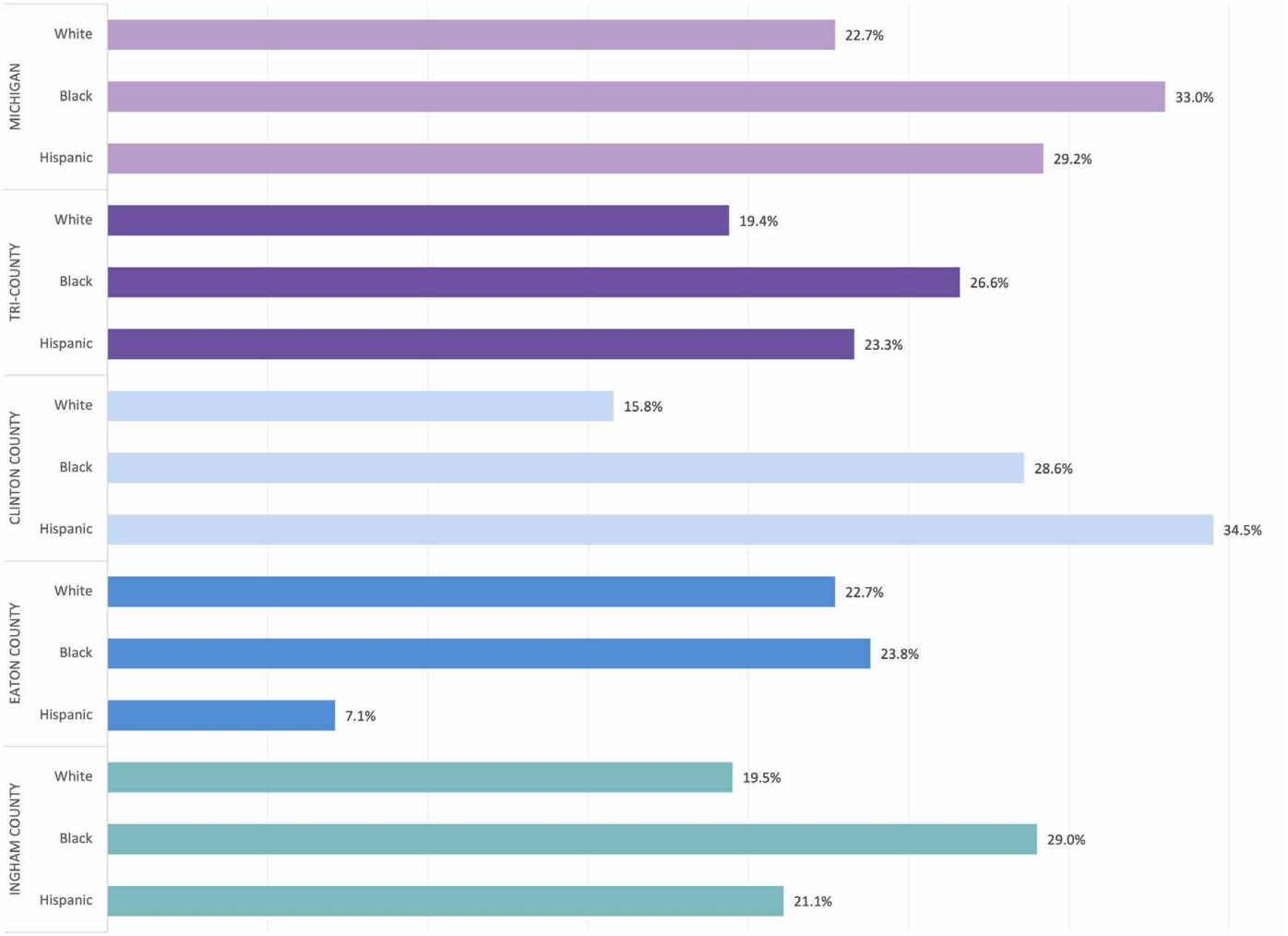
PERCENT OF ADULTS ENGAGING IN NO LEISURE-TIME PHYSICAL ACTIVITY, 2017-2019

Between 2017 and 2019, approximately one in four adults in Michigan and one in five adults in the tri-county area reported not engaging in any leisure time physical activity within the past month. The prevalence of no leisure time physical activity was fairly consistent across the three counties, but was lowest in Clinton County at 16.1%.



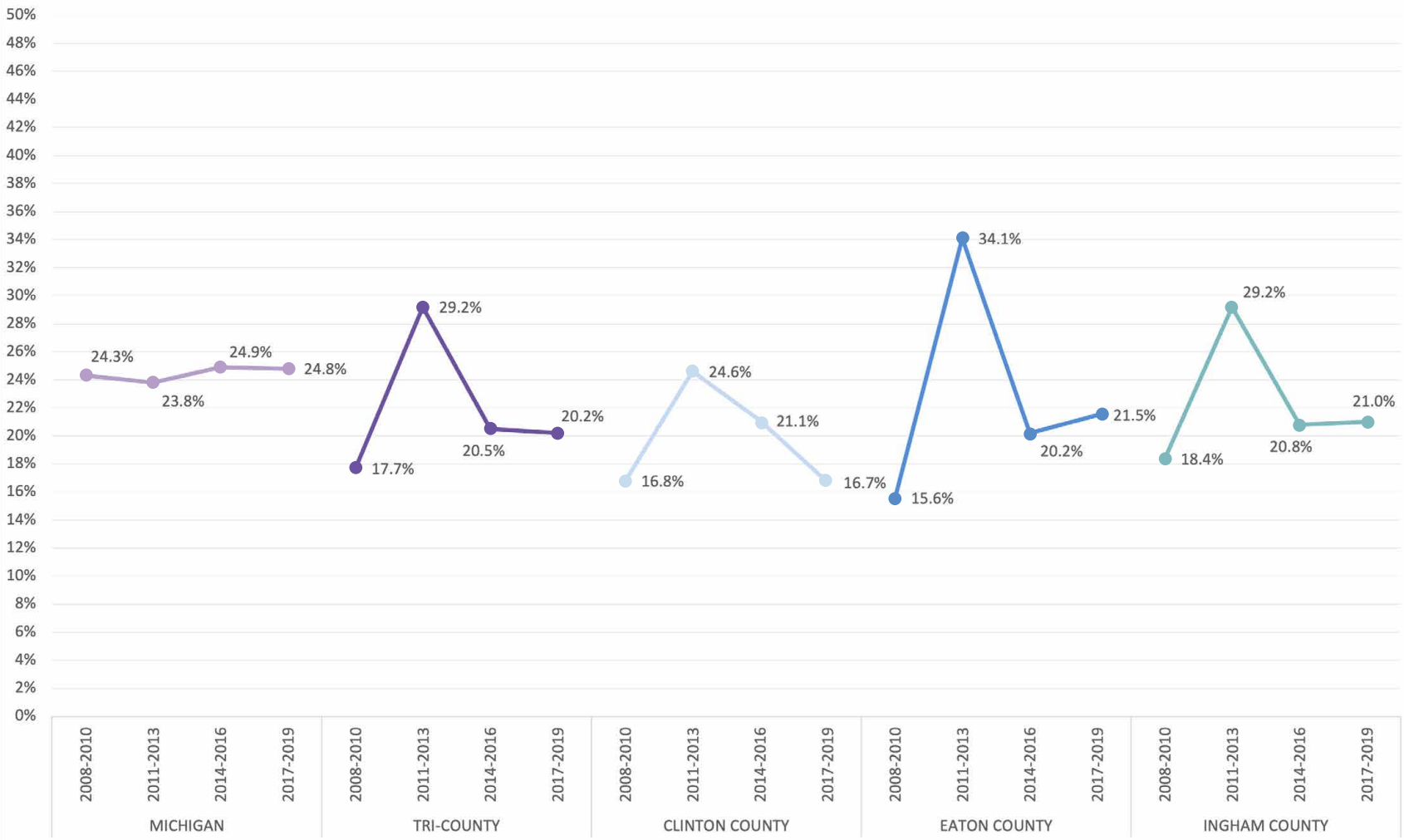
PERCENT OF ADULTS ENGAGING IN NO LEISURE-TIME PHYSICAL ACTIVITY, 2014-2016 (BY RACE/ETHNICITY)

When stratified by race and ethnicity, the prevalence of adults not engaging in any leisure time physical activity was generally higher amongst racial/ethnic minorities than for White adults, both in Michigan and in the Capital Area. Differences between racial/ethnic groups were especially prominent for Clinton County with 34.5% of Hispanic residents engaging in no leisure time physical activity. In Ingham and Clinton County, approximately 29% of Black residents did not participate in any leisure time physical activity in the past month.



TREND IN PERCENT OF ADULTS ENGAGING IN NO LEISURE-TIME PHYSICAL ACTIVITY, 2008-2019

The trend for Michigan adults who reported no leisure time physical activity was steady from 2008-2010 to 2017-2019; however, there were observable increases in the percentage of persons not experiencing leisure time physical activity in the Capital Area from 2008-2010 to 2011-2013. Statistics for the 2011-2013 survey were unusually high for the Capital Area counties, which may have been the result of methodological changes in how the survey was administered during that time period. Since then, the overall level of physical activity has decreased overall. In the 2014-2016 cycle, all counties reported increased physical activity levels, but only Clinton County continued to show a positive trend in activity levels at 16.7% of residents not engaging in leisure time physical activity. Ingham and Eaton County show approximately the same level of activity as the previous cycle, with Eaton having a slight worsening result.



Nutrition - Adults

MEASURE
Percentage of adults who consume ≥5 servings (or times) of fruits and vegetables per day.

DATA SOURCES
- Michigan Behavioral Risk Factor Surveillance System
- Capital Area Behavioral Risk Factor Surveillance System

YEARS
2013-2019 MI BRFSS
2011-2019 Capital Area BRFSS

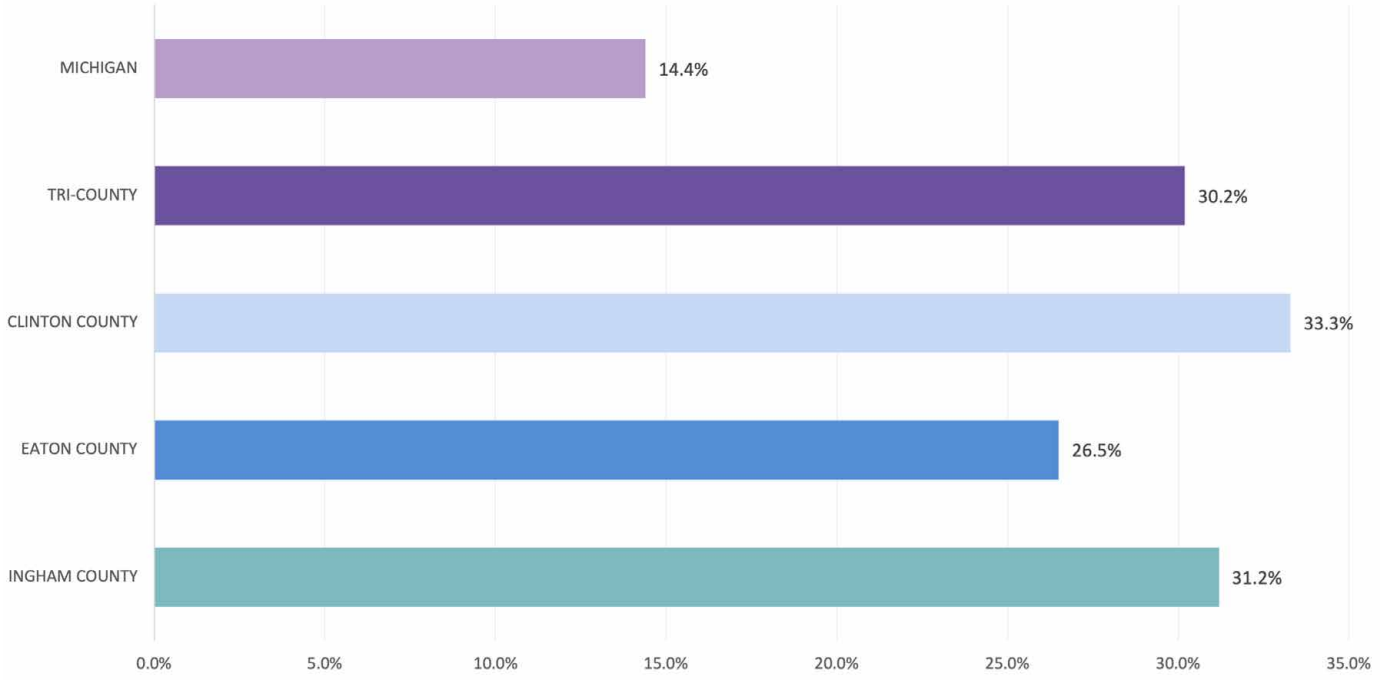
REASON FOR MEASURE
Most adults consume a diet heavy in carbohydrates and fats but have limited (both in amount and in type) fruit and vegetable consumption. Fruits and vegetables provide numerous nutrients and fiber. A plant-based diet is associated with decreased risk for chronic diseases, like cancer, diabetes, and obesity. Consuming a variety of fruits and vegetables is necessary to obtain the whole spectrum of nutrients necessary for optimum health.

NOTES ABOUT MEASURE
- In 2010, the questions about nutrition in the Capital Area BRFS changed. Consequently, nutrition statistics from generated 2008-2010 differ from those in the 2011-2013 and 2014-2016 surveys. 2008-2010 data is not presented in this report, and it is not recommended that they be used for trends.
- In 2011, the methodology of the Capital Area BRFS was changed to incorporate cell phones as well as landline telephones.

PERCENT OF ADULTS WHO CONSUME AN ADEQUATE AMOUNT OF FRUITS AND VEGETABLES DAILY, 2017-2019

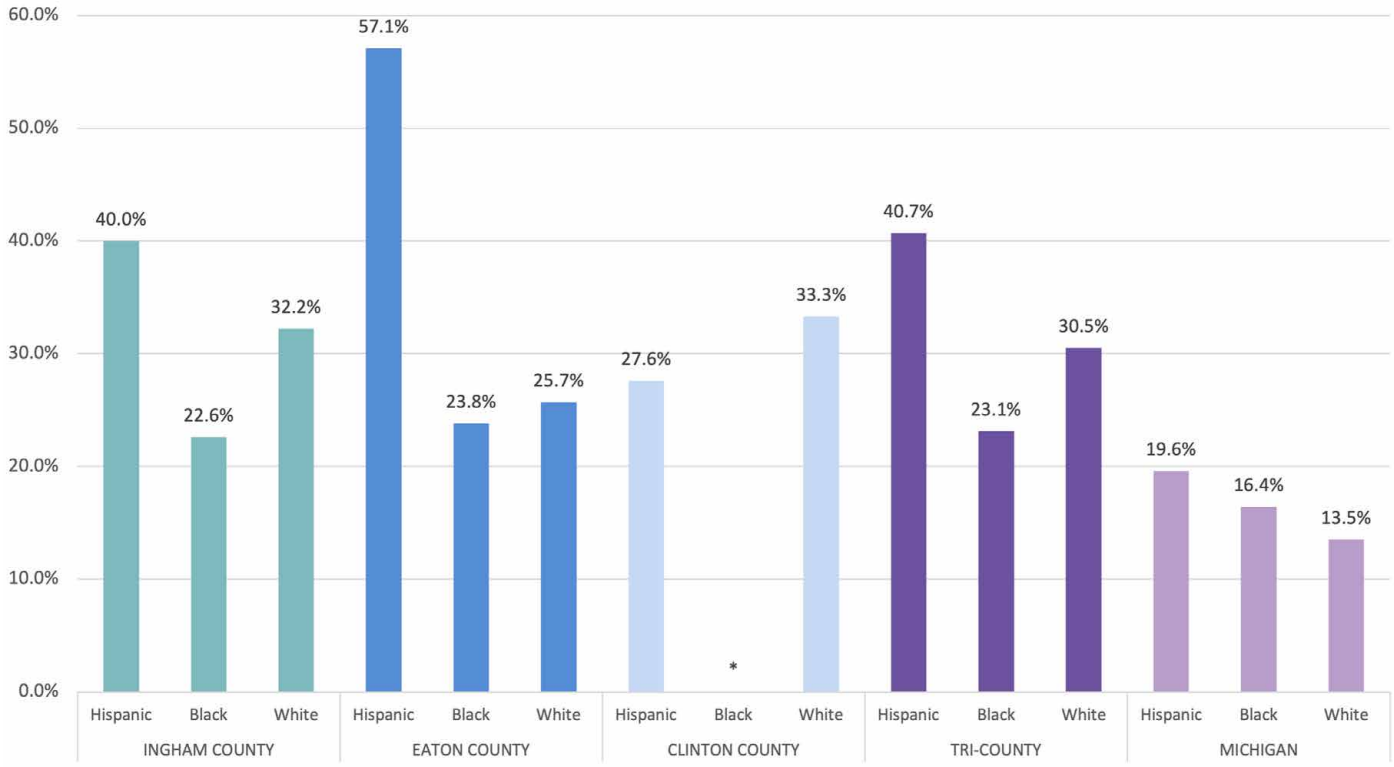
The nutrition question asked on the Michigan BRFS survey is worded differently than the corresponding questions asked in the Capital Area BRFS. The statistics are not equivalent, thus no direct comparison should be made between the state estimate and that of the Capital Area.

In the Capital Area, just under one-third of adults consume at least five or more servings of fruits and vegetables daily. Among the individual counties, adequate fruit and vegetable consumption is slightly higher in Ingham and Clinton County than Eaton county.



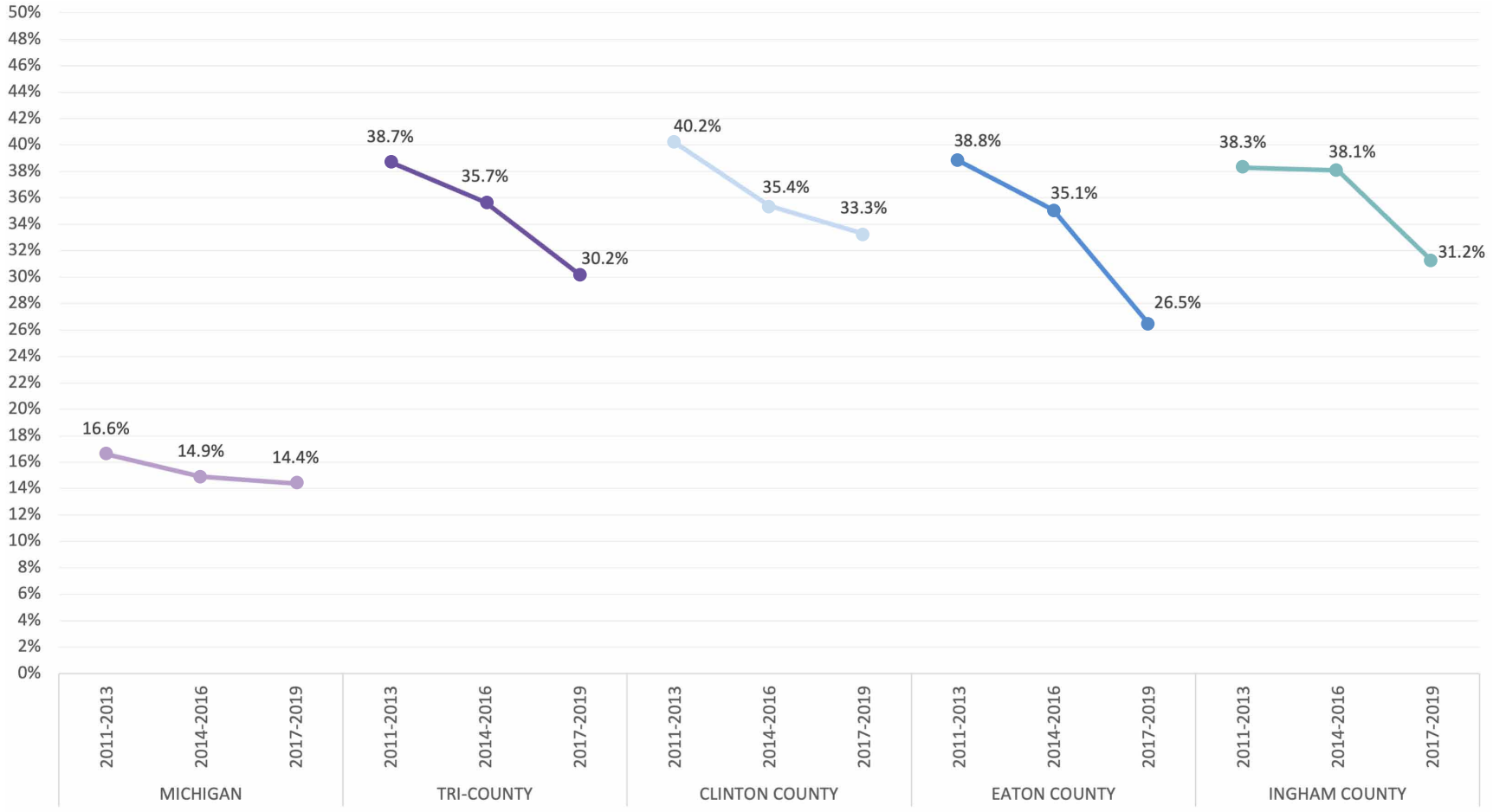
PERCENT OF ADULTS WHO CONSUME AN ADEQUATE AMOUNT OF FRUITS AND VEGETABLES DAILY, 2017-2019 (BY RACE/ETHNICITY)

In the Capital Area, more Hispanic adults consumed the recommended amount of fruits and vegetables than their White and Black peers. Findings were similar for Ingham County. Eaton County had a considerable difference between fruit and vegetable consumption in the Hispanic population compared to their Black and White counterparts. Data for Black residents of Clinton County was suppressed due to low sample size.



TREND IN PERCENT OF ADULTS WHO CONSUME AN ADEQUATE AMOUNT OF FRUITS AND VEGETABLES DAILY, 2011-2019

In the tri-county area, there has been a decline in the number of adults reporting adequate amount of fruits and vegetables across all time periods. Clinton County showed the slowest rate of decline from 35.4% to 33.3%, while Eaton County showed a drastic change in decreasing from 35.1% in 2014-2016 to 26.5% in 2017-2019. Ingham County also experienced a sharp decline, after the previous two cycles were roughly the same.



Nutrition - Adolescents

MEASURE
Percentage of 9th and 11th grade students who ate five or more servings of fruits and vegetables per day during the past seven days.

DATA SOURCE
Michigan Profile for Healthy Youth Survey (MiPHY)

YEARS
2013-2014, 2015-2016, 2017-2018, 2019-2020

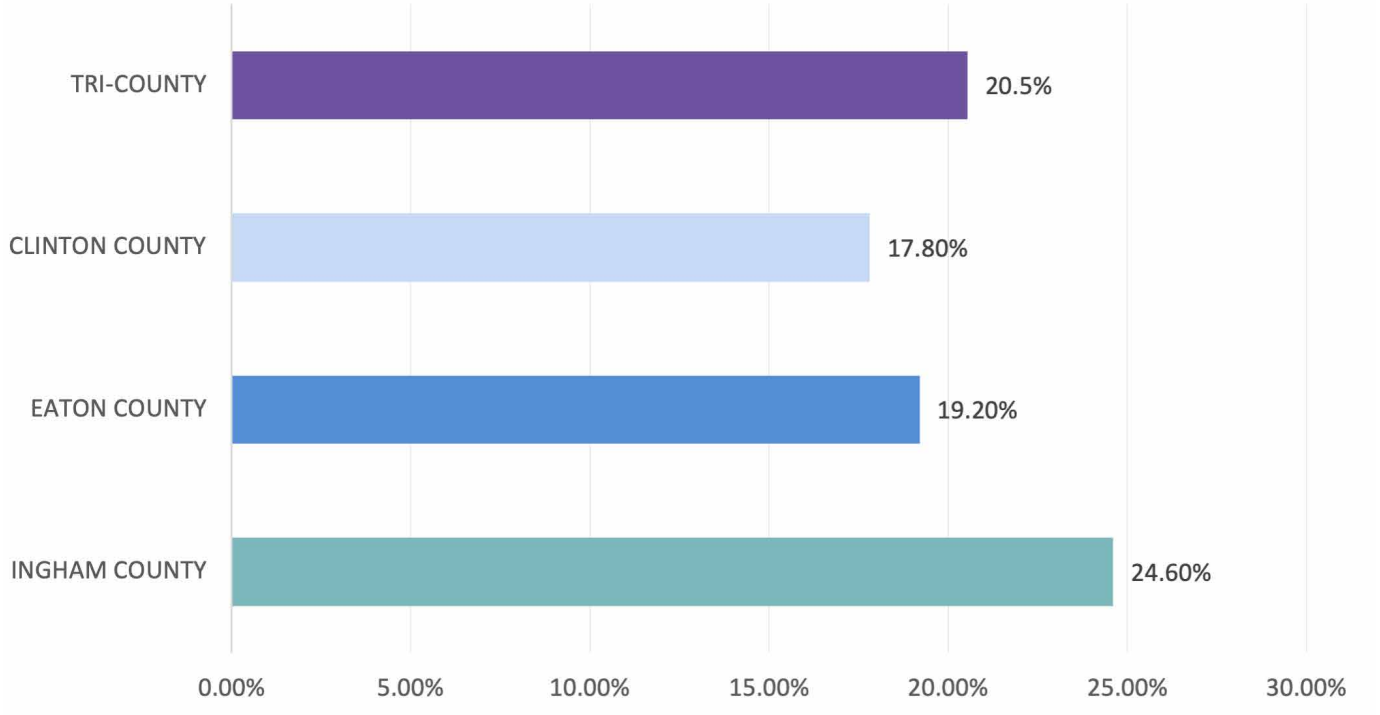
REASON FOR MEASURE
Consuming a variety of nutrients is important for proper growth and development. More importantly, epidemiological evidence suggest that adolescence is a key period for the development of lifelong nutritional habits. Adequate nutritional intake by children sets the stage for maintaining good health later in life.

NOTES ABOUT MEASURE
Statistics on fruit and vegetable consumption cannot be compared between Michigan and individual counties, as different questions were asked on the MiPHY survey (for individual counties) and the Michigan Youth Risk Behavior Survey (statewide).

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

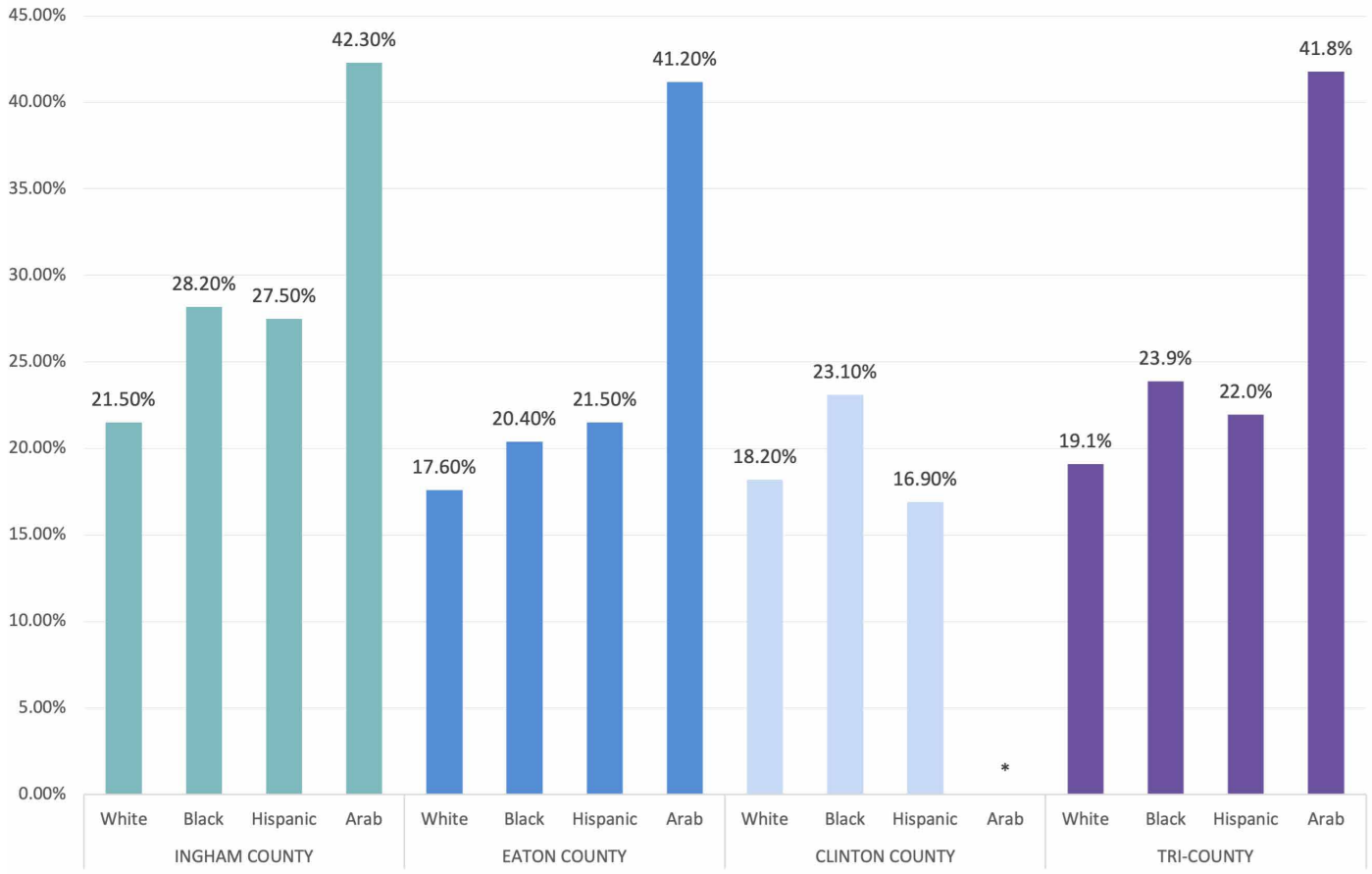
PERCENTAGE OF STUDENTS WHO ATE FIVE OR MORE SERVINGS PER DAY OF FRUITS AND VEGETABLES DURING THE PAST SEVEN DAYS (2019-20)

Approximately one in five adolescents in the tri-county area consumed the recommended amount of fruits and vegetables on a daily basis during the 2019-2020 MiPHY survey cycle. This percentage was lower for Eaton County (17.8%) and Clinton County (19.2%) than Ingham County (24.6%).



PERCENTAGE OF STUDENTS WHO ATE FIVE OR MORE SERVINGS PER DAY OF FRUITS AND VEGETABLES DURING THE PAST SEVEN DAYS (2019-20) BY RACE AND ETHNICITY

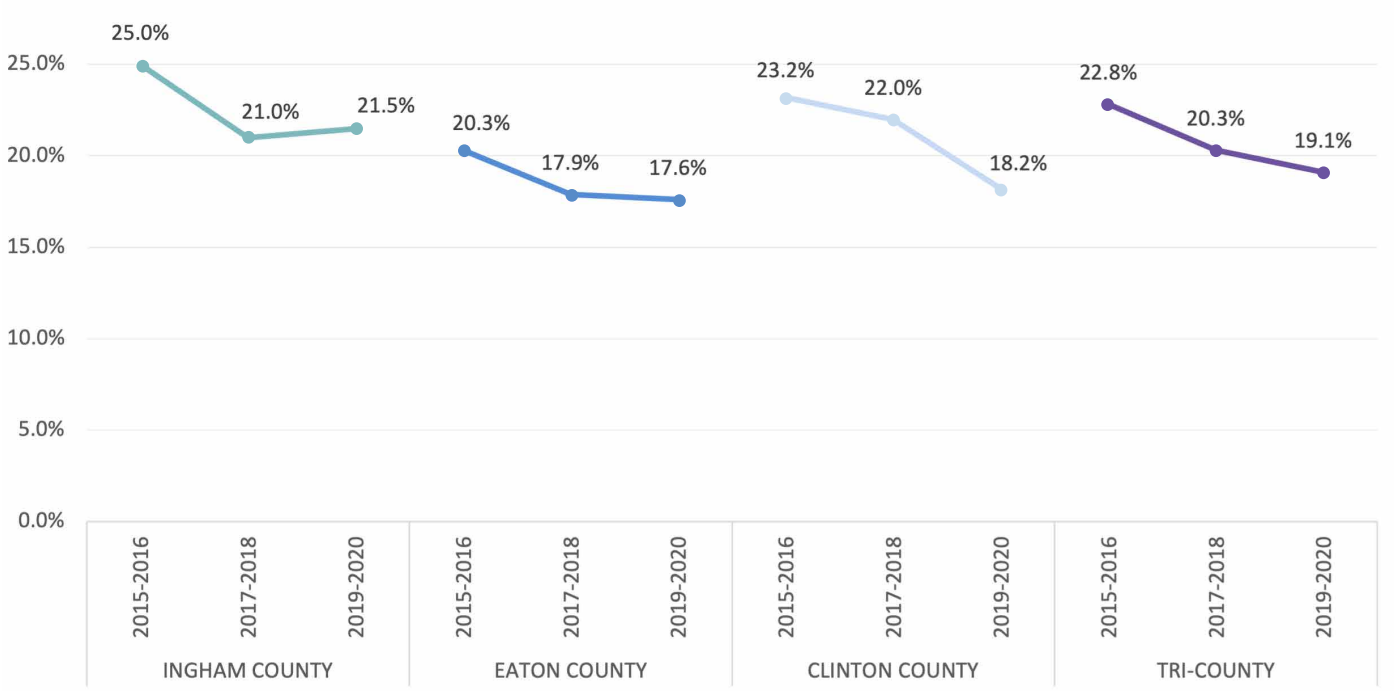
Among the reported geographies, the proportion of adolescents who consumed five or more servings of fruits and vegetables per day in the tri-county region was higher among racial/ethnic minorities than their White peers, except in Clinton County where Hispanic high school students had a slightly lower rate of consumption. Arab high schools students in Ingham and Eaton County had the highest rate of fruit and vegetable consumption at 42.3% and 41.2%, respectively.



*Data for Arab students in Clinton County was suppressed due to low sample size.

PERCENTAGE OF STUDENTS WHO ATE 5 OR MORE SERVINGS OF FRUITS AND VEGETABLES PER DAY DURING THE PAST 7 DAYS (2015-2020)

Across all counties in the Capital Area, the proportion of adolescents who consumed the recommended daily amount of fruits and vegetables had a noticeable decline from 2015-2016 to 2019-2020. The decline in Clinton County accelerated in 2019-2020 compared to 2017-2018, while the decline in Eaton County was more gradual. Ingham County had a slight increase in consumption of fruits and vegetables but was still below the rate in 2015-2016.



Access to Primary Care

MEASURE
The percent of adults who reported not having someone that they consider to be their personal doctor or primary care provider.

DATA SOURCES
- Michigan Behavioral Risk Factor Surveillance System
- Capital Area Behavioral Risk Factor Surveillance System

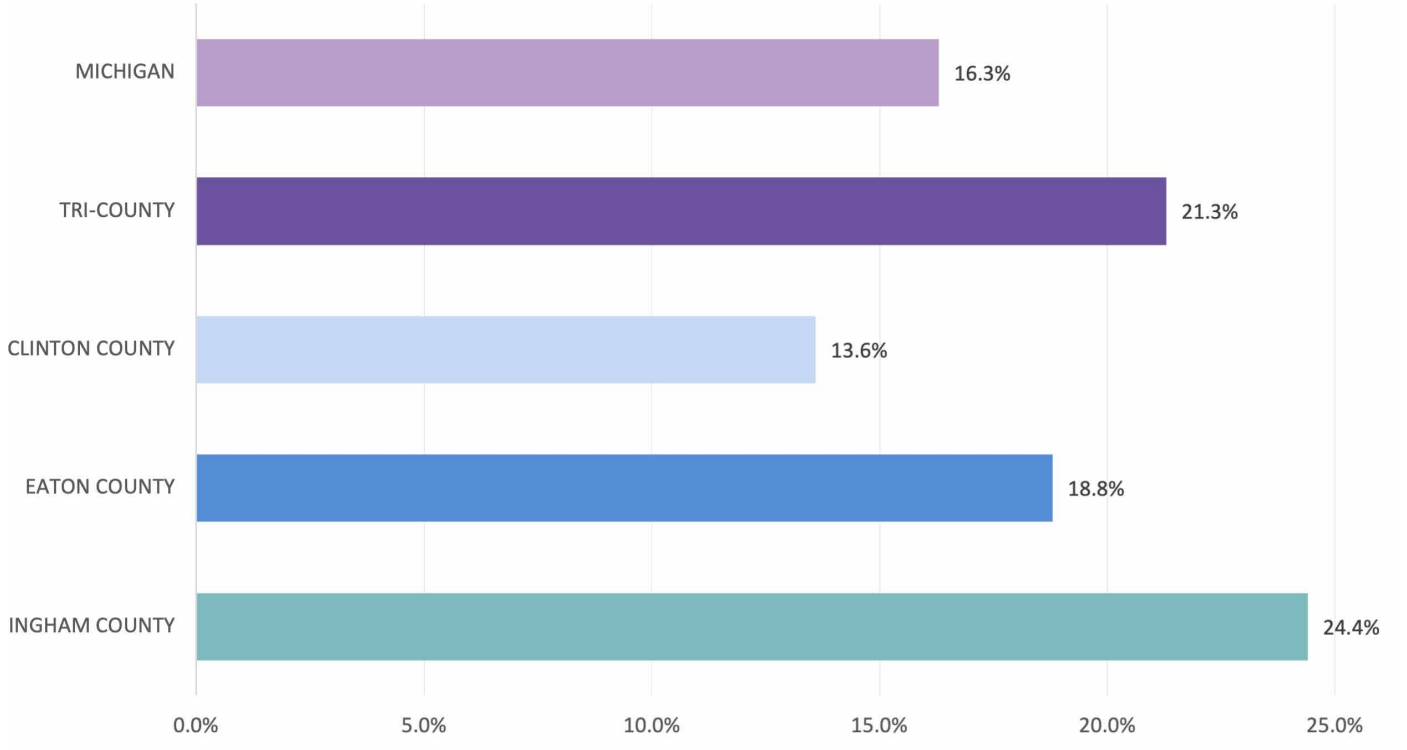
YEARS
2008-2019

REASON FOR MEASURE
Having access to care requires not only having financial coverage but also access to providers. While high rates of specialist physicians has been shown to be associated with higher, and perhaps unnecessary, utilization, having sufficient availability of primary care physicians (i.e. a physician practicing in a primary care specialty such as general medicine, family medicine, internal medicine, pediatrics, or gynecology) is essential so that people can get preventive and primary care, and when needed, referrals to appropriate specialty care.[CHR]

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

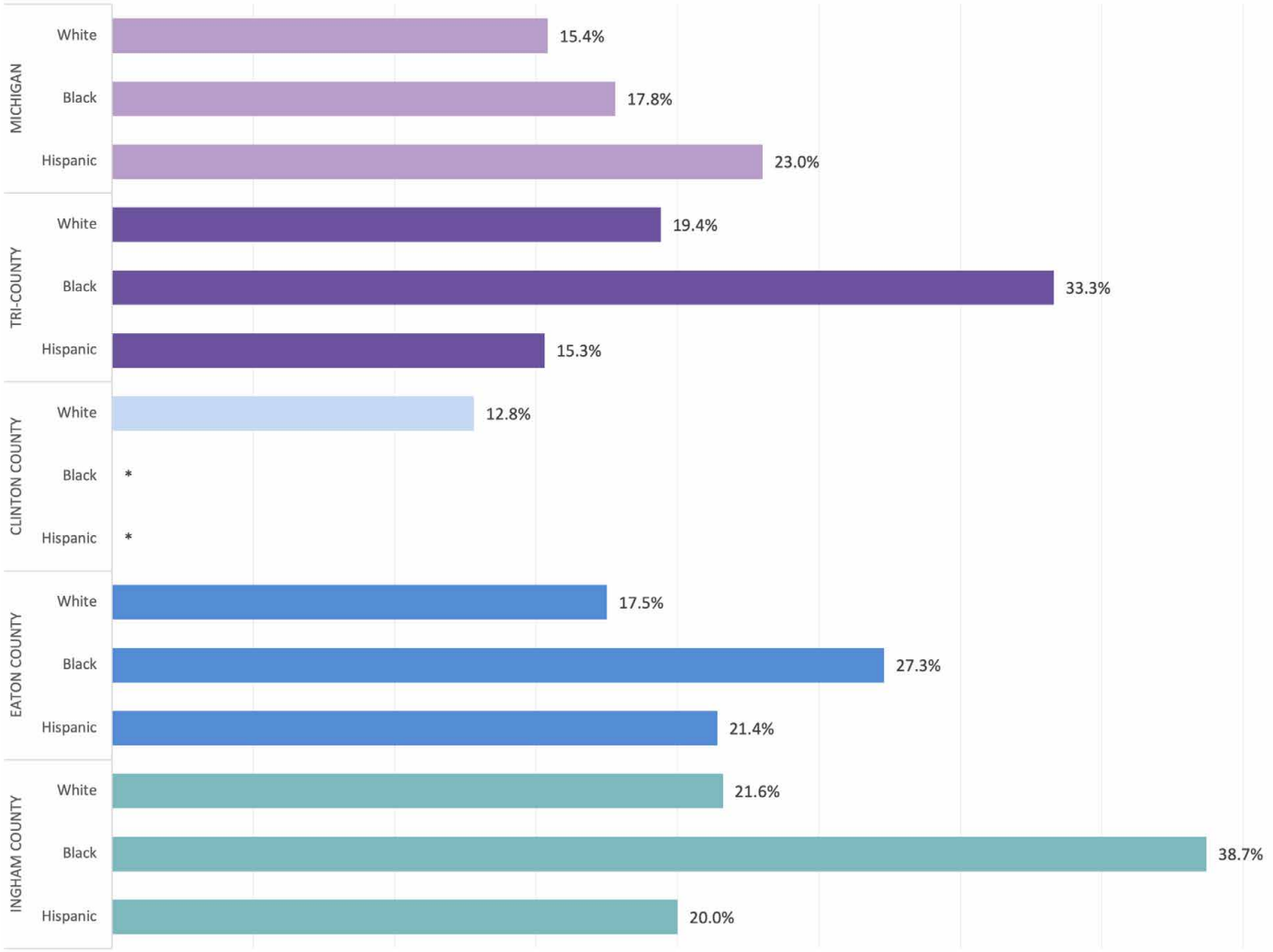
PERCENT OF ADULTS WHO REPORTED NOT HAVING A PERSONAL DOCTOR/HEALTH CARE PROVIDER, BY GEOGRAPHY, 2017-2019

The percentage of Michigan adults who reported not having a primary care provider or somebody that they consider to be their personal doctor was 16.3%. The percentage of adults who reported not having a personal doctor or healthcare provider was higher in the Tri-County area at 21.3%. For the individual counties in the Capital Area, Ingham had the highest percentage of those without a personal doctor at 24.4% followed by Eaton at 18.8% and Clinton at 13.6%.



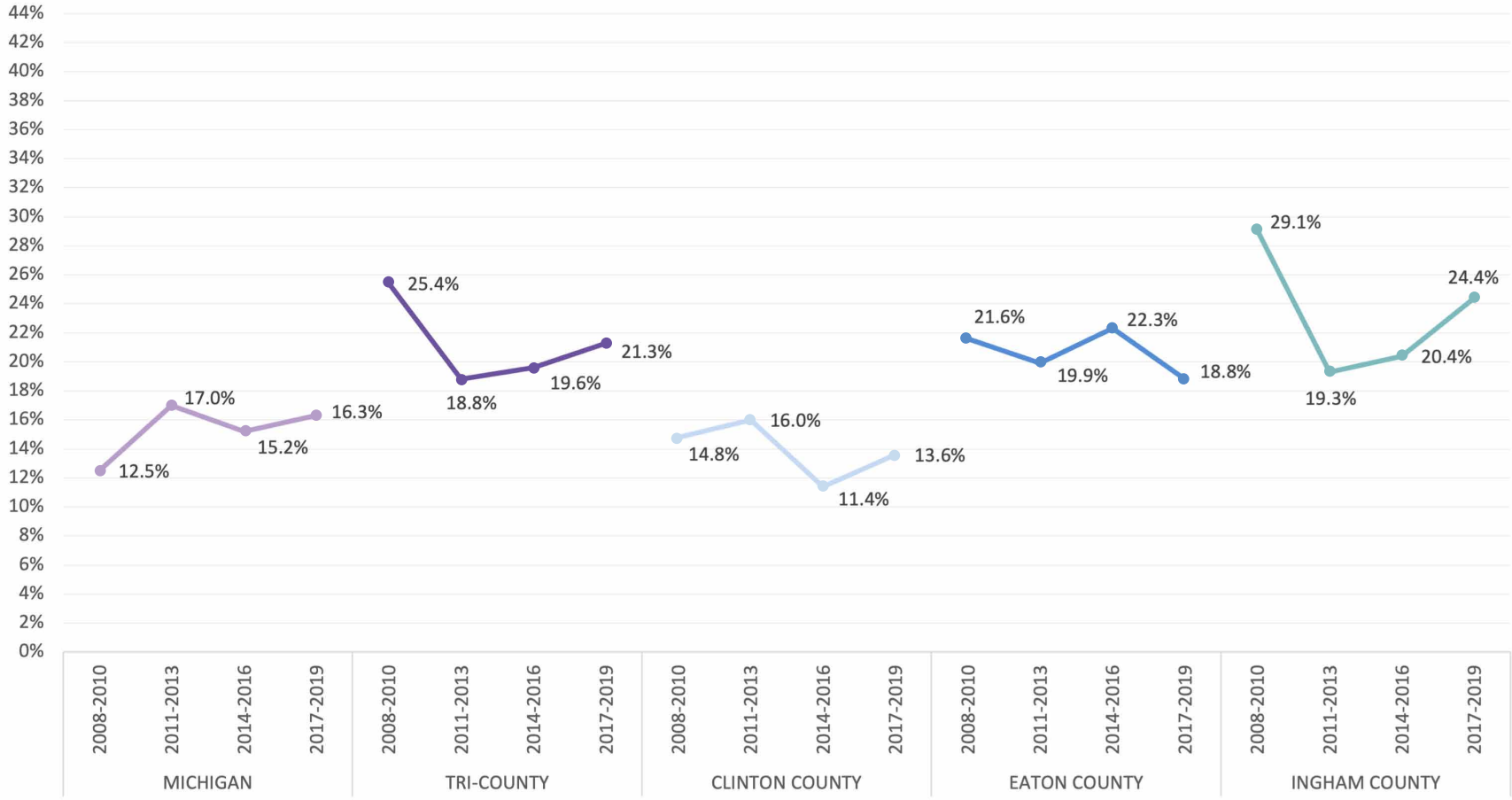
PERCENT OF ADULTS WHO REPORTED NOT HAVING A PERSONAL DOCTOR/HEALTH CARE PROVIDER, BY GEOGRAPHY, 2017-2019 (BY RACE/ETHNICITY)

The percentage of Michigan adults who reported not having a primary care provider or somebody that they consider to be their personal doctor was 16.3%. The percentage of adults who reported not having a personal doctor or healthcare provider was higher in the Tri-County area at 21.3%. For the individual counties in the Capital Area, Ingham had the highest percentage of those without a personal doctor at 24.4% followed by Eaton at 18.8% and Clinton at 13.6%.



PERCENT OF ADULTS WHO REPORTED NOT HAVING A PERSONAL DOCTOR/HEALTH CARE PROVIDER, BY GEOGRAPHY, 2017-2019

Since the 2008-2010 survey, there has been an increasing trend in Michigan residents not having a primary care provider, from 12.5% in 2008-2010 to 16.3% in 2017-2019. In Ingham County, there was an initial drastic decline in those without a PCP from 2008-2010 to 2011-2013. Since then, the percentage of those without a PCP has increased from 19.3% in 2011-2013 to almost one-in-four adults (24.4%). In Clinton and Eaton Counties, the percentage of those without a PCP has varied across BRFS survey cycles. Between 2017 and 2019 Eaton County had its lowest percentage at 18.8% down from 22.2%. Clinton County had small increase from 11.4% to 13.6%.



Access to Health Insurance

MEASURE
Percentage of adults 18-64 years old without health insurance

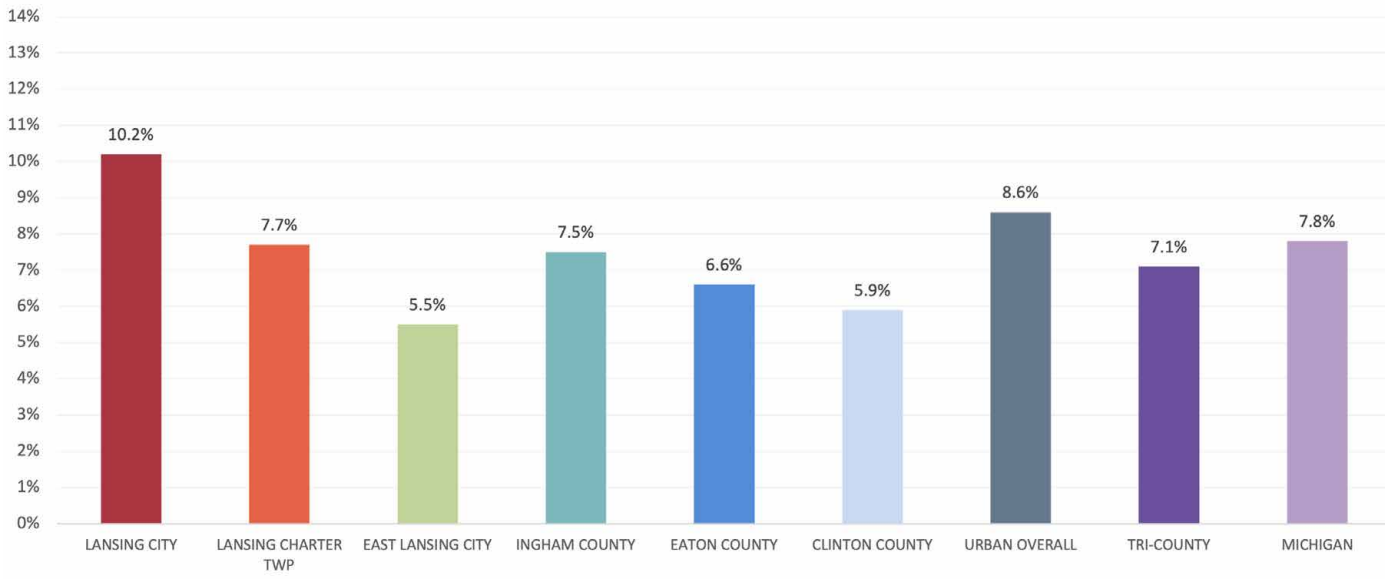
DATA SOURCE
American Community Survey

YEARS
2017-2019

REASON FOR MEASURE
Health insurance coverage helps patients gain entry into the health care system. Lack of adequate coverage makes it difficult for people to get the health care they need and, when they do get care, burdens them with large medical bills. Uninsured people are more likely to have poor health status; less likely to receive medical care; more likely to be diagnosed later; and more likely to die prematurely. The Patient Protection and Affordable Care Act (ACA), a comprehensive law passed in 2010, provided new strategies to reduce the number of uninsured and to improve the organization and delivery of health care.

PERCENT OF ADULTS 18 TO 64 YEARS OLD WITH NO HEALTH INSURANCE, 2019

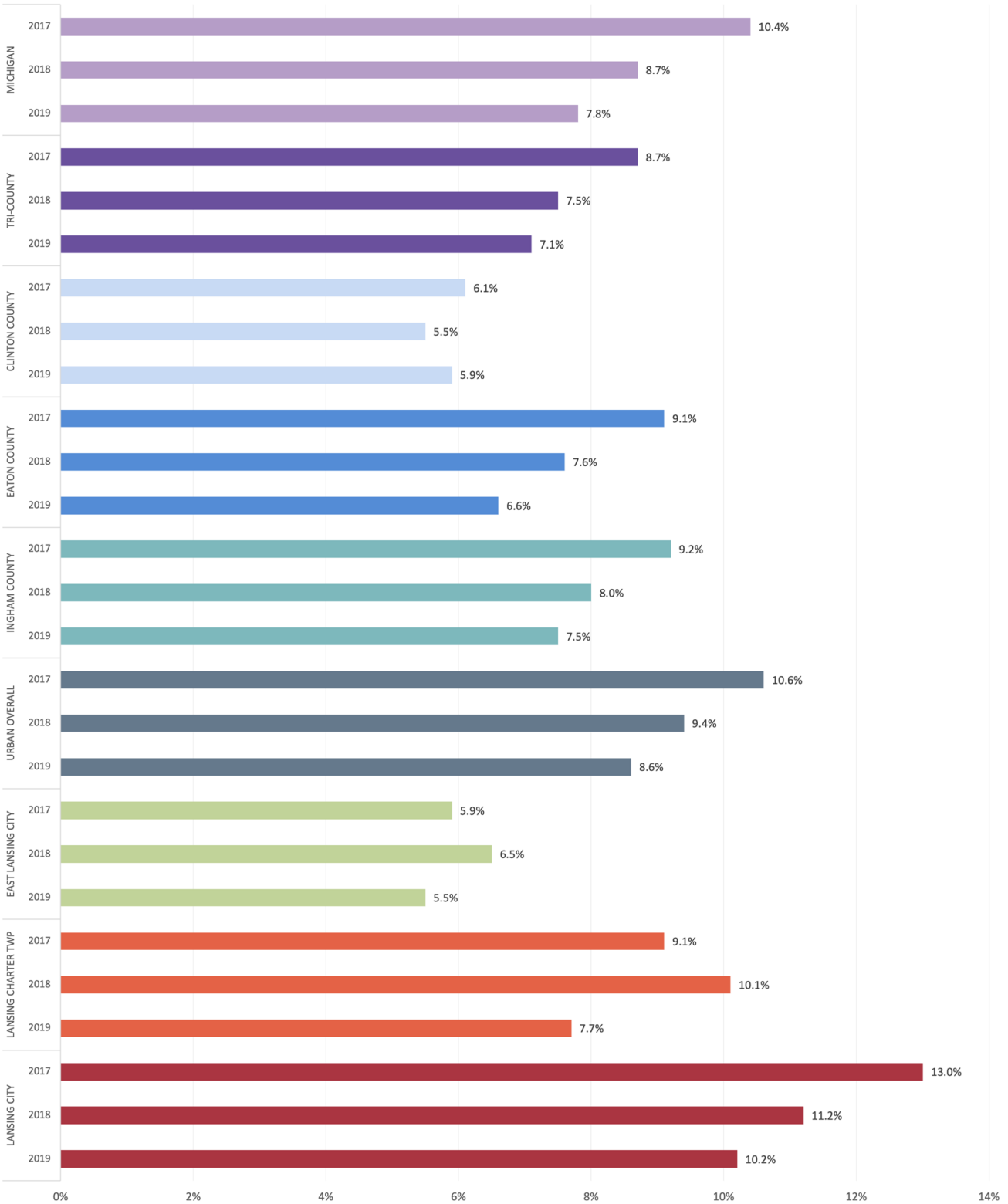
Despite an overall increase in access to health insurance through passage of the Affordable Care Act in 2010 and Michigan's expansion of Medicaid through the Health Michigan Plans in 2014, there are still adults who do not have health insurance. In 2019, most geographies in the Capital Area had a lower percentage of uninsured residents compared to the State of Michigan. However, Urban centers (8.6%) and the City of Lansing (10.2%) both had considerably higher percentages of uninsured residents compared to the Tri-County area and the State. The City of East Lansing had the lowest uninsured rate at 5.5%.



Access to Health Insurance

PERCENT OF ADULTS 18 TO 64 YEARS OLD WITH NO HEALTH INSURANCE, 2017-2019

Based on the 2017-2019 five-year estimates from the American Community Survey, the percentage of adults 18-64 years old without health insurance decreased in most geographies. The City of East Lansing and Lansing Charter Township saw decreases in 2019 after an increase in 2018 with Lansing Charter Township's rate decreasing from 10.1% to 7.7%. Clinton County's rate of uninsured residents has remained mostly stable between 5.5 and 6.0% in 2017 and 2019. All other geographic groupings show a continued trend in decreasing the percentage of uninsured residents.



Communicable Disease Prevention - Immunizations

MEASURE
Rate of non-medical immunization waivers claimed for schoolchildren.

Waiver data is assessed for kindergarteners, 7th graders, and any new students entering a school district.

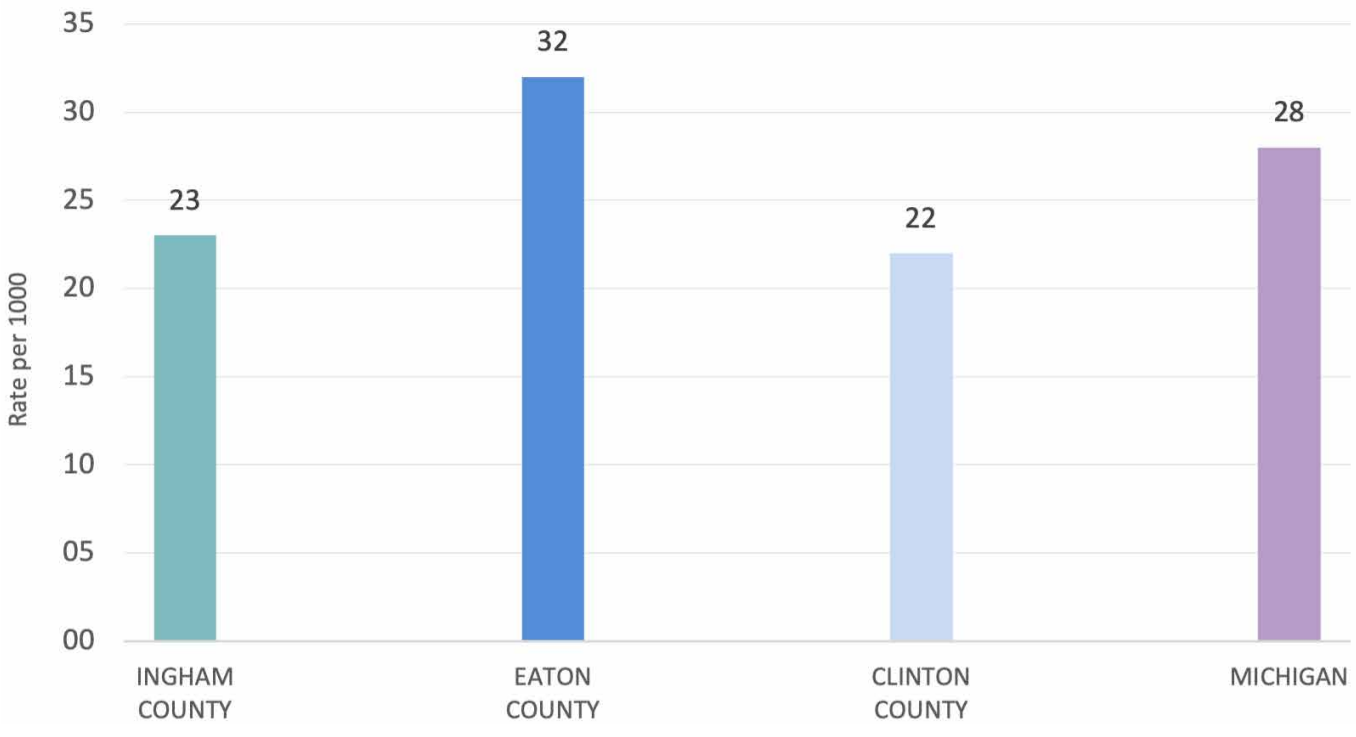
DATA SOURCE
Michigan Care Improvement Registry

YEARS
2016 (running rate from June 2015-June 2016), 2017 (running rate from June 2016-June 2017), 2018 (running rate from June 2017-June 2018), 2019 (running rate from June 2018-June 2019)

REASON FOR MEASURE
Many infectious diseases thought to be eliminated from this country, e.g. pertussis, mumps, measles, have reemerged in recent years. Outbreaks related to these and other vaccine-preventable diseases threaten the lives and well-being of the most vulnerable populations: children under age one, those who are too young to be vaccinated, and children and adults who are immune-suppressed due to other medical conditions. For this reason, it is important that contacts of these people be vaccinated. However, parents in many states may opt out of vaccinating their children by seeking legal exemptions to public school immunization requirements. Fear over certain vaccine components and perceived risk of side effects or complications result in some parents opting to forego vaccination for their children. This puts unvaccinated children and adults at risk, because it increases the number of unvaccinated people they are exposed to and facilitates disease spread.

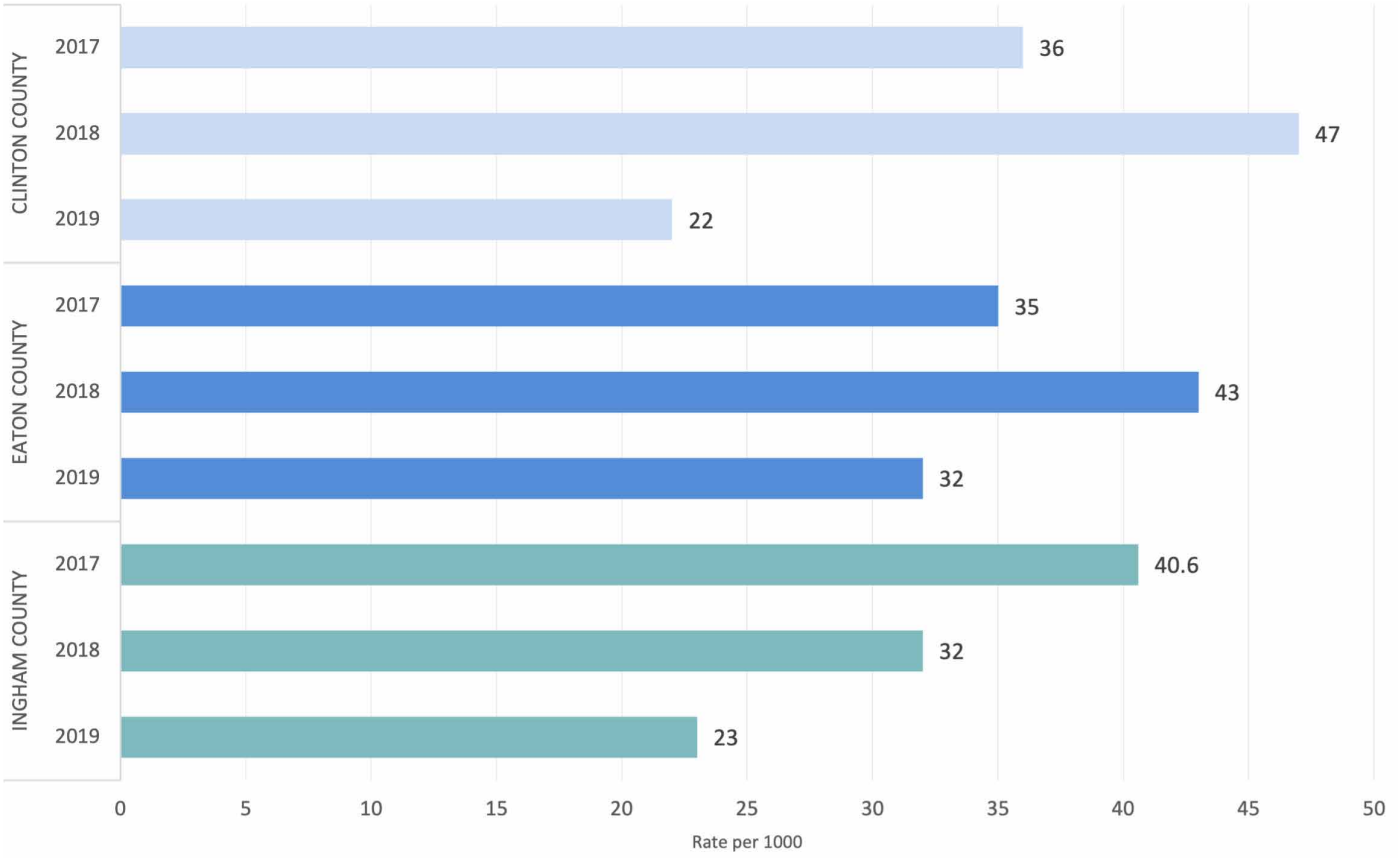
RATE OF NON-MEDICAL IMMUNIZATION WAIVER CLAIMED FOR SCHOOL CHILDREN, 2019

For every 1,000 students in Michigan, 28 (2.8%) were issued a non-medical immunization waiver. In Eaton County, the non-medical immunization waiver rate was higher than the state rate (32 per 1,000y). Ingham County and Clinton County had a waiver rate lower than Michigan's at 23 and 22 per 1,000 students, respectively.



TREND IN RATE OF NON-MEDICAL IMMUNIZATION WAIVER CLAIMED FOR SCHOOL CHILDREN 2017-2019

The rate of granted immunization waivers was the lowest for all three counties in the last three year period. All three counties also decreased the rate per 1,000 students in 2019 compared to 2018.



Mental Health - Adults

MEASURE
Percentage of adults with poor mental health.

See notes below for definitions of this measure.

DATA SOURCES
- Michigan Behavioral Risk Factor Survey (MI-BRFS)
- Capital Area Behavioral Risk Factor Survey (Capital Area BRFS)

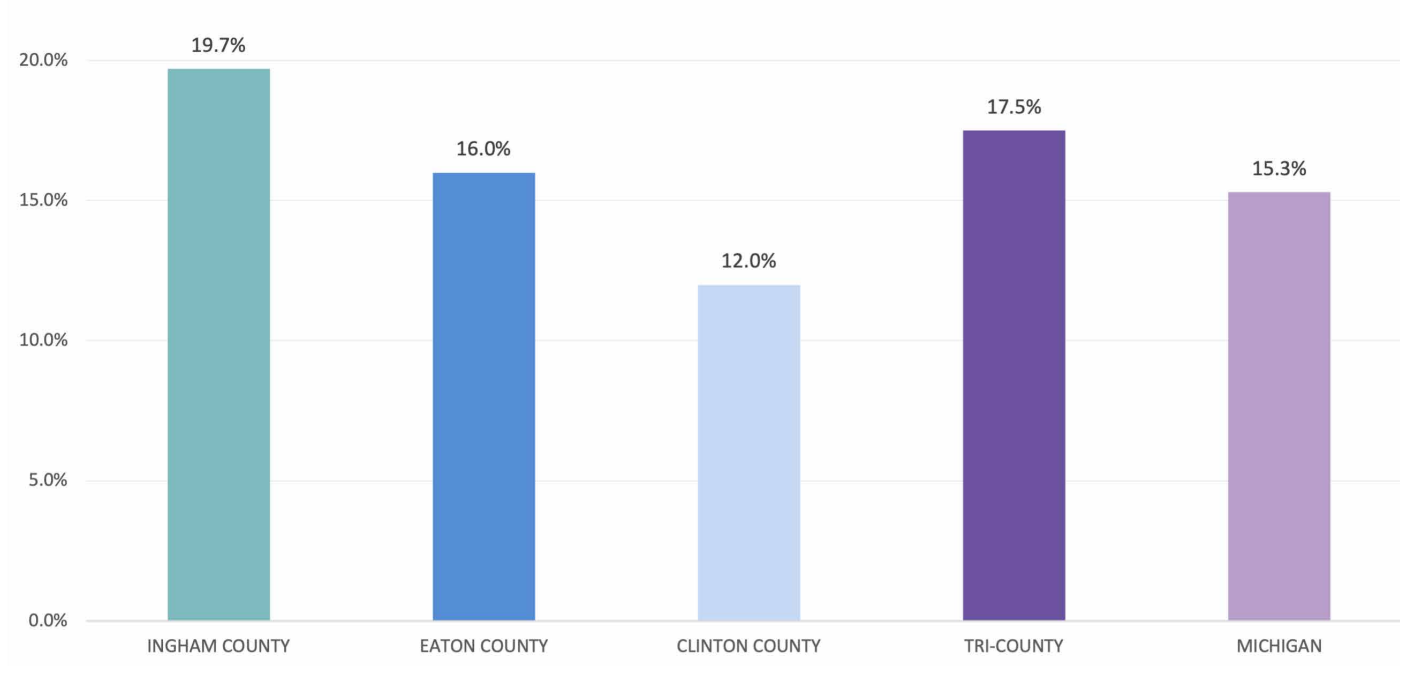
YEARS
2008-2019

REASON FOR MEASURE
Overall health depends on both physical and mental well-being. Measuring the number of days when people report that their mental health was not good, i.e., poor mental health days, represents an important facet of health-related quality of life.[CHR]

NOTES ABOUT MEASURE
Mental health statistics from the MI-BRFS may not be directly comparable to those from the Capital Area BRFS, because the questions for mental health were different in both survey instruments. The MI-BRFS question reads "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?", whereas in the Capital Area BRFS, the question was "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?" Poor mental health was defined has having poor mental health 14 or more days in the past 30 days.

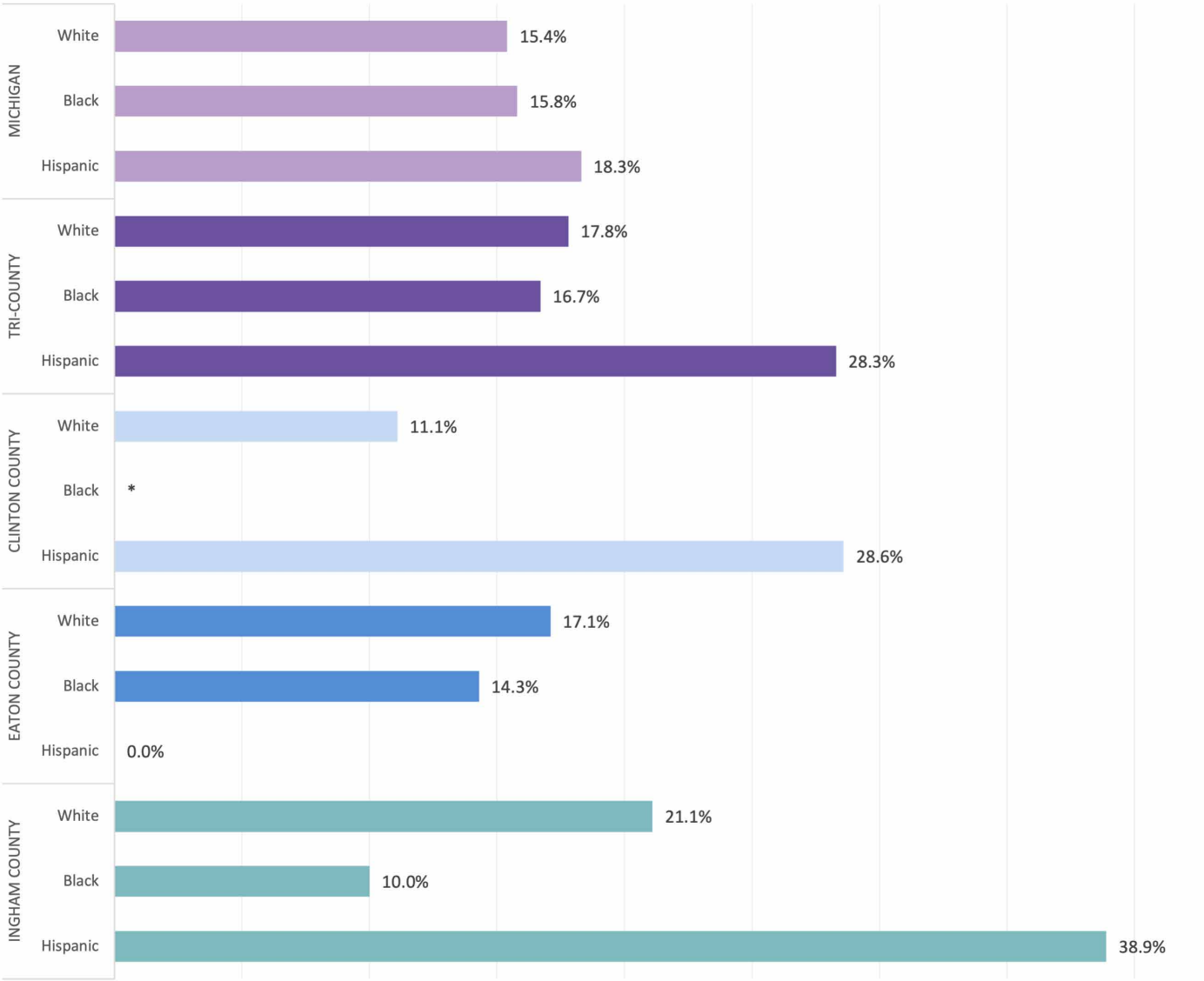
PERCENT OF ADULTS WHO EXPERIENCED POOR MENTAL HEALTH, BY GEOGRAPHY, 2017-2019

The number of adults experiencing poor mental health is higher in the Capital Area than the state of Michigan. In the Capital Area, 17.5% of adults were categorized as experiencing poor mental health, while in Michigan, the prevalence was 15.3%. For the individual counties, the prevalence of poor mental health varied from county to county, ranging from 12.0% in Clinton County to 19.7% in Ingham County.



PERCENT OF ADULTS WHO EXPERIENCED POOR MENTAL HEALTH, BY GEOGRAPHY, 2017-2019 (BY RACE/ETHNICITY)

Some dissimilarities in poor mental health were seen among racial/ethnic groups. In the state of Michigan, the proportion of adults experiencing poor mental health ranged from 15.5% among White adults to 18.3% among Hispanic adults. In the tri-county area, the prevalence of adults experiencing poor mental health was slightly higher across all counties, especially in the Hispanic population (28.3%) compared to White (17.8%) and Black (16.7%) residents. In Clinton and Ingham counties, Hispanic adults had the highest prevalence of poor mental health, while White adults had the highest prevalence in Eaton County.

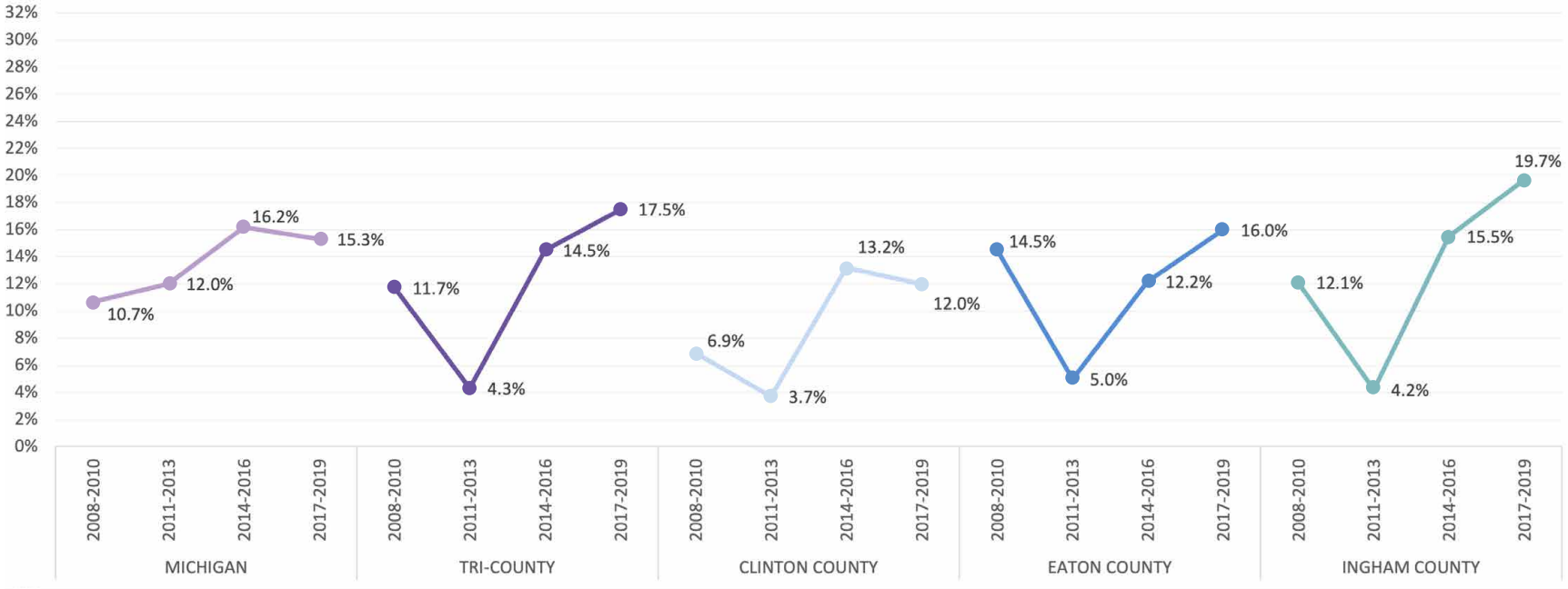


*Data for Black Clinton County residents was suppressed due to low sample size.

Mental Health - Adults

TREND IN PERCENT OF ADULTS WHO EXPERIENCED POOR MENTAL HEALTH, BY GEOGRAPHY, 2008-2019

Excluding statistics from the 2011-2013 Capital Area BRFS*, there is an increase in the number of adults experiencing poor mental health both in the Capital Area and in the state compared to 2008-2010. Within the counties in the Capital Area, poor mental health increased in Eaton and Ingham counties, while Clinton County had a slight decline in the percentage of adults who reported experiencing poor mental health.



*The wording of the question on the BRFS survey instrument changed from 2008-2010 and was changed again for 2014-2016. The change in the question resulted in a considerably lower percentage of those responding they had mental health concerns or poor mental health days.

Mental Health - Adolescents

MEASURE

Adolescents with symptoms of depression, as measured by the percentage of 9th and 11th grade students who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months.

DATA SOURCES

- Michigan Youth Risk Behavior Survey (MI YRBS)
- Michigan Profile for Healthy Youth Survey (MiPHY)

YEARS

MI YRBS: 2012-2013, 2014-2015, 2016-2017, 2018-2019

MiPHY: 2013-2014, 2015-2016, 2017-2018, 2019-2020

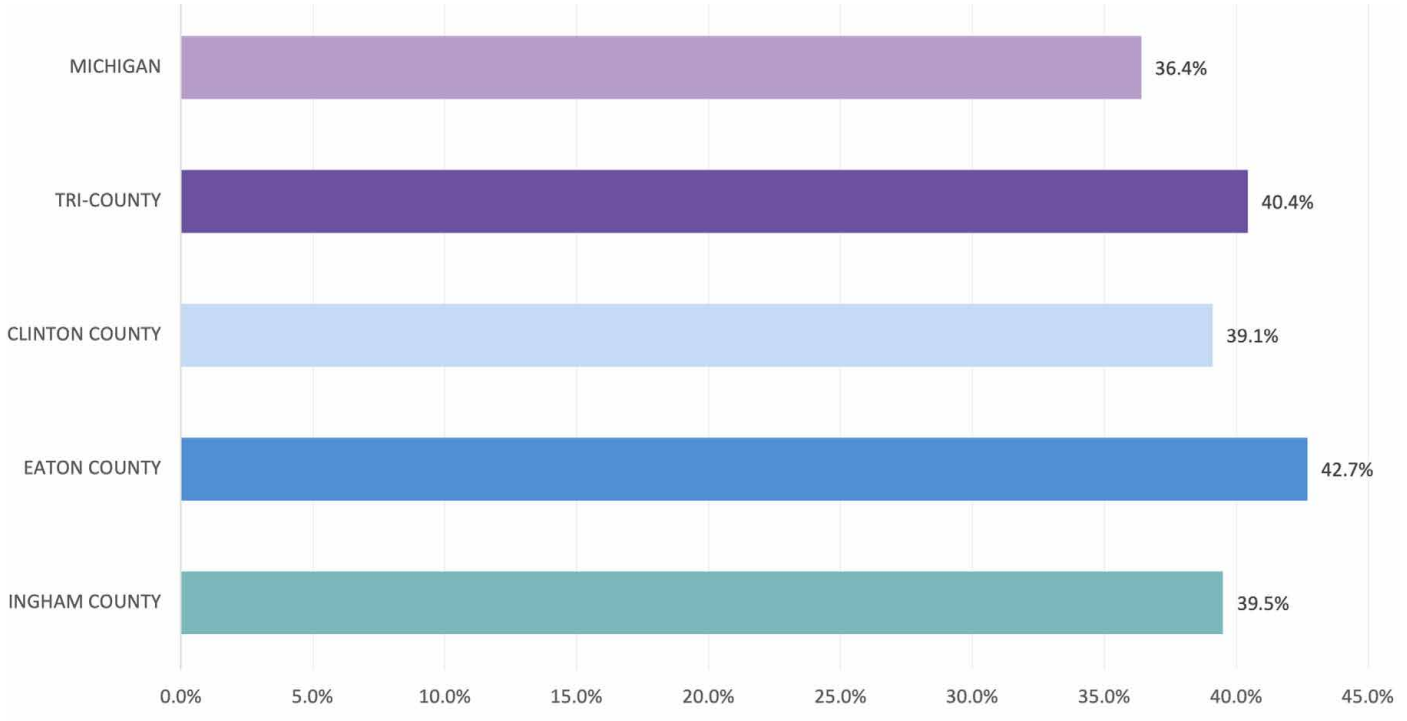
REASON FOR MEASURE

Overall health depends on both physical and mental well-being. Measuring the number of days when people report feeling depressed represents an important facet of health-related quality of life.[CHR]

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

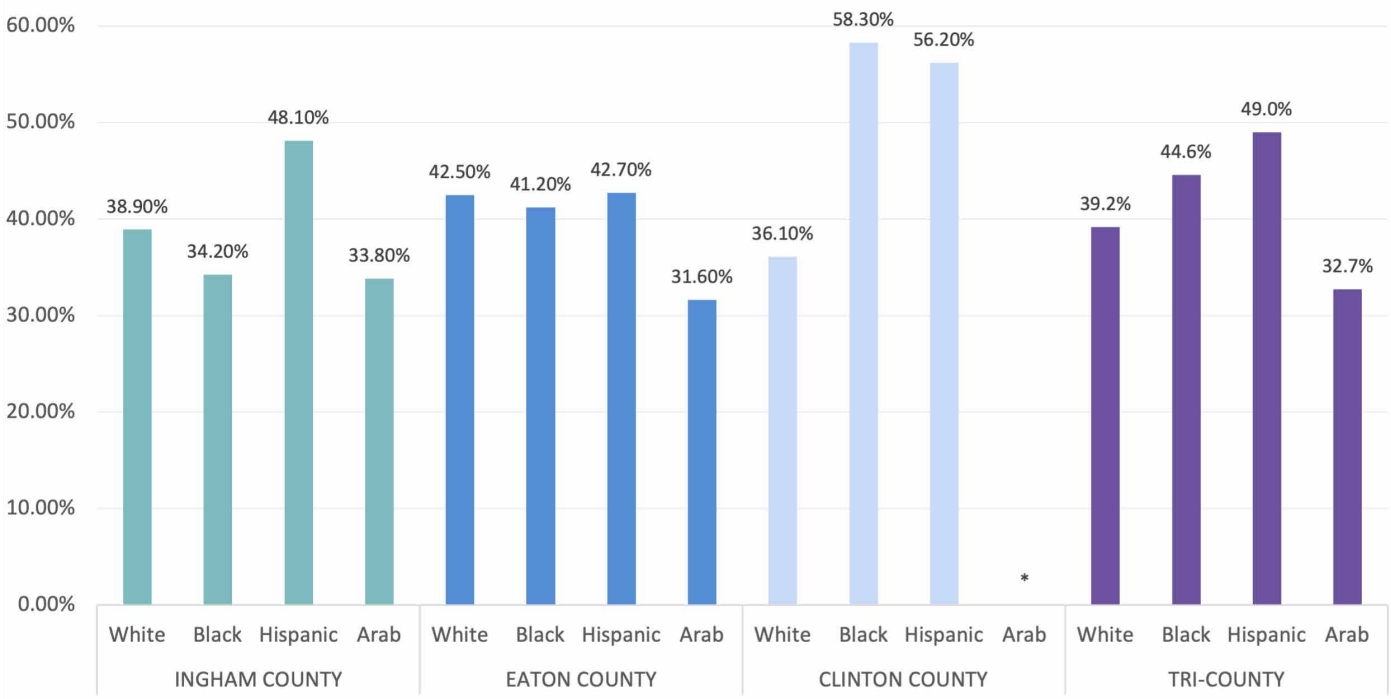
PERCENT OF HIGH SCHOOL STUDENTS WITH SYMPTOMS OF DEPRESSION IN PAST YEAR (2019-20)

The proportion of adolescents in the Capital Area who reported symptoms of depression within the past year was higher when compared to the state, 40.4% and 36.4%, respectively. Among the individual counties, Clinton County had a lower proportion of adolescents (39.4%) who reported symptoms of depression than adolescents in Eaton County (42.7%) and essentially the same as Ingham County (39.5%).



PERCENT OF HIGH SCHOOL STUDENTS WITH SYMPTOMS OF DEPRESSION IN PAST YEAR (2019-20) BY RACE AND ETHNICITY

In Clinton County, Black (58.3%) and Hispanic (56.2%) high school students were considerably more likely to have experienced symptoms of depression than White (36.1%) students. In Eaton County, Arab (31.6%) students were least likely to have experienced symptoms of depression compared to their Hispanic (42.7%), Black (41.2%) or White (42.5%) peers. Hispanic students in Ingham County were considerably more likely to report symptoms of depression (48.1%) than other racial and ethnic groups.

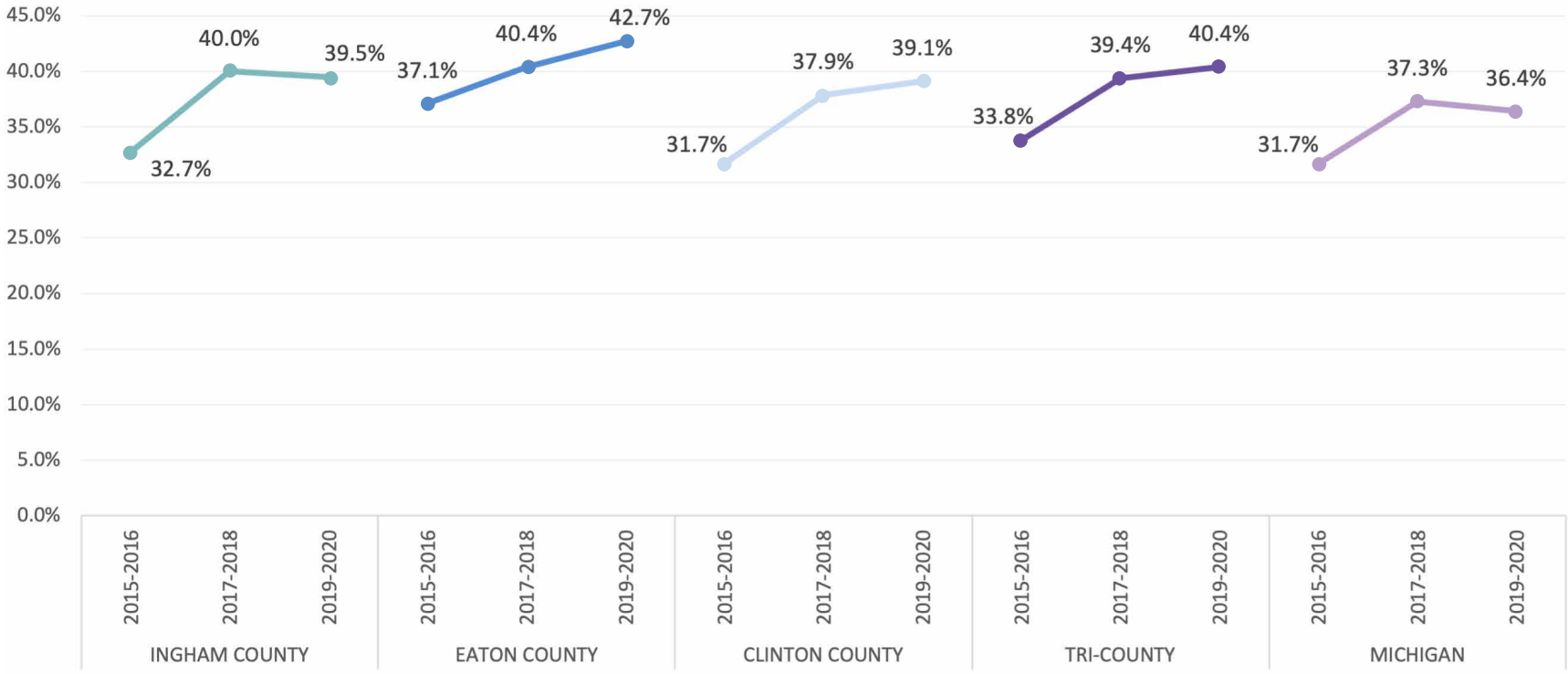


*Data for Arab students in Clinton County was suppressed due to low sample size.

Mental Health - Adolescents

TREND IN PERCENT OF HIGH SCHOOL STUDENTS WITH SYMPTOMS OF DEPRESSION IN PAST YEAR (2019-20)

The proportion of adolescents who reported symptoms of depression has consistently increased in Eaton County, Clinton County and the Tri-County area overall. Only Ingham County remained mostly flat between the 2017-2018 and 2019-2020 cycles and after a sharp rise from 2015-2016 to 2017-2018.



Health Outcomes

Child Health

MEASURE
The rate of age-specific, asthma-related preventable hospitalizations per 10,000 persons among children 18 years old or younger.

DATA SOURCES
Michigan Resident Inpatient Files (via Michigan Department of Health and Human Services)

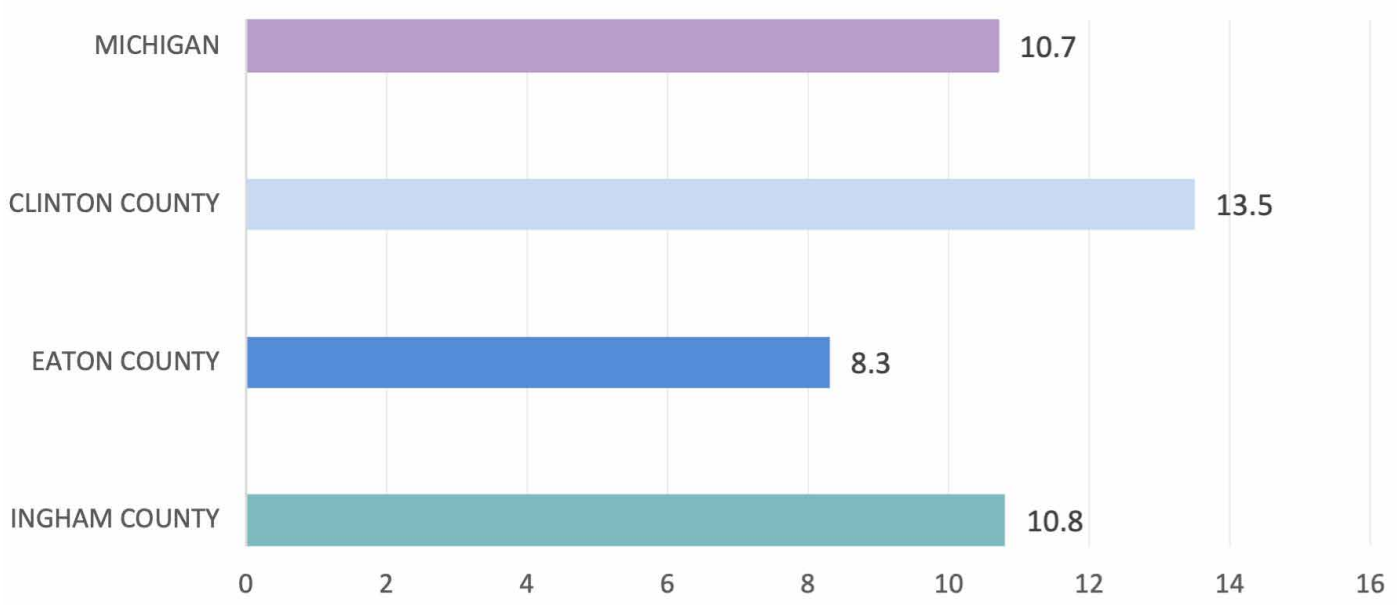
YEARS
2013-2018

REASON FOR MEASURE
Asthma is an inflammation of the airways. The inflammation of asthma is chronic, which means it is always present and never goes away. Many factors can influence the prevalence of asthma and lead to asthma attacks. A majority of these factors are due to the environment, such as dust, pollen, and proximity to highways. Asthma attacks can include wheezing, breathlessness, chest tightness, and coughing.

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

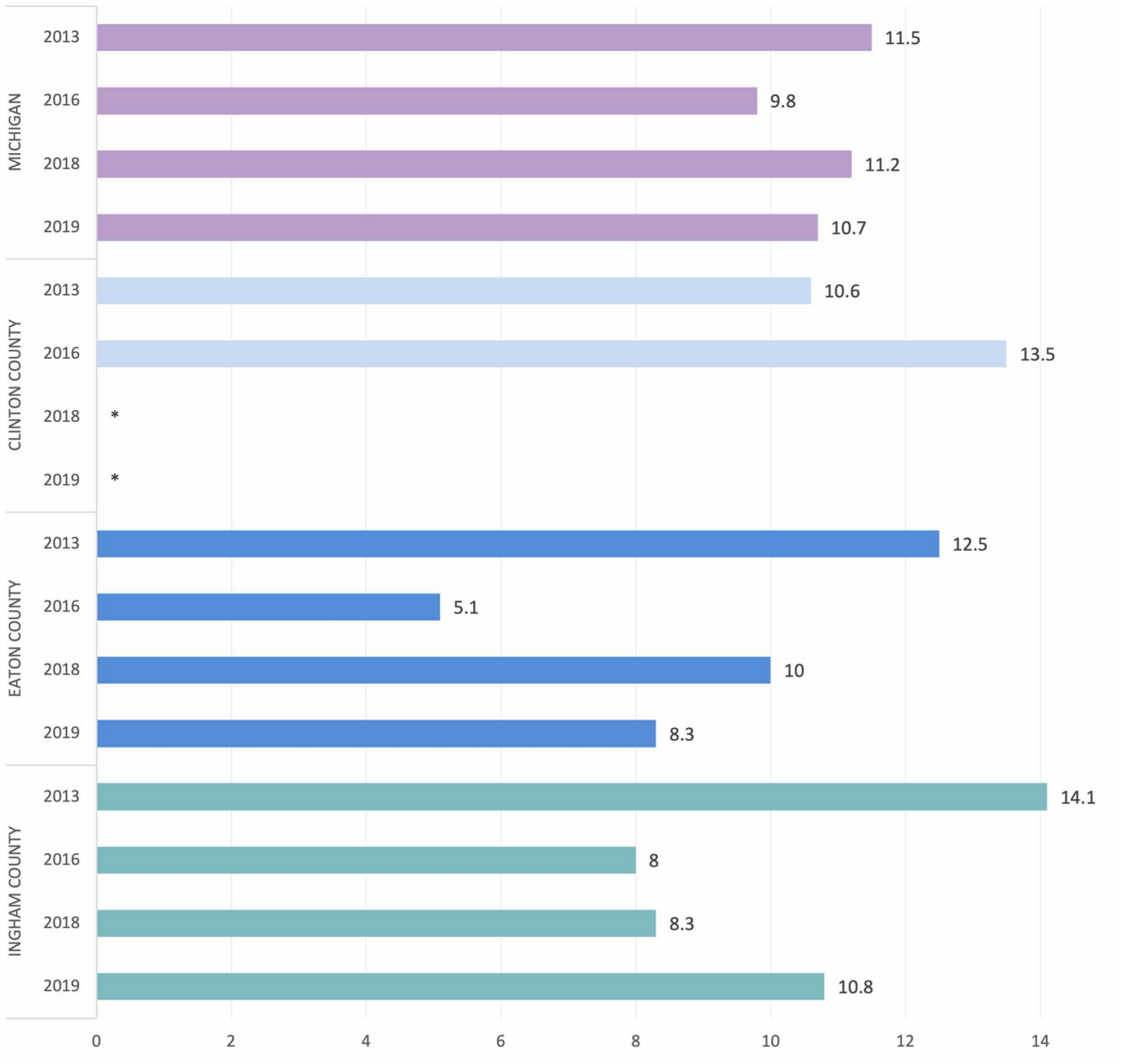
PREVENTABLE HOSPITALIZATION RATE PER 10,000 PATIENTS UNDER 18 YEARS OF AGE, 2018

Eaton County had a lower rate of Preventable Asthma Hospitalizations in patients under 18 years of age (8.3) compared to Michigan (10.7). Ingham County was roughly equal to Michigan at 10.8 per 10,000 patients. Clinton County has not had a data update since 2014.



TREND IN CHILDHOOD ASTHMA HOSPITALIZATION RATE PER 10,000 PATIENTS UNDER 18 (2013-2019)

Preventable hospitalization rates in Eaton County vary over the years, while Ingham County had an initial sharp decrease and has now increased for three consecutive years. Clinton County has not had a data update since 2014.



Adult Health – Preventable Diabetes Hospitalizations

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

DATA SOURCE
Michigan Resident Inpatient Files (via Michigan Department of Health and Human Services)

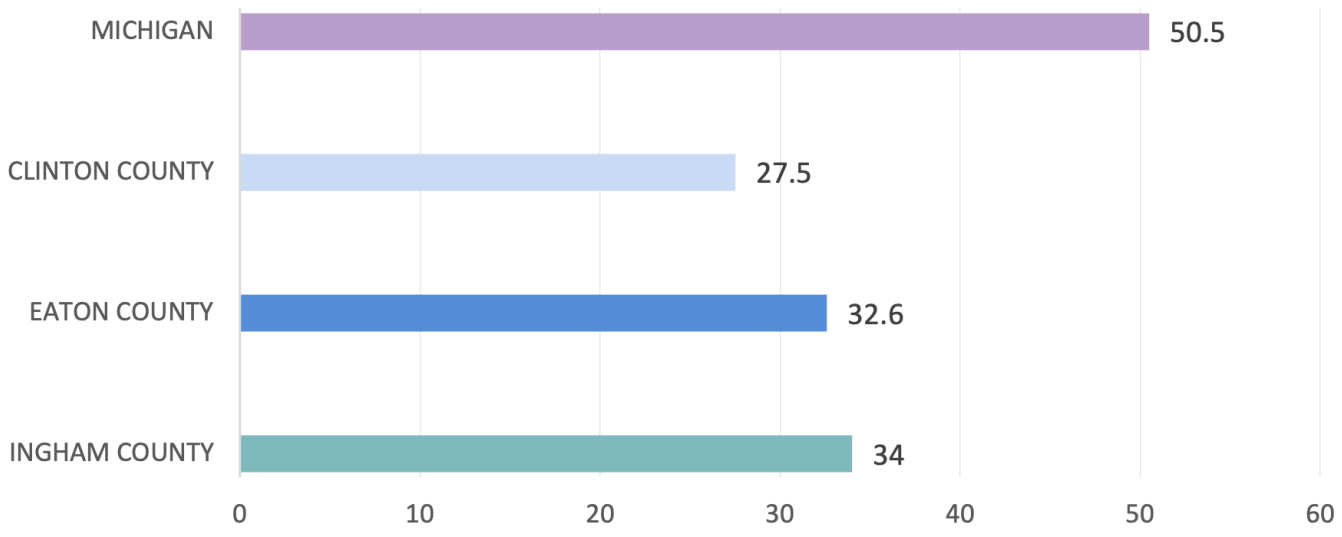
YEARS
2013-2019

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

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

PREVENTABLE HOSPITALIZATIONS RATE DUE TO DIABETES PER 10,000 ADULTS (2019)

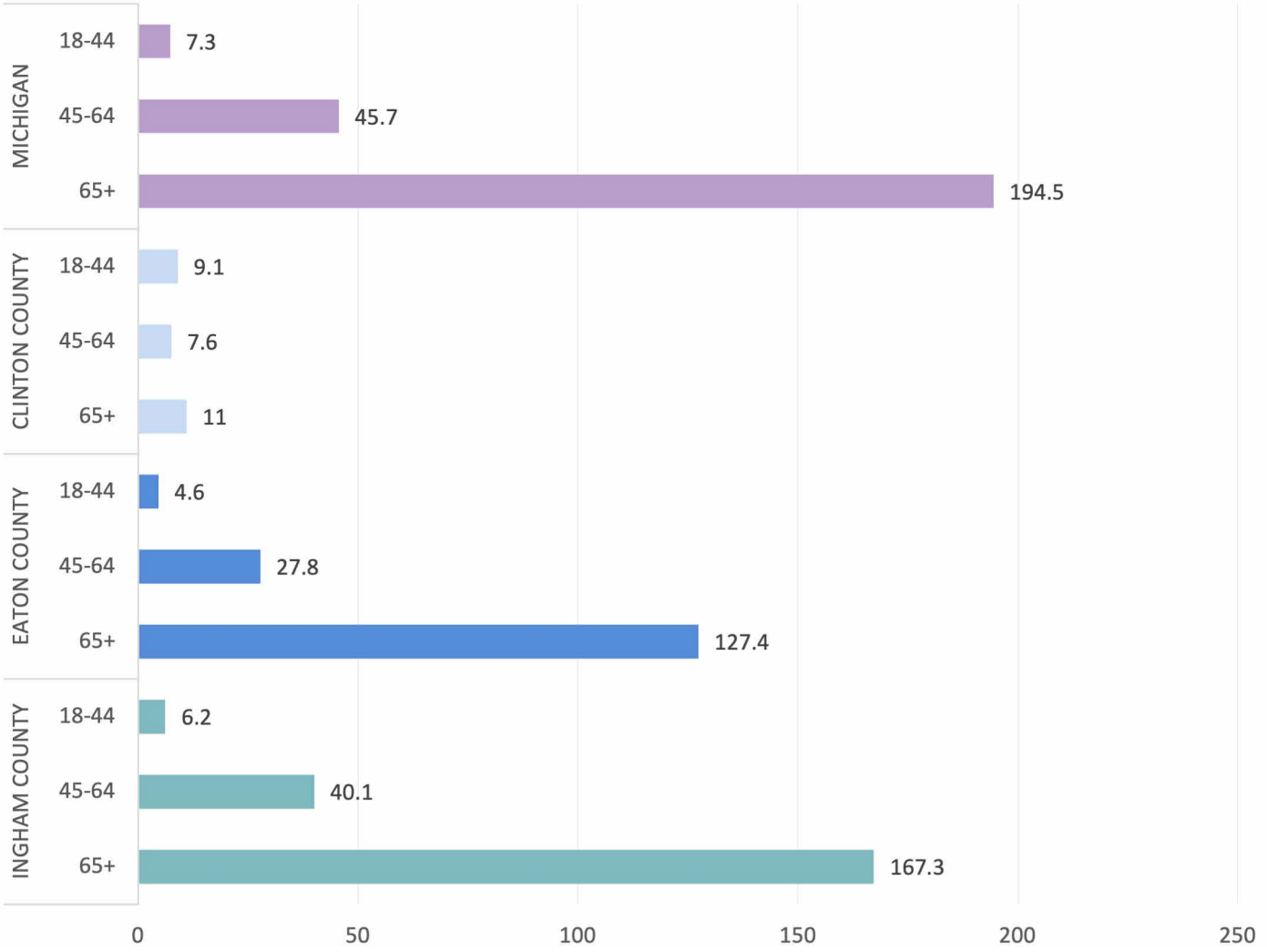
The rate of preventable hospitalizations related to diabetes in adults was lower in each of the counties in the Capital Area compared to the rate for Michigan, especially for Clinton County.



Adult Health – Preventable Diabetes Hospitalizations

PREVENTABLE HOSPITALIZATION RATE DUE TO DIABETES PER 10,000 ADULTS, BY AGE GROUP (2018)

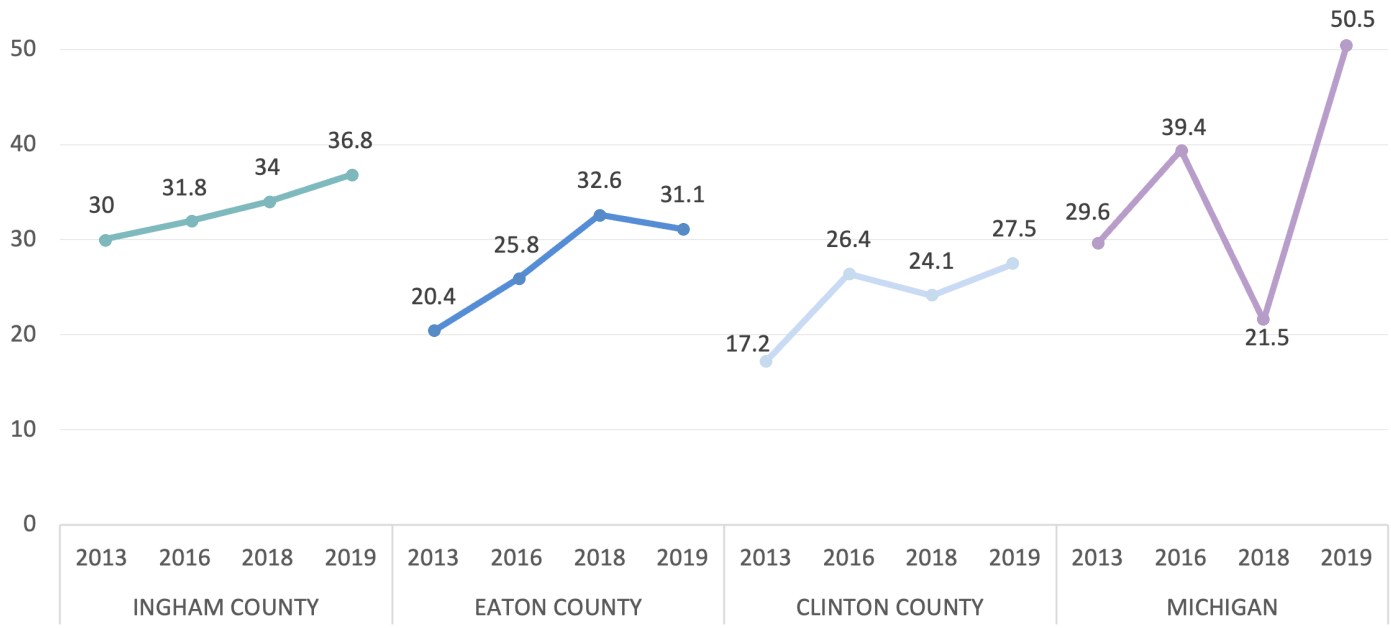
In the state of Michigan, as age increases, so does the prevalence of preventable hospitalizations in adults due to diabetes. Only Clinton County does not follow this pattern among the counties in the Capital Area. Clinton County has the highest rate of preventable diabetes hospitalizations among 18-44 year olds, but also the lowest rate – by far – in the 65 and over age range.



Adult Health – Preventable Diabetes Hospitalizations

PREVENTABLE HOSPITALIZATION RATE FOR DIABETES PER 10,000 ADULTS (2013-2019)

After a considerable decrease from 2016 to 2018, the State of Michigan had a very large increase in preventable diabetes hospitalizations in 2019. Two of the three counties, Ingham and Clinton, also had their rates increase from 2018 to 2019. The hospitalization rate in Eaton decreased slightly but still follows an upward trend in 3 of the last 4 data points. All counties in the Capital Area show an increasing trend.



Communicable Disease

MEASURE
Rate of chlamydia cases per 100,000 persons

DATA SOURCE
Michigan Sexually Transmitted Diseases Database, STD & HIV Prevention Section, Bureau of Epidemiology, Michigan Department of Health and Human Services

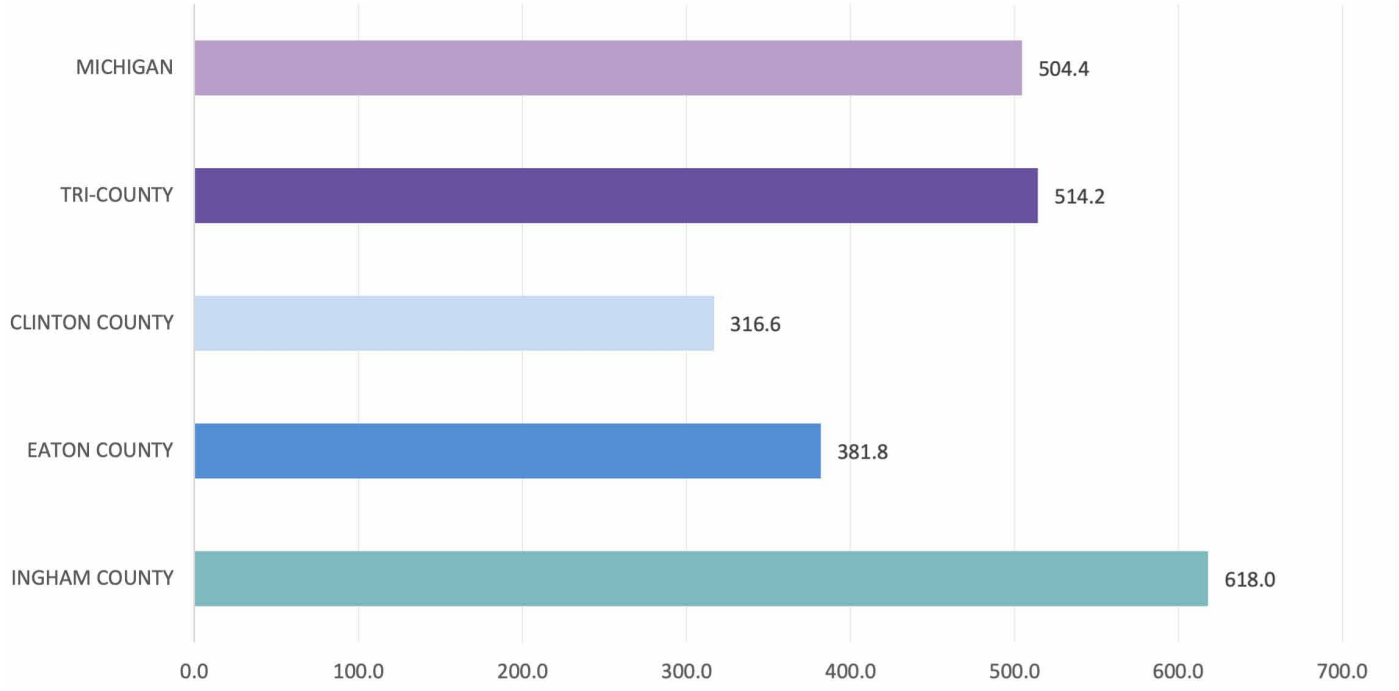
YEARS
2017-2019

REASON FOR MEASURE
Chlamydia is a common sexually transmitted infection caused by the bacterium *Chlamydia trachomatis*. Chlamydia is of public health significance because of the impacts of untreated disease on reproductive outcomes, transmission of other sexually acquired infections, and the costs to health systems. The costs of treating subfertility due to chlamydia are high, as tubal surgery and in-vitro fertilization are expensive. The costs of treating the complications of undiagnosed *C. trachomatis* infection, including pelvic inflammatory disease and tubal infertility, are high both in psychosocial and financial terms. Additionally, as with other inflammatory sexually transmissible infections, chlamydia facilitates the transmission of HIV infection in both males and females.

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

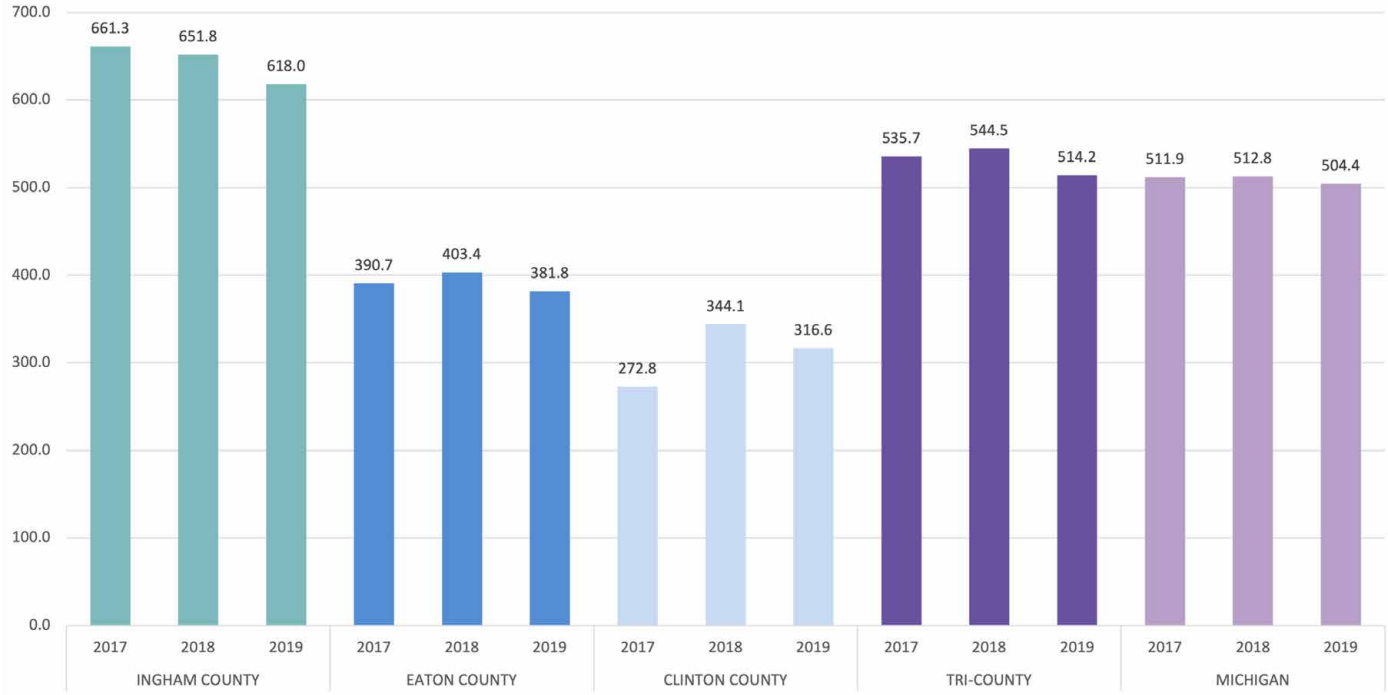
RATE OF CHLAMYDIA CASES PER 100,000 PERSONS, BY GEOGRAPHY, 2019

The rate of chlamydia in the tri-county region was higher than the rate for Michigan by about 10 cases per 100,000 population. This high rate was driven by Ingham County, which experienced 618 cases of chlamydia per one hundred thousand persons in 2019. The rates for Clinton and Eaton County were considerably lower than Michigan at 316.6 and 281.8 per 100,000 residents, respectively.



TREND IN RATE OF CHLAMYDIA CASES PER 100,000 PERSONS, BY GEOGRAPHY, 2017-2019

Between 2017 and 2019, there was a modest decline in the statewide rate of chlamydia per hundred thousand persons. In the Capital Area, there was a similar decrease in rate in the same time period, except for Clinton County which had rates increase from 2017 (272.8) to 2018 (3441.) and falling slightly in 2019 (316.6).



Older Adult Health

MEASURE
Age-specific preventable hospitalization rate per 10,000 persons related to congestive heart failure among adults 65 years old or older.

DATA SOURCE
Michigan Resident Inpatient Files (via MDHHS)

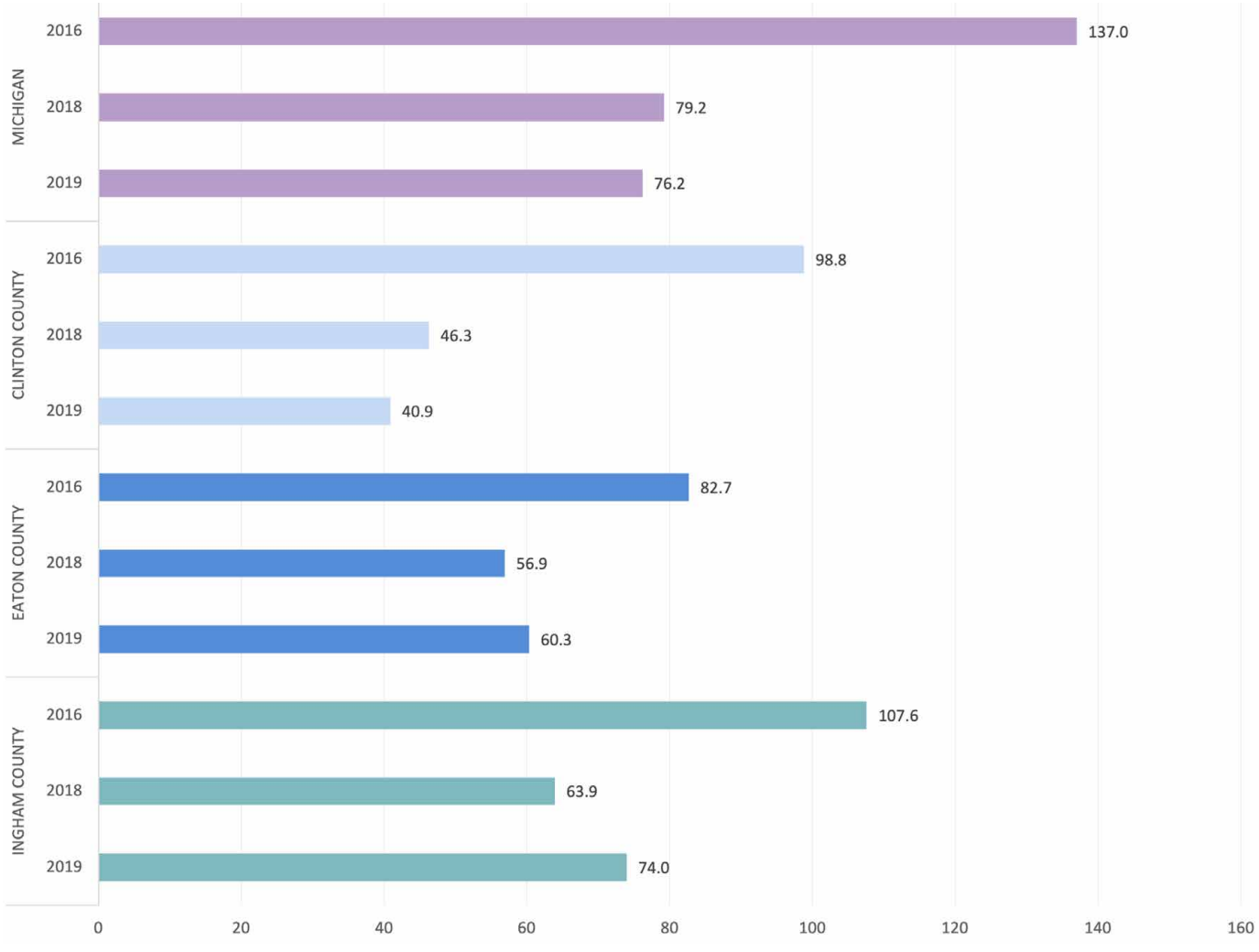
YEAR
2016, 2018, 2019

REASON FOR MEASURE
Congestive heart failure (CHF) is a chronic long-term condition in which the heart becomes increasingly incapable of pumping efficiently and therefore distributing a sufficient amount of blood throughout the body. It is primarily associated with high blood pressure (hypertension) and/or heart attacks, but it is also associated with a variety of chronic diseases. CHF is associated with disability and poor quality of life among older adults. CHF is also an ambulatory care sensitive condition, meaning that, if properly managed, acute episodes and hospitalization should be rare.

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

RATE OF PREVENTABLE HOSPITALIZATION DUE TO CONGESTIVE HEART FAILURE PER 10,000 POPULATION FOR PATIENTS 65 YEARS OF AGE OR OLDER, 2019

All individual counties in the Capital Area have rates of congestive heart failure hospitalization for older adults that are lower than the rate for the state. Individual rates range from 40.9 hospitalizations per 10,000 persons for Clinton County to 74.0 hospitalizations per 10,000 persons for Ingham County. Eaton County and Ingham County increased slightly from 2018 to 2019 but are still considerably lower than 2016.



Mortality

MEASURE
All ages, age-adjusted death rate per 100,000 persons

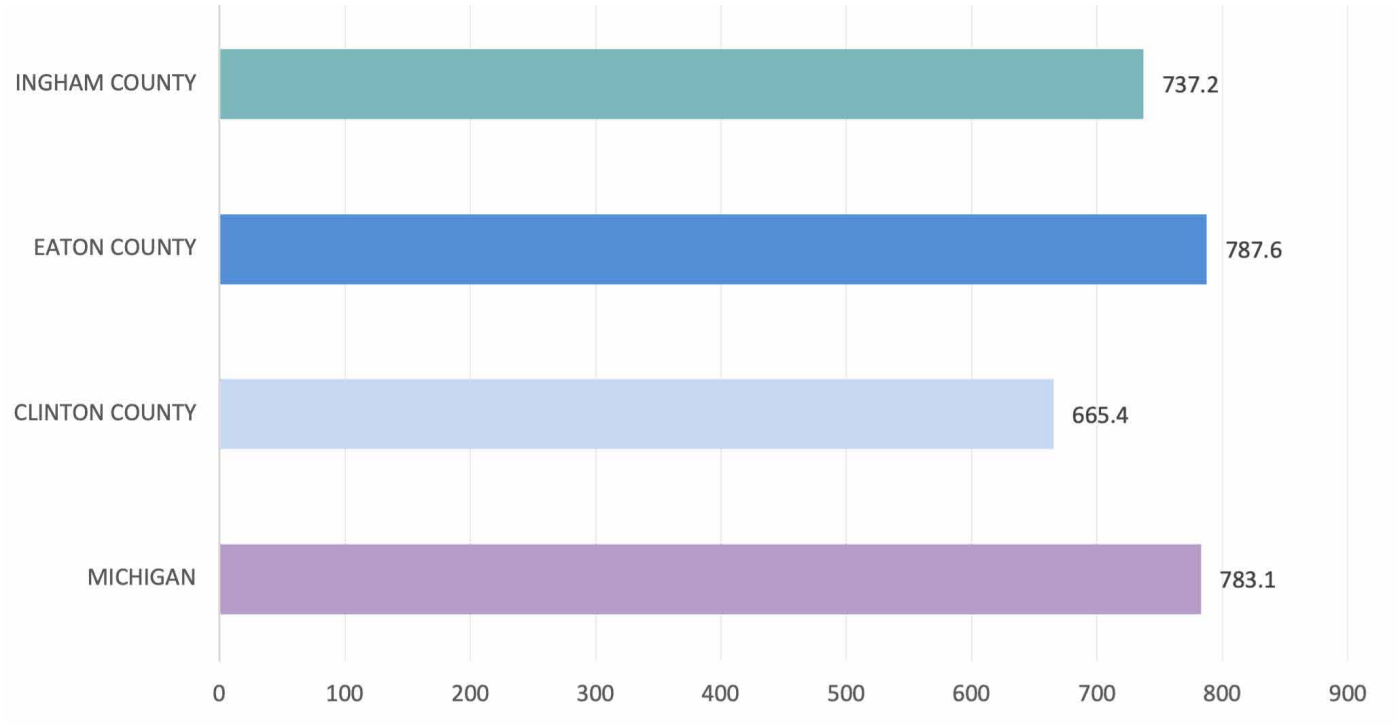
DATA SOURCES
- • 2017-2019 Geocoded Michigan Death Certificate Registries Division for Vital Records & Health Statistics, Michigan Department of Health & Human Services
- • Population Estimate (latest update 7/2020), National Center for Health Statistics, U.S. Census Populations with Bridged Race Categories

YEARS
2013-2015

REASON FOR MEASURE
Age-adjusted death rates are useful when comparing different populations because they remove the potential bias that can occur when the populations being compared have different age structures. *https://www.cdc.gov/nchs/products/databriefs/db355.htm*

DEATH PER 100,000 PERSONS, 2018

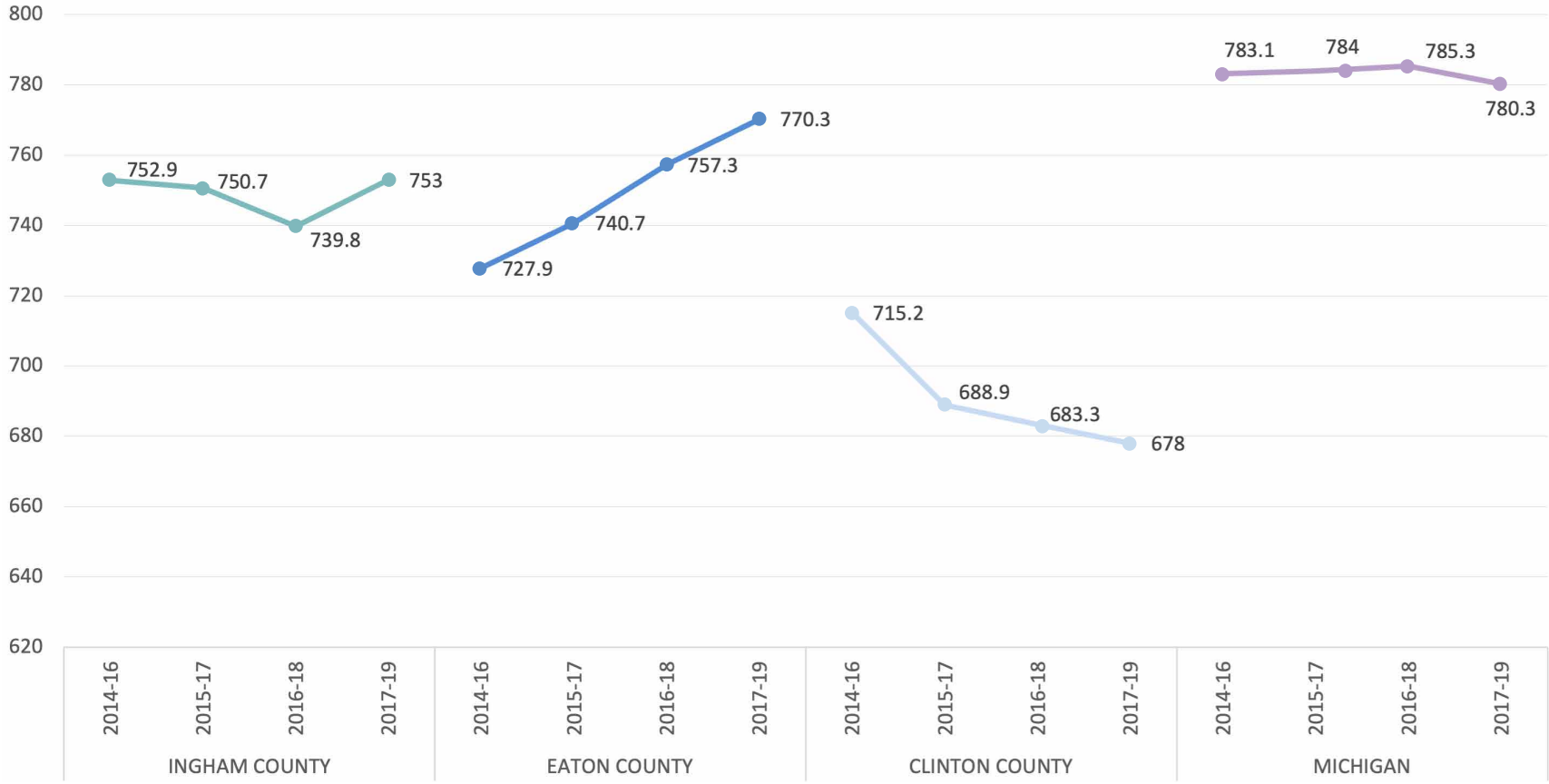
The statewide mortality rate was 783.1 deaths per 100,000 persons. Eaton County's mortality rate was slightly higher at 787.6, while Ingham and Clinton Counties were lower at 665.4 and 737.2, respectively.



Mortality

TREND IN RATE OF DEATH PER 100,000 USING 3 YEARS MOVING AVERAGES (ALL AGES, ALL CAUSES)

Ingham County's mortality rate has remained largely flat over time, with a decrease in 2016-2018 but returning to near baseline in 2017-2019. Eaton County has had a continuous and considerable rise since 2014-2016. Clinton County has seen their mortality rate decline considerably in 2015-2017 and a slower but continued trend to 2017-2019.



Maternal & Child Health

MEASURE

The number of live born infants who die before their first birthday, per every 1000 live births, over three years.

DATA SOURCES

- • Michigan Department of Health & Human Services Resident Birth File
- • Michigan Department of Health & Human Services Resident Linked Birth and Death File

YEARS

2014-2016, 2015-2017, 2016-2018, 2017-2019

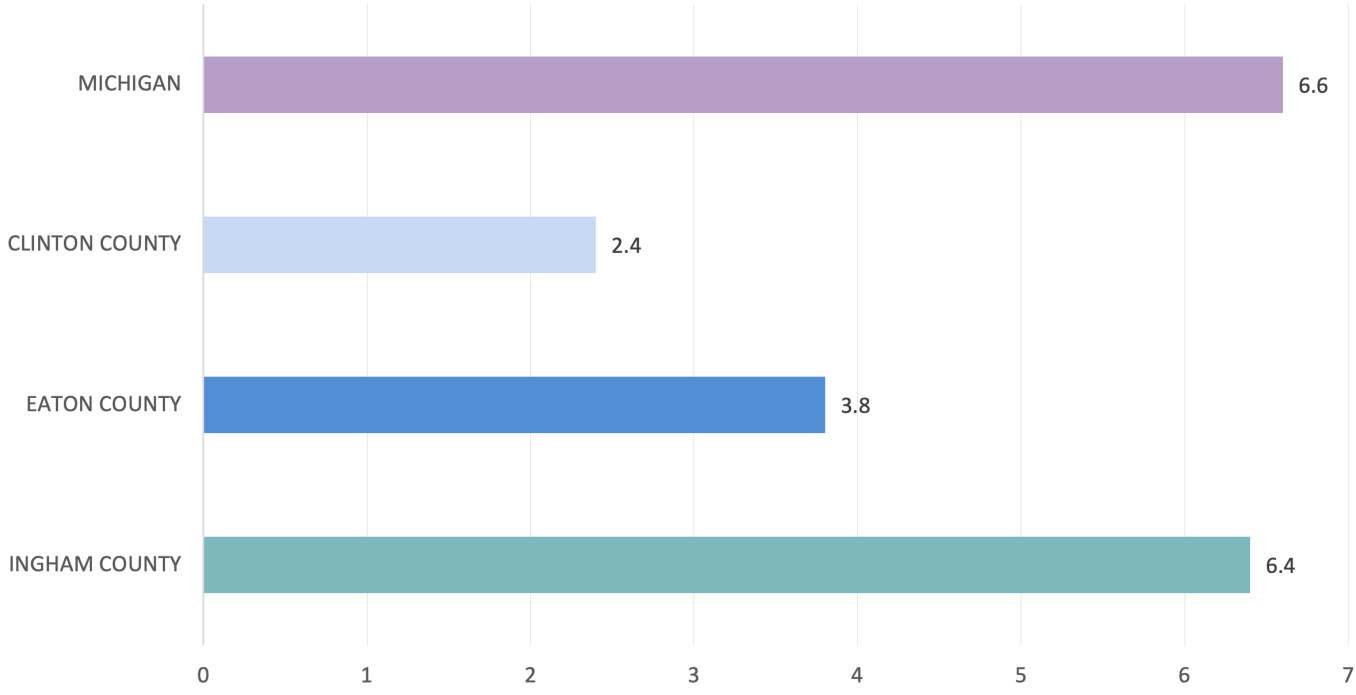
REASON FOR MEASURE

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

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

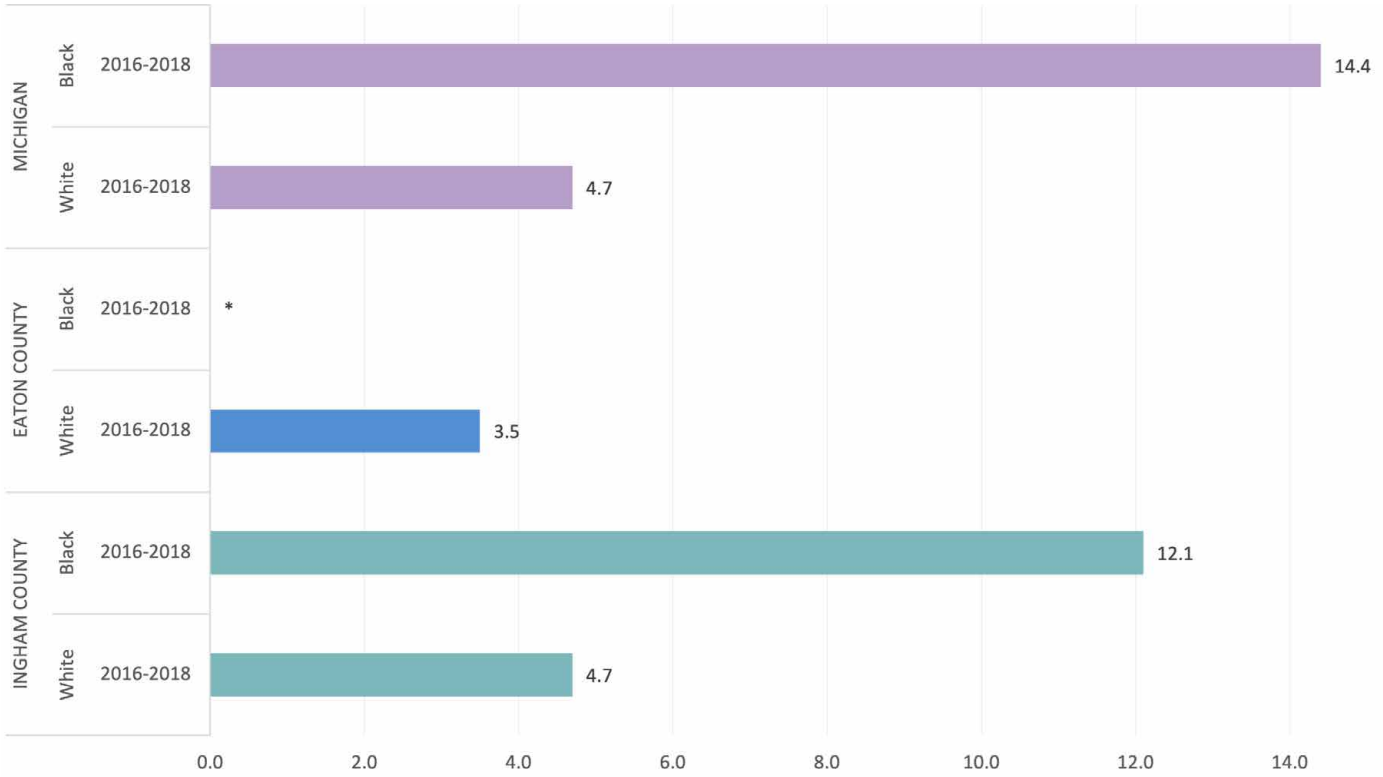
THREE-YEAR INFANT DEATH RATES, BY GEOGRAPHY, 2016-2018

Infant mortality rates for the state of Michigan and Ingham County were nearly even at 6.6 and 6.4 per 1,000 live births, respectively. However, none of the geographies met the Healthy People 2020 goal of 5.0 deaths per 1,000 live births. Clinton County did not have enough data to construct a rate, so the rate of 2.4 per 1,000 was used. Eaton County's rate was 3.8 per 1,000 in the 2017-2019 time period.



TREND IN THREE-YEAR INFANT DEATH RATES, BY GEOGRAPHY, 2016-2018 (BY RACE/ETHNICITY)

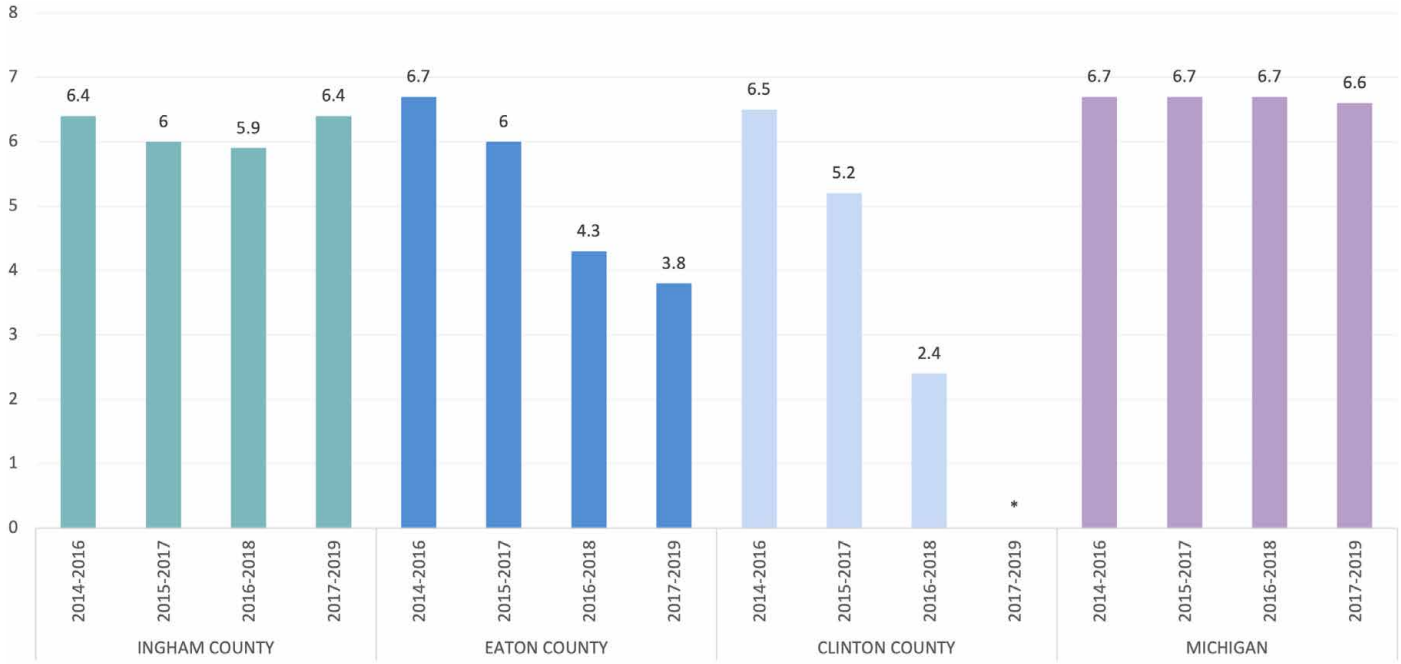
The problem of infant mortality in the state and the tri-county region becomes extremely clear when analyzing rates between racial groups. Both at the state and county levels, Black infants died before their first birthday at rate much higher than their White peers. For Michigan, there was over a threefold difference in the death rate between Black and White infants. In Ingham County, the difference was just over twofold. Statistics could not be reported for Clinton or Eaton counties, because each had too few infant deaths for reliable and confidential statistics to be calculated. Ethnicity data was also not available with the data sources used.



*No data available for 2016-2018

TREND IN THREE-YEAR INFANT DEATH RATES, BY GEOGRAPHY, 2014-2019

For both the state of Michigan and Ingham County, the trend in the rate of infant deaths was steady over the past three years; meanwhile, Clinton and Eaton counties experienced decreases in their infant mortality rates. It should be kept in mind that in situations for which there are a small number of deaths, a small change (± 1 or 2 deaths), can result in large changes in incidence rates.



Chronic Disease - Cardiovascular

MEASURE
The age-adjusted death rate due to diseases of the heart per 100,000 residents.

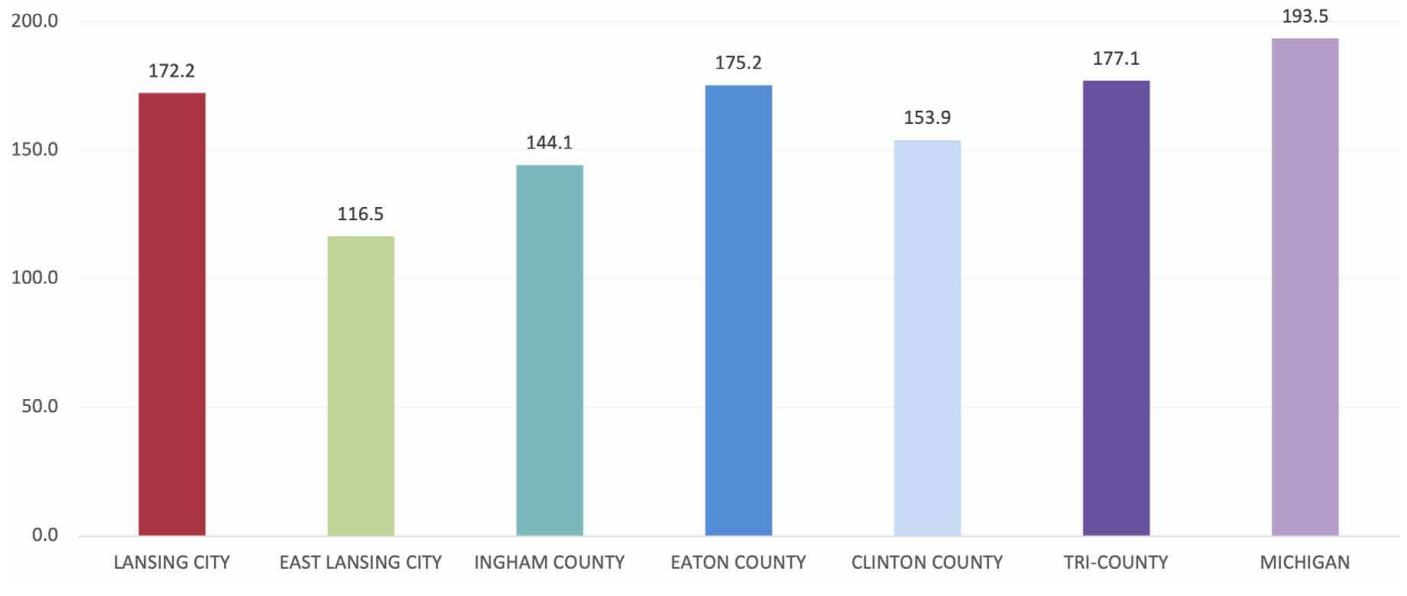
DATA SOURCE
Michigan Department of Health & Human Services Resident Death File

YEARS
2016-2019

REASON FOR MEASURE
Cardiovascular disease is the most common cause of death in Michigan. Cardiovascular disease includes diseases of the heart and blood vessels in the body. Examples of such diseases are coronary heart disease, heart failure, sudden cardiac death, and hypertensive heart disease. Cardiovascular disease is an important indicator to track due to the risk of chronic morbidity and mortality that accompany it. Cardiovascular disease is often linked to other factors that can influence health; low education, low income, and low socioeconomic status have all been associated with increased cardiovascular disease and cardiac arrests.

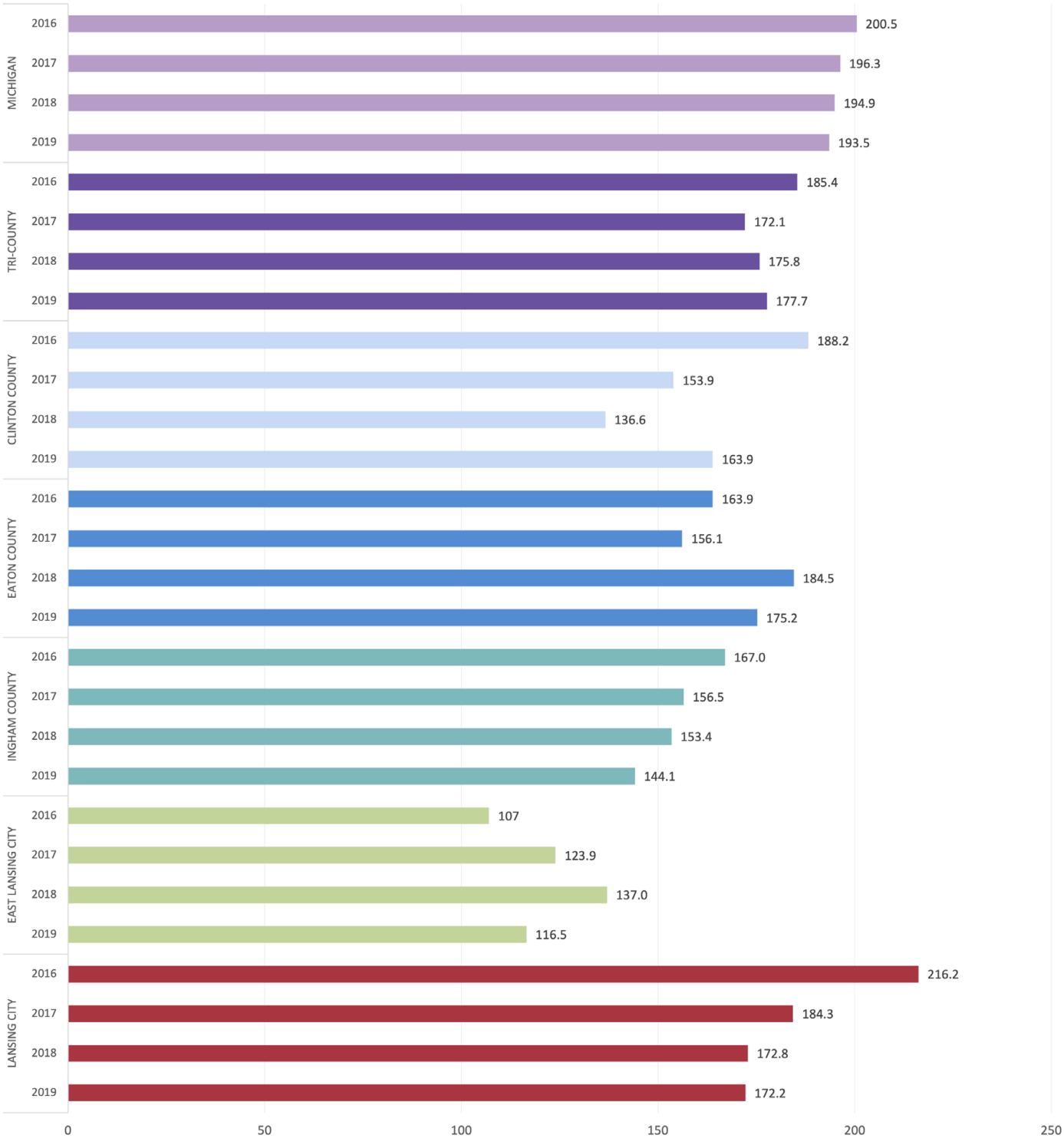
AGE-ADJUSTED MORTALITY RATES DUE TO CARDIOVASCULAR DISEASE, BY GEOGRAPHY, 2019

All geographies in the Tri-County area had lower rates of cardiovascular mortality than Michigan in 2019. The rates varied from 116.5 per 100,000 residents in the City of East Lansing to 175.2 in Eaton County. The City of Lansing also had an elevated rate at 172.2 per 100,000. Clinton and Ingham Counties, 163.9 and 144.1 respectively, also had lower rates compared to Eaton County and Michigan.



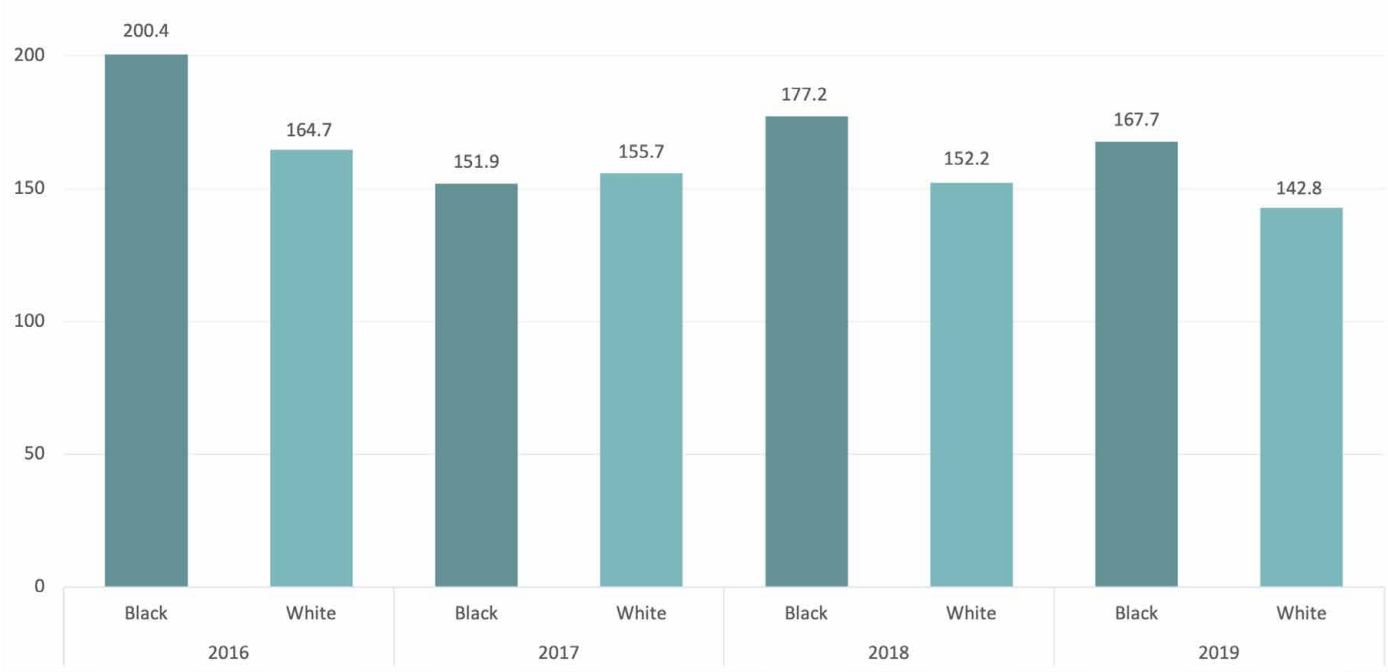
TREND IN AGE-ADJUSTED MORTALITY RATES DUE TO CARDIOVASCULAR DISEASE, BY GEOGRAPHY, 2017-2019

For the overall tri-county area, there is a small trend of increasing cardiovascular mortality rate after an initial decrease from 2016 to 2017. Ingham County has decreased from 167.0 per 100,000 in 2016 to 144.1 in 2019. The rate in Eaton County has decreased from 2018 (184.5) to 2019 (175.2), but has increased compared to 2016 (163.9). Clinton County's rate increased to 153.9 in 2019 from 136.6 in 2018, breaking a downward trend in the previous two years.



INGHAM COUNTY CARDIOVASCUAL DISEASE MORTALITY RATE BY RACE (2016-2019)

Considerable racial and gender disparities exist in Michigan and Ingham County for Cardiovascular Disease mortality rate. Black residents, especially Black Males, have higher rates of mortality than White residents. In 2019, Black residents of Michigan had a mortality rate 41% higher than White residents. In Ingham County, the mortality rate was approximately 17% higher.



INGHAM COUNTY CARDIOVASCUAL DISEASE MORTALITY RATE BY GENDER (2016-2019)

Gender disparities also exist in all geographic groups, with Males having a cardiovascular disease mortality rate between 1.4 and 1.8 times higher than Females. This disparity persists over all reported years as well.

GEOGRAPHY	YEAR	OVERALL RATE	MALE	FEMALE
MICHIGAN	2016	200.5	248.3	161.1
	2017	196.3	245.7	156
	2018	194.9	244.9	154.9
	2019	193.5	242.6	153.6
INGHAM COUNTY	2016	167	223.9	124.5
	2017	156.5	201.7	122.9
	2018	153.4	201	119.3
	2019	144.1	194.7	106.7
EATON COUNTY	2016	165.6	193.7	139.4
	2017	156.1	190.1	130.4
	2018	184.5	214	156.8
	2019	175.2	224	141
CLINTON COUNTY	2016	188.2	222.9	160.5
	2017	153.9	228.2	98.6
	2018	136.6	173.2	104.4
	2019	163.9	197.3	135.7

Safety Policies & Practies – Unintentional Injury

MEASURE
The age-adjusted death rate due to unintentional (accidental) injury per 100,000 persons.

Accidental injury deaths (sometimes called unintentional injury) include transportation accidents, burns, suffocation, drowning, falls, exposure, accidental poisonings, and other unintentional injuries. It does not include homicide or suicide deaths.

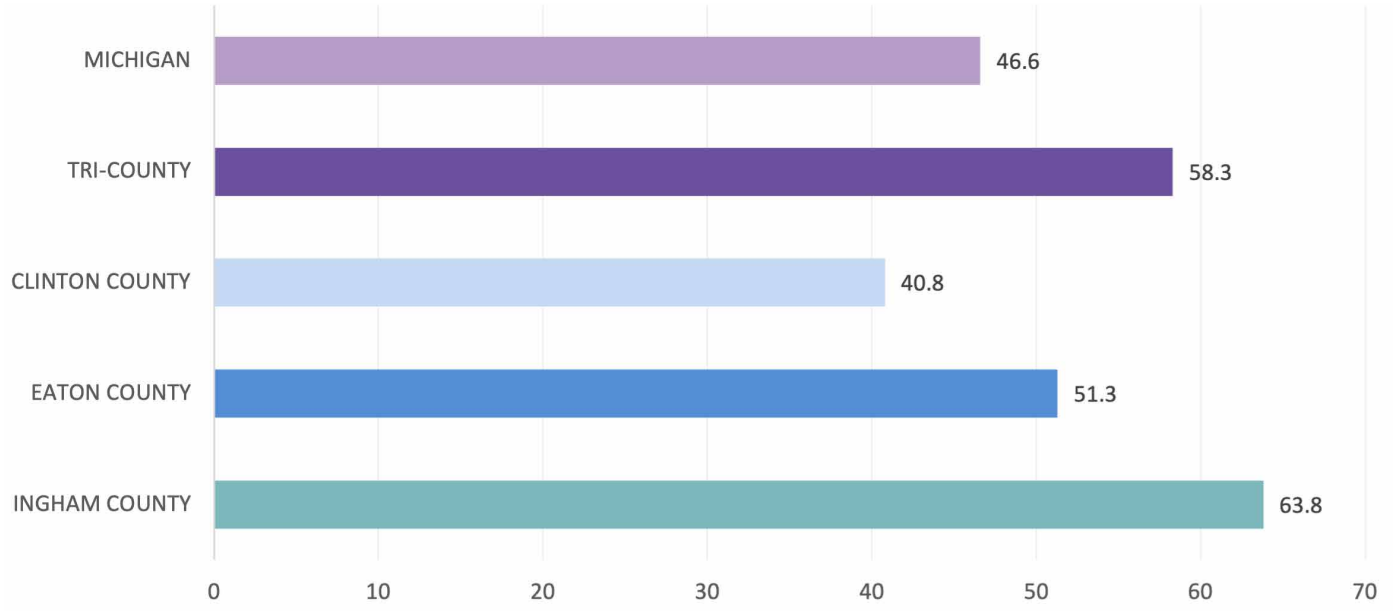
DATA SOURCE
Michigan Department of Health & Human Services Resident Death File

YEARS
2016-2020

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

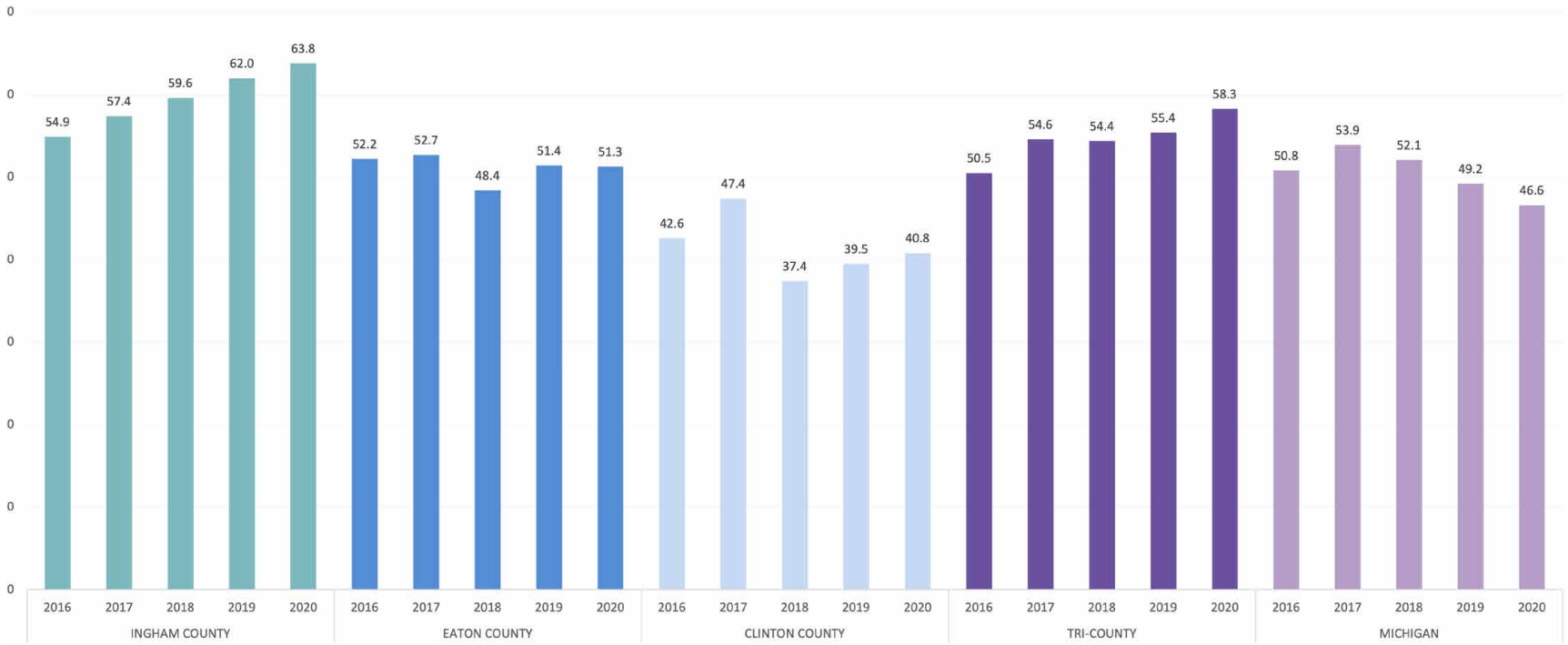
AGE-ADJUSTED MORTALITY RATES DUE TO UNINTENTIONAL INJURY, BY GEOGRAPHY, 2020

The rate of deaths due to unintentional injuries in 2020 were higher in the Tri-County area than in the State of Michigan. The rate in Ingham County (63.8 per 100,000) was the main cause of the tri-county area exceeding that of the state. However, Eaton County (51.3 per 100,000) was also higher than Michigan. Clinton County was the lowest of the three counties at 40.8.



TREND IN AGE-ADJUSTED MORTALITY RATES DUE TO UNINTENTIONAL INJURY, BY GEOGRAPHY, 2016-2020

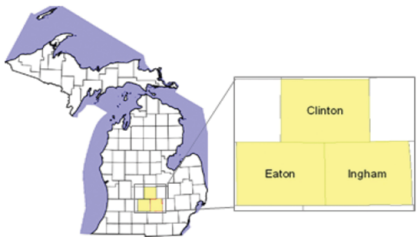
Between 2017 and 2020, the rate of deaths due to unintentional injuries in Michigan has decreased; however, in the tri-county area, the rate increased during that same time, largely due to increases in the rate in Ingham County. Eaton County's rate of death due to unintentional injury has remained essentially flat over the last 5 years. Clinton County has seen a minor overall rate decrease since 2016, but the rate has continued to rise in the last 3 years from a low in 2018 of 37.4 per 100,000 residents.



Indicators by Geography

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

Tri-County



POPULATION	ESTIMATE
Population in 2000	450,728
Population in 2010	462,889
Population in 2015	468,737
Population in 2019 (estimate)	478,432
AGE GROUP	**ESTIMATE**
Under 5 years old	5.6%
5-19 years old	19.4%
20-44 years old	35.7%
45-64 years old	24.6%
65-74 years old	9.0%
75+ years old	5.8%
RACE/ETHNICITY	**ESTIMATE**
White, non-Hispanic/Latino	80.3%
Black/ African American	8.9%
Hispanic/Latino	6.7%
American Indian/Alaskan Native	0.4%
Asian	4.9%
Pacific Islander	0.03%
Other	1.3%
Multi-racial	4.2%

LANGUAGE	ESTIMATE
Only English	92.2%
Language other than English	8.0%
SCHOOL ENROLLMENT	**ESTIMATE**
Pre-school	4.7%
Kindergarten	4.6%
Grade 1 - 4 (Elementary school)	16.9%
Grade 5 - 8 (Middle school)	18.4%
Grade 9 - 12 (High school)	19.2%
College, undergraduate	30.3%
Graduate/professional school	6.0%
HOUSING	**ESTIMATE**
Occupied housing units	191,628
Owner-occupied housing	71.5%
Renter-occupied housing	28.5%
EMPLOYMENT	**ESTIMATE**
In the labor force	250,162
Unemployment rate	4.6%
Private wage and salary workers	77.3%
Government Workers	18.0%
Self-employment	4.7%
Unpaid family workers	0.1%

MEASURE	GROUP ESTIMATE	COMPARISION TO THE STATE	TREND
Gini coefficient of income inequality	0.43	≈	→

MEASURE	GROUP ESTIMATE	COMPARISION TO THE STATE	TREND
% of households below ALICE threshold	NA	NA	NA
% of adults 25 years old or older with a Bachelor's degree or higher	34.90%	👍	↗
% of adolescents who know adults in the neighborhood they could talk to about something important	48.3%	NA	→
Rate of violent crimes	NA	NA	NA
% of households who spend more than 30% of income on housing	27.2%	≈	↘
% of children < 6 years of age with elevated blood lead level	2.9%	👎	NA
% of the population that lives in a USDA-defined 'food desert'	25.8%	👎	↗

MEASURE	GROUP ESTIMATE	COMPARISION TO THE STATE	TREND
% of adults who are obese	35.10%	👎	↗
% of adolescents who are obese	17.30%	👎	↗
% of adults who currently smoke	19.60%	≈	→
% of adolescents who smoked cigarettes during the past 30 days	2.50%	👍	↘
% of adults who binge drank during the past 30 days	20.20%	👍	↗
% of adolescents who binge drank during the past 30 days	8.50%	👍	NA
% of students who used marijuana in the past 30 days	15.50%	👍	↗
% students who tried marijuana prior to 13 years of age	4.80%	👍	→
% of adults engaging in no leisure time physical activity	20.20%	👍	↘
% of adults who consume ≥ 5 servings of fruits and vegetables per day	30.20%	👍	↘
% of adults with no primary care provider	21.30%	👎	↗
% of adults 18-64 years old without health insurance	7.10%	≈	↘
Rate of non-medical immunization waivers granted for schoolchildren	NA	NA	NA
% of adults with poor mental health	17.50%	👎	↗
% of adolescents with symptoms of depression in past year	40.40%	👎	↗

MEASURE	GROUP ESTIMATE	COMPARISION TO THE STATE	TREND
Rate of preventable asthma hospitalizations among youth < 18 years	NA	NA	NA
Rate of preventable diabetes hospitalizations in adults >18 years	NA	NA	NA
Rate of chlamydia cases	514.2	👎	→
Rate of preventable congestive heart failure hospitalization among adults ≥ 65 years old	NA	NA	NA
Mortality Rate per 100,000	NA	NA	NA
Rate of infant mortality	NA	NA	NA
Rate of deaths due to cardiovascular disease	177.7	👍	↗
Rate of deaths due to accidental injury	58.3	👎	↗

Clinton County

POPULATION	ESTIMATE
Population in 2000	67,753
Population in 2010	74,235
Population in 2015	76,905
Population in 2019 (estimate)	78,389
AGE GROUP	**ESTIMATE**
Under 5 years old	5.6%
5-19 years old	19.4%
20-44 years old	30.2%
45-64 years old	28.5%
65-74 years old	9.9%
75+ years old	6.6%
RACE/ETHNICITY	**ESTIMATE**
White, non-Hispanic/Latino	93.6%
Black/African American	1.8%
Hispanic/Latino	4.5%
American Indian/Alaskan Native	0.2%
Asian	1.5%
Pacific Islander	0.0%
Other	0.4%
Multi-racial	2.5%

LANGUAGE	ESTIMATE
Only English	96.1%
Language other than English	4.7%
SCHOOL ENROLLMENT	**ESTIMATE**
Pre-school	5.1%
Kindergarten	4.9%
Grade 1 - 4 (Elementary school)	19.2%
Grade 5 - 8 (Middle school)	21.4%
Grade 9 - 12 (High school)	21.2%
College, undergraduate	23.0%
Graduate/professional school	5.4%
HOUSING	**ESTIMATE**
Occupied housing units	31,087
Owner-occupied housing	83.6%
Renter-occupied housing	16.4%
EMPLOYMENT	**ESTIMATE**
In the labor force	39,992
Unemployment rate	2.2%
Private wage and salary workers	77.9%
Government Workers	16.4%
Self-employment	5.7%
Unpaid family workers	0.1%

OPPORTUNITY MEASURES	GROUP ESTIMATE	COMPARISION TO THE STATE	TREND
Gini coefficient of income inequality	0.42	👍	→

SOCIAL, ECONOMIC, & ENVIRONMENTAL FACTORS	GROUP ESTIMATE	COMPARISION TO THE STATE	TREND
% of households below ALICE threshold	31.0%	👍	NA
% of adults 25 years old or older with a Bachelor's degree or higher	32.1%	👍	→
% of adolescents who know adults in the neighborhood they could talk to about something important	54.9%	NA	↘
Rate of violent crimes	123.1	👍	↘
% of households who spend more than 30% of income on housing	20.0%	👍	↘
% of children < 6 years of age with elevated blood lead level	2.0%	👍	↗
% of the population that lives in a USDA-defined 'food desert'	4.6%	👎	↘

BEHAVIORS, STRESS, & PHYSICAL CONDITIONS	GROUP ESTIMATE	COMPARISION TO THE STATE	TREND
% of adults who are obese	37.7%	👎	↗
% of adolescents who are obese	15.9%	👎	↗
% of adults who currently smoke	21.8%	👎	↗
% of adolescents who smoked cigarettes during the past 30 days	3.9%	👍	NA
% of adults who binge drank during the past 30 days	19.9%	≈	↗
% of adolescents who binge drank during the past 30 days	8.7%	👍	NA
% of students who used marijuana in the past 30 days	14.6%	👍	↗
% students who tried marijuana prior to 13 years of age	2.8%	👍	→
% of adults engaging in no leisure time physical activity	16.7%	👍	↘
% of adults who consume ≥ 5 servings of fruits and vegetables per day	33.3%	👍	↘
% of adults with no primary care provider	13.6%	👍	→
% of adults 18-64 years old without health insurance	6.1%	👍	→
Rate of non-medical immunization waivers granted for schoolchildren	23.0	👍	NA
% of adults with poor mental health	12.0%	👍	↗
% of adolescents with symptoms of depression in past year	39.1%	👎	↗

HEALTH OUTCOMES	GROUP ESTIMATE	COMPARISION TO THE STATE	TREND
Rate of preventable asthma hospitalizations among youth < 18 years	13.5*	NA	NA
Rate of preventable diabetes hospitalizations in adults >18 years	27.5	👍	↗
Rate of chlamydia cases	316.6	👍	NA
Rate of preventable congestive heart failure hospitalization among adults ≥ 65 years old	40.9	👍	↘
Mortality Rate per 100,000	678.0	👍	↘
Rate of infant mortality	2.4**	👍	↘
Rate of deaths due to cardiovascular disease	153.9	👍	NA
Rate of deaths due to accidental injury	40.8	👍	↗

* 2014 data

**2018 data

NA = Not available for this measure

Eaton County

POPULATION	ESTIMATE
Population in 2000	103,655
Population in 2010	107,759
Population in 2015	108,341
Population in 2019 (estimate)	109,456
AGE GROUP	**ESTIMATE**
Under 5 years old	5.5%
5-19 years old	17.9%
20-44 years old	30.9%
45-64 years old	27.7%
65-74 years old	10.9%
75+ years old	7.0%
RACE/ETHNICITY	**ESTIMATE**
White, non-Hispanic/Latino	86.4%
Black/ African American	6.8%
Hispanic/Latino	5.4%
American Indian/Alaskan Native	0.6%
Asian	2.3%
Pacific Islander	0.03%
Other	1.2%
Multi-racial	2.7%

LANGUAGE	ESTIMATE
Only English	93.3%
Language other than English	6.7%
SCHOOL ENROLLMENT	**ESTIMATE**
Pre-school	5.3%
Kindergarten	5.2%
Grade 1 - 4 (Elementary school)	18.9%
Grade 5 - 8 (Middle school)	20.3%
Grade 9 - 12 (High school)	23.5%
College, undergraduate	23.2%
Graduate/professional school	3.5%
HOUSING	**ESTIMATE**
Occupied housing units	44,950
Owner-occupied housing	72.3%
Renter-occupied housing	27.7%
EMPLOYMENT	**ESTIMATE**
In the labor force	56,217
Unemployment rate	4.8%
Private wage and salary workers	78.0%
Government Workers	17.5%
Self-employment	4.4%
Unpaid family workers	0.1%

MEASURE	GROUP ESTIMATE	COMPARISION TO THE STATE	TREND
Gini coefficient of income inequality	0.41	👍	→

MEASURE	GROUP ESTIMATE	COMPARISION TO THE STATE	TREND
% of households below ALICE threshold	29.0%	👍	↘
% of adults 25 years old or older with a Bachelor's degree or higher	27.8%	≈	↗
% of adolescents who know adults in the neighborhood they could talk to about something important	42.4%	NA	↘
Rate of violent crimes	276.6	👍	→
% of households who spend more than 30% of income on housing	22.3%	👍	↘
% of children < 6 years of age with elevated blood lead level	1.50%	👍	↘
% of the population that lives in a USDA-defined 'food desert'	9.70%	👍	NA

MEASURE	GROUP ESTIMATE	COMPARISION TO THE STATE	TREND
% of adults who are obese	36.9%	👎	↗
% of adolescents who are obese	20.0%	👎	NA
% of adults who currently smoke	20.2%	≈	↘
% of adolescents who smoked cigarettes during the past 30 days	3.4%	👍	↘
% of adults who binge drank during the past 30 days	16.8%	👍	↗
% of adolescents who binge drank during the past 30 days	8.4%	👍	NA
% of students who used marijuana in the past 30 days	17.5%	👎	↗
% students who tried marijuana prior to 13 years of age	7.1%	👎	↗
% of adults engaging in no leisure time physical activity	21.5%	👍	NA
% of adults who consume ≥ 5 servings of fruits and vegetables per day	26.5%	👍	↘
% of adults with no primary care provider	18.8%	👎	→
% of adults 18-64 years old without health insurance	6.60%	👍	↘
Rate of non-medical immunization waivers granted for schoolchildren	32	👎	NA
% of adults with poor mental health	16.0%	≈	↗
% of adolescents with symptoms of depression in past year	42.7%	👍	↗

MEASURE	GROUP ESTIMATE	COMPARISION TO THE STATE	TREND
Rate of preventable asthma hospitalizations among youth < 18 years	8.3	👍	NA
Rate of preventable diabetes hospitalizations in adults >18 years	31.1	👍	↗
Rate of chlamydia cases	381.8	👍	→
Rate of preventable congestive heart failure hospitalization among adults ≥ 65 years old	60.3	👍	NA
Mortality Rate per 100,000	770.3	👍	↗
Rate of infant mortality	3.8	👍	↘
Rate of deaths due to cardiovascular disease	175.2	👍	→
Rate of deaths due to accidental injury	51.3	👎	→

Ingham County

POPULATION	ESTIMATE
Population in 2000	279,320
Population in 2010	280,895
Population in 2015	283,491
Population in 2019 (estimate)	290,587
AGE GROUP	**ESTIMATE**
Under 5 years old	5.6%
5-19 years old	20.0%
20-44 years old	39.0%
45-64 years old	22.3%
65-74 years old	8.0%
75+ years old	5.1%
RACE/ETHNICITY	**ESTIMATE**
White, non-Hispanic/Latino	74.3%
Black/ African American	11.7%
Hispanic/Latino	7.8%
American Indian/Alaskan Native	0.4%
Asian	6.8%
Pacific Islander	0.04%
Other	1.5%
Multi-racial	5.3%

LANGUAGE	ESTIMATE
Only English	87.3%
Language other than English	12.7%
SCHOOL ENROLLMENT	**ESTIMATE**
Pre-school	3.7%
Kindergarten	3.6%
Grade 1 - 4 (Elementary school)	12.6%
Grade 5 - 8 (Middle school)	13.4%
Grade 9 - 12 (High school)	12.8%
College, undergraduate	44.7%
Graduate/professional school	9.2%
HOUSING	**ESTIMATE**
Occupied housing units	115,591
Owner-occupied housing	58.5%
Renter-occupied housing	41.5%
EMPLOYMENT	**ESTIMATE**
In the labor force	153,953
Unemployment rate	6.7%
Private wage and salary workers	75.9%
Government Workers	20.0%
Self-employment	3.9%
Unpaid family workers	0.2%

MEASURE	GROUP ESTIMATE	COMPARISION TO THE STATE	TREND
Gini coefficient of income inequality	0.47	≈	→

MEASURE	GROUP ESTIMATE	COMPARISION TO THE STATE	TREND
% of households below ALICE threshold	43%	👎	→
% of adults 25 years old or older with a Bachelor's degree or higher	38.9%	👍	→
% of adolescents who know adults in the neighborhood they could talk to about something important	47.5%	NA	→
Rate of violent crimes	628.9	👎	↗
% of households who spend more than 30% of income on housing	31.0%	👎	↘
% of children < 6 years of age with elevated blood lead level	3.40%	👎	↗
% of the population that lives in a USDA-defined 'food desert'	42.2%	👎	↗

MEASURE	GROUP ESTIMATE	COMPARISION TO THE STATE	TREND
% of adults who are obese	34.6%	👎	↗
% of adolescents who are obese	15.9%	≈	↗
% of adults who currently smoke	18.3%	👍	↘
% of adolescents who smoked cigarettes during the past 30 days	1.6%	👍	↘
% of adults who binge drank during the past 30 days	21.5%	👎	↗
% of adolescents who binge drank during the past 30 days	8.3%	👍	→
% of students who used marijuana in the past 30 days	14.5%	👍	↗
% students who tried marijuana prior to 13 years of age	4.3%	👍	↘
% of adults engaging in no leisure time physical activity	21.0%	👍	NA
% of adults who consume ≥ 5 servings of fruits and vegetables per day	34.2%	👍	↘
% of adults with no primary care provider	24.4%	👎	↗
% of adults 18-64 years old without health insurance	7.5%	≈	↘
Rate of non-medical immunization waivers granted for schoolchildren	23.0	👍	↘
% of adults with poor mental health	19.7%	👎	↗
% of adolescents with symptoms of depression in past year	39.5%	👎	↗

MEASURE	GROUP ESTIMATE	COMPARISION TO THE STATE	TREND
Rate of preventable asthma hospitalizations in youths < 18 years	10.8	≈	↗
Rate of preventable diabetes hospitalizations in adults >18 years	34.0	👍	↗
Rate of chlamydia cases	618.0	👎	↘
Rate of preventable congestive heart failure hospitalization among adults ≥ 65 years old	74	👍	NA
Mortality Rate per 100,000	753.0	👍	→
Rate of infant mortality	6.4	≈	→
Rate of deaths due to cardiovascular disease	144.1	👍	↘
Rate of deaths due to accidental injury	63.8	👎	↗

Speaking of Health

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

Focus Groups

Participant Demographics

26 TOTAL PARTICIPANTS*

When presented alongside quantitative (numerical) data, qualitative data enriches information by revealing the thoughts and beliefs of community members by using their own words. Qualitative data is especially beneficial when gaining the perspective of traditionally vulnerable groups, who are often underrepresented when using quantitative survey methodology.

Five focus groups were conducted over several months. An emphasis was placed on gathering feedback from participants representing groups that experience greater health disparities, have greater health needs, or are traditionally hard-to-survey.

These included:

- Individuals who are uninsured or utilize Medicaid
- Individuals with low or no income
- Individuals experiencing or have experienced homelessness
- Individuals from racial, ethnic, and linguistic minority groups
- Individuals with health conditions
- Individuals with disabilities
- Individuals who are in recovery

Focus groups were conducted in two counties: Eaton Rapids (Eaton Rapids High School) in Eaton County and Lansing (Peckham, Allen Neighborhood Center, and Forest Community Health Center) in Ingham County. One additional focus group was conducted virtually over Zoom. Group size ranged in size from 2 to 9 participants. The format of the group was informal discussion—the facilitator asked questions revolving around certain topics, and participants were able to join the conversation as desired. All focus group participants were compensated a $25 gift card to Meijer and provided with dinner. Many thanks to the organizations and individuals who assisted us in coordinating and recruiting for these focus groups.

*Numbers in each category may not equal the total number of participants. Some participants did not fill out all the information but still qualified for the focus group they attended. Other participants did not submit any information and attended the focus group the same day. Only information provided to us is included in the tables above. Some categories also allowed more than a single response.

AGE	# PARTICIPANTS
18-24	1
25-34	6
35-44	3
45-54	3
55-64	2
65-74	0
75+	0
No Response	11

EMPLOYMENT STATUS	# PARTICIPANTS
Not working, looking for work	2
Not working, not looking for work/ On disability	3
Working part-time	2
Working full-time	1
Stay at home parent/ Homemaker	1
Retired	1
No Response	16

RACE/ETHNICITY	# PARTICIPANTS
White or Caucasian (non-Hispanic/Latino)	13
Black or African American (non-Hispanic/Latino)	4
Hispanic/Latino (any race)	10
Native American	0
More than one race	1
No Response/Other	8

HOUSEHOLD INCOME	# PARTICIPANTS
Less than $20,000	3
$20,000-$34,999	4
$35,000-$49,999	5
$50,000-$74,999	3
$75,000 or greater	0
No Response	11

Focus groups were recorded, and the data was analyzed by two individuals. For analysis at the individual group level, participants' responses to each question were summarized; topics that recurred throughout the group were noted and the discussion surrounding them summarized. Having read the discussion and using the summaries, the analysts noted themes of deeper meaning where applicable. For analysis among the groups, the analyst compared data for each question and topic. Main similarities and differences among the groups were noted, and topic themes and deeper themes were highlighted. Throughout this process, relevant quotations were pulled out to support themes.

Concept maps are also used as a data visualization method. The analyst developed these based on the data narrative and represent how various concepts and themes are related.

NOTE ABOUT SPANISH LANGUAGE FOCUS GROUP

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

HEALTH CARE COVERAGE	# PARTICIPANTS
Private Insurance	8
County/ Health Department Plan	0
Healthy Michigan	3
Military Health Plan (TriCare)	0
Medicaid	1
Medicare	2
Other	0
Uninsured	1
No Response	11

DISABILITY STATUS	# PARTICIPANTS
Mental Health Condition	8
Physical Disability	4
Sensory Impairment	1
Developmental Disability	2
Other	0
Caretaker for person with disability	2
In recovery from substance addiction	0
Used or currently use WIC	3
Used or currently use SNAP or food bank/pantry	6
No Response	10

HOUSING STATUS	# PARTICIPANTS
Permanent Housing	15
No Permanent Housing	0
Temporary Housing (shelter, transitional housing)	0
Staying with friend, relative, etc.	0
Prior homelessness	1
Prior use of housing services (local housing services, vouchers, shelters, etc.)	1
Other	0
No Response	11

1. How has COVID-19 impacted you and your family? Was there anything (resources) that you couldn't access as you could prior to the pandemic?

The COVID-19 pandemic has impacted our community in many ways. Just one of those impacts is related to how people can or cannot access healthcare during the pandemic. Some are happy to see providers embrace telehealth while others are frustrated with wait times for all kinds of care.

DAY-TO-DAY CHALLENGES

"Honestly, it's been tough, really because there have not been a lot of supports because of the fact that everything has been changed. I mean, everything. I'm a single parent and I see the difficulty that the pandemic has brought about for my child. In terms of just basic things. Thankfully I don't have a lot of the challenges with just regular socialization for a child, not being able to do those things. And then just dealing with my own mental health and all of those things. The supports have just not been there because everything has been altered. The things that would normally be there in regular, non-pandemic time, they weren't available because again, everything is different. So it really has just been a matter of, well, I'm just trying to pull on every ounce of personal strength that I've had. And so they've honestly, I don't know how I've done it, you know, it's just been by grace alone."

TELE-HEALTH / VIRTUAL VISITS

"I've known people that took advantage of the [telemedicine]...they seem to like it. So [they] do it more often."

"So I think the pandemic, the experience of COVID has made some things a little easier. I think entities that [had not had virtual options] were either struggling or hadn't quite bridged to the virtual environment. I think they have made tip toe steps in that direction. Some people, some organizations have made giant leaps. I mean, let's face it, they've taken a rocket and they're in finally 2021. But there are still lots of organizations that are in 1982..."

ACCESS TO RESOURCES (SUPPLIES, FOOD, RESOURCES, ETC.)

"Time of the doors being open or closed, they cut back because the workers, [so there was] less time to shop"

DENTAL CARE

"...even for the dentists...because of the pandemic, my dentist appointment is not until July and I scheduled that back in April."

FEAR OF USING HEALTH SERVICES

"...a friend of mine [from college]. He was a year under me, he's 31 years old. He actually works for BWL and he just broke his hand. And I was like, are you going to the doctor? He was like, no, I'm just going to wrap it up. I'm like, bro, you have health insurance. He was like, I'm not going to the hospital so [he doesn't] catch COVID. That's literally what he told me."

Has it impacted your mental health?

Another major impact of the pandemic has been on the mental health of the community. People often struggling with feeling isolated, anxious or depressed. In some cases these are new things to deal with, in others they have been heightened by the unique challenges of the pandemic and living through it. Others, who were unlucky enough to have become ill with COVID, expressed fear and uncertainty.

"Isolation. Yeah. I mean, you just [have to communicate with people], you know, I don't have Wi-Fi at home, because I'm limited... And then you lose them anyway [on a call]. So I was like, okay, nice seein' ya, yeah."

"You feel very sad, very lonely because you used to do things you could do before that you can't do right now. You are very restricted."

"We definitely had a lot more bottle returns during the pandemic. Well you couldn't [return them] for a while, [but] we had a lot more bottles [returned]."

"[I'm] more concerned about depression and [those who are] already isolated, isolated in the bedroom even though you live with them... those kinds of things."

"I still think twice about [leaving] home, as she said. I think twice before going to so-and-so's house, or before going on a trip because you can't tell how people are going to react."

"It was hard and challenging, like living by myself and thinking about my family and, um, different things like that in terms of my own mental health. Um, but I think at the beginning of the pandemic, I was trying to like make sure that I was walking and like exercising, but it's words, you know, the past few months I just been like trying to survive like mentally and emotionally..."

"And the end of the side of December I thought that's what it was [allergies] until my smell and taste was gone. And I freaked out, because I had been around my 87 year old grandmother... So for me, I had other close losses to me, like a close college friend who actually passed from COVID and then me knowing myself once I contracted it, you know, what was going to happen to me."

"There were nights where I literally didn't know if I was going to wake up the next morning because of shortness of breath..."

What helped you get through the COVID-19 pandemic?

One of the ways most common ways people have gotten through the pandemic is by leaning on friends, family and loved ones – even if it is only through virtual means. Others have sought professional help as they were feeling overwhelmed.

"For me, I actually started taking antidepressants at the beginning of the pandemic last year."

"...one way of coping and being able to talk to my family, [we] started having family zoom chats. And that was really cool too. Cause we started like talking about unpacking, our family trauma, which was hard but important and necessary, especially in like a black family, being able to say, 'mom, this hurt me growing up when you did this' or 'dad, this hurt me when you did this.' And then our parents, you know, and they were arguing and stuff, but you know, we got it together and we, you figured it out and we, um, you know, talk through some stuff, but that was really, really important."

"I recently talked with my sister and because of the experience of what I distanced myself from my family, um, it was great to hear that she had been seeing a therapist. And when she opened up with that, I was like, thank you, Jesus. Because, um, that outside opinion is so important. And I'm very fortunate that I have friends and, um, and mentors in different like age spans that allow me to have my therapy. And, but she finally had that and it was really great. And so we had a two and a half hour conversation and she was able to listen, um, because the therapist said, why haven't you talked to him? He told you, you could call him. Um, and, and she's, she finally did it because she told her therapist, she says, I'm going to talk to him before next session. And it was great..."

"...choosing myself, when you feel like you are not going to be on this earth anymore...it changes your perspective on what you allow in your circle. And so for me, I had to allow the things that make me happy, surround myself with those people that I know that are good people and just continue to be positive. And actually for a while, I didn't even watch the TV or watch the news, um, just because it wasn't even something that I even wanted to hear about. It's really been about surrounding myself with people and also things and doing things that make me happy and even including travel."

2. Has there been a time recently when you or someone you know needed care but didn't get it (or had trouble getting it)? Did having insurance, no insurance, Medicaid at the time make a difference?

Many participants stated that they have had trouble getting the health care they feel they need, for a wide variety of reasons that aren't necessarily limited to individuals with low income or with or without private insurance:

NOT ENOUGH LOCAL PROVIDERS OR SPECIALISTS

"They're not in this area…there are no doctors that are very available. My mom lives in Potterville…and she used to go to Cherry Health in the Health Department, then it shut down during the pandemic. And now, she's like, that was the only doctor I had and now they're sending me somewhere [else]."

"I have been on a waiting list for - 3 months - just to get [a specialist appointment]."

LACK OF QUALITY CARE OR A LACK OF PROVIDERS WHO ARE ABLE TO DIAGNOSE WHAT'S WRONG;

"I took [my son] to the urgent care again and [they said], "He's constipated." They did some X-rays…he threw up on the doctor's office. I said, "There you go." Do you know what was happening? His appendix burst. My son was dying. He was in the hospital for a week without eating because of doctors' nonsense here. They don't know anything. They don't know."

INSURANCE COMPANIES (INCLUDING MEDICAID)

"…my family has private insurance and my son has Medicaid. So, when they see Blue Cross Blue Shield, it's like all the doors, open up everything. …Whenever I need, I want. But, if they just look at my son's Medicaid and not the fact that it's secondary doors shut instantly… And so I really seen the difference that having good private health insurance provided by your employer really made a difference during this pandemic. It makes a difference."

Participants acknowledged that being low income and/or having Medicaid affected their ability to get care and the quality of care. However, just having insurance doesn't guarantee affordability of care due to high out-of-pocket costs for office visits, prescriptions and even transportation.

HEALTHCARE WITH MEDICAID AND MEDICARE:

There is a lack of providers who accept Medicaid, especially in some localities. Mental health care, specialty care, and dental care were specifically mentioned as hard to find care for. Participants described about how, once they find a provider that accepts Medicaid, the wait can be exceedingly long before they can get an appointment, and that it is difficult to change doctors when you are on Medicaid.. Participants feel that they are discriminated against for being on Medicaid (or for being low-income). Some participants were frustrated that Medicare does not cover dental or vision care.

"A lot of providers will not accept straight Medicaid. They will not."

"I just have Medicare, [and] Medicare doesn't care. I have no dental coverage whatsoever, which is absolutely crazy."

"I think the dental care that's afforded by Medicaid, it really is abysmal."

"…to get Medicaid just makes me dizzy thinking about all the numbers I would have to get."

HEALTHCARE WITH NON-MEDICAID INSURANCE:

One participant, who had private insurance, stated that they had no issues finding providers; several other echoed that sentiment.

"It depends on how good your insurance is. If you have a good insurance company, they check you up wholly, but if you don't have insurance…"

INSURANCE-INDEPENDENT ISSUES AFFECTING CARE:

Participants indicated that regardless of whether one has Medicaid, private insurance and or is uninsured, the medical system can be burdensome for persons with limited income. This financial burden includes costs of medication, office visits, and incidental expenses and having to see a doctor in order to get medication refills.

"I ran out of my albuterol inhaler for my asthma and I also use a daily control and getting that while uninsured they wanted more than $200. So I had to buy it on the street…and I felt like a criminal cause it was $200 when [my] hours [got] cut. …And so I had met a random person on the street and they charged me $75…"

"…we pay money [and] we pay out of pocket. I think it's terrible, like myself, [I] haven't had insurance for a few years. So it's like [is it] going to lead to something bad? But you just kind of hope it goes away, you know? But eventually it's going to come back to bite me as I get older… I can't go to Canada [for affordable care], even if I wanted to."

Are you able to get the preventive services that you need, like yearly physicals, well-child visits, dental care, etc.?

ALL-INSURANCE:

Largely due to the pandemic, participants in all focus groups reported difficulty in getting timely appointments or delaying care to avoid getting sick while visiting a healthcare setting.

"And so now everybody wants to go to the doctor, which means that you might have to wait six or seven months to get into the doctor because that's how far their appointments are pushed out. So if you are having something that really needs to be addressed sooner, rather than later, your choices are either to just kind of wait until the six or seven months, or if it is urgent or emergent, then you need to go to the emergency room or the urgent care "

3. How do you feel about the relationship with your doctor or other health care provider? Do you feel that your health care provider listens to you? Do they make sure that you understand what they are telling you? Do they allow you to help make decisions regarding your medical care or treatment?

Participants commented on both the good and bad aspects of their relationship(s) with their healthcare providers. Some participants mentioned having stronger relationships with specialists than with their primary care doctors, while others felt ignored or misdiagnosed despite repeated insistence they felt something was not right.

Good providers were associated with going above and beyond by listening to patients (e.g., having time, feeling like your concerns are taken seriously, having the doctor prioritize your main symptom, having a relationship), complying with patients' requests and letting them make decisions about their care, not doing anything to make patients "second guess them," being on time, being respectful, and acting in a timely manner.

"She treats me very well. She is very helpful. She talks to me and everything."

"...the specialists...we have a great relationship, but it's trying to access them [that is] a struggle."

"[My] Psychiatrist is really good about [listening to me], but most of the other ones aren't, it just depends."

Bad providers were associated with prescribing medication inappropriately or dismissing concerns that patients believe to be serious, talking down to patients (e.g., you need to do this or that), not listening closely, judging patients on their appearance, not being able to diagnose or treat a problem, and making decisions on treatment without really listening to the patient (or seeming like they don't).

"So I also know that there are a lot of people that get railroaded, if you will that doctors, could tell them anything, [like] 'you have a blueberry fever' and expect that they would believe that...because if someone's speaking in [medical] jargon or lingo, [their level of understanding is] up here [and] your level of understanding is down here, again, speak in plain English."

"And I'm tired of this doctor, this PA fat shaming [me]. I exercise, I get over 12,000 steps a day, according to the halo fitness tracker that I have, which I got because I was sick of the doctor that shaming me so that I could prove that I'm active. ...I'm not lazy. I just don't lose weight between the fibroid, the depression that you know, all these different issues. And so stop teaching me about my weight, but then we'd have a better relationship if she would just [listen]"

"[When someone isn't feeling healthy,] emotionally it'd be that the person ... would be more isolated, wouldn't want to talk, would stay away from the group. Or also, he could think about other things ... like not wanting to live ... feeling pain, fatigue, and a lot of stress."
... "The consequences of stress are very bad."

In terms of relationships with providers and getting care, one participant spoke strongly of needing to take an active role, including being their own advocate and working or having certain knowledge to get what they want from the relationship or in treatment.

"I have to be my own best advocate. And so I tell him what I'm feeling suicidal. I tell him if I'm having [intrusive] thoughts, because it scares me and I want to stay alive. And so I do everything I can to stay alive. And so you have to build that kind of relationship and well, and the trust. You have to be able to trust that doctor, not to send you to the psych ward, just because you're having thoughts. There's a difference between having thoughts and acting on thoughts and a lot of younger doctors, psychiatrists, family, doctors, they don't understand that you have to have a doctor that's willing to listen, ask probing questions. And if they're not asking probing questions, you're fired, you're fired."

Communication between providers also doesn't always happen as well as it should.

"And I was using forest community health center just getting bounced around between doctors. So every year it feels like they, one of them leaves enough to start all over..."

Some participants mentioned that because they do not appear sick, or having an "invisible condition" their doctor, provider or the community does not treat them as seriously as someone who is more apparently of ill health.

"With these [issues], especially the ones that you see where they don't have 'litmus tests'. Oh yeah. There it goes. That's what you [have]. Those things that connective tissue disorders, it seems like you got these range of symptoms. You can have an advocate with you all the way along and it still doesn't mean smack because nobody likes to put an actual label on. Which means if you can't get a diagnosis, then how you have support from insurance - medical, support from your family, any of those kinds of things. I see some real problems with the level of communication, it's just it's I understand, sometimes I feel guilty... It's like the opposite was he was trying to prove you're sick or something. He wants to go through, no one wants to go through this kid of crap."

Participants also had a sense that time can dictate the provider visit. There was also comparisons made between American health care and health care in other countries—often the other countries' were seen as better for the factors being compared.

"It is as if they had a timer. They arrive, they spend three minutes there, and then they have to go. It seems like they're already prepared—You have to wait one hour in the waiting room, half an hour with the nurse and three minutes with the doctor. The doctors receive bonuses for doing that. Just like cops receive one for

each ticket. It is the same."

Participants also spoke of a desire to have physicians who look and sound like them, to help them feel at ease in a medical setting. Others cited a lack of health care providers of color as a concern in the greater capital area.

"...personally only liked to [get care from] people who look like me, preferably a man, and this area lacks people of color in medical professions all over and the closest black male doctor that I found within the network that I have access to was 45 minutes away from me. And I was like, well, I'll just keep my primary care physician in North Carolina. But I can't because that person is out of network..."

"I've called the insurance company and there's no one who speaks Spanish."

"I would think, "Isn't there even one therapist that speaks Spanish who can treat me?" There isn't one. There is an interpreter for everything. I feel embarrassed that the interpreter has to know every detail about your life. It is a headache. That has been frustrating to me, the interpreter. It happens in Michigan, but it doesn't happen in Miami or Kentucky, but it does here in Lansing."

"There are things about medicine that we don't understand in Spanish. Well, in other language is worse. They have to do it in our language."

4. What has been your experience dealing with your mental health? Have you ever tried to access mental or behavioral health services? If so, what was your experience?

ACCESS TO CARE:

Many participants expressed frustration at mental health services often being hard to access, whether because they are expensive, difficulty finding providers that accept Medicaid, and language barriers. Concerns were heightened during the pandemic because even more people sought help, stressing an already limited community health resource.

"In terms of mental health with therapists in this area, I think first of all, people, the fact that people have been able to access their mental health therapists there, they should consider themselves very, very fortunate because there is a severe shortage of mental health professionals in this area. Those that are available, especially if you are a person who requires medication the number of psychiatrists are remarkably low, even though Michigan State has two medical schools, which is laughable. We have two medical schools. Yet here are no psychiatrists in Lansing."

"I tried going to U of M I had to wait. I was put on a waiting list. It took me like four months before they called and they actually didn't call me. They sent it through my, my chart account, which is the portal online. Well, I don't know about the rest of you, but I don't usually check my portal online every Sunday. So it sends you an email to your regular email to let you know that there's a message. Yeah, that's what I do if I didn't have that set up. So, you know what, that's one of the things that I think is really interesting. And then for a while, during the pandemic, everybody was going crazy. So there was an even bigger shortage of appointments that were available and it's, you know, that's one of the things, when you said, how back in the beginning, how would you cope? You're pretty much just on your own because there was nobody to help you cope. Because there was a shortage of doctors."

Access can be especially difficult when seeking mental health care for children or adolescents.

"Well, let me start out by saying mental health in this area sucks for children." •

"She has ADHD and it took me three years around her pediatrician to find a therapist who would take her..."

"I have a friend who had a daughter in crisis. They spent five hours [in] McLaren's ER, and they were calling around themselves to find an open bed for her daughter and finally found one in Pinerest in Grand Rapids. ...They told her, it's like, you have to be here in 90 minutes or we're going to give [the bed] away."

Culture can also be a barrier to care:

"[During my appointment] I would think, 'Isn't there even one therapist that speaks Spanish who can treat me?' There isn't one."

"I feel like there are just so many layers because sometimes it's like doctors and like [another participant] was talking about having doctors who look like you, and are able to communicate with you in ways that you understand and are culturally competent, that becomes an issue or a barrier."

5. What's your experience with chronic diseases? How do they change your life? How do you get treatment for your condition? What has been your experience been like trying to get it under control?

Participants' normal activities or even sense of self can be impacted by chronic disease. There were several instances when participants felt they had trouble adjusting to their "new normal" or new limitations in their lives whether the condition affected them personally or someone close to them. Others realized that they have put off managing their care and feel wary of where that will leave them when their condition progresses.

"My brother, he had renal failure and he passed away. [I would] take him to dialysis and I'd get up at five o'clock in the morning and take him over to dialysis and come to work. It's just a disease that you can fight or give up or not when you didn't get help before, because he had diabetes before [it progressed]. And it didn't [get better], it just progressed into kidney failure and he wasn't candidate for transplant so it just took its toll."

"…something I've learned over the years, too, with [being a] mom, or life, or you don't take care of yourself, it will catch up to you…"

"There is the…stubbornness of trying to change or to make certain changes happen…sadly, it's not until it's sometimes worse [that people seek treatment or help.]"

Medications can be invaluable when trying to control chronic conditions and sometimes it can be a challenge to get a prescription renewed or refilled.

"It took lots of calling and lots of patients and lots of crying. I finally did get a refill on my [blood pressure medicine], after I told them [and had to] explain how blood pressure issues can be life threatening for me. And then they finally made it virtual appointment that I had to wait and it was terrifying."

"And it hadn't even occurred to me that I would run out, even though it happens. I've been on same medicine I'm so used to just going and getting more and that wasn't something I could do [after I lost my insurance]."

"The insurance wants to tell me the Healthy Michigan program that I can only fill the prescription I've been on for 17 years, 30 days at a time, I'm not going to not need it. Guys, just fill it for the 90 days and move on. That's the dumbest restriction. But yet this woman who is on a controlled substance and presents her driver's license at four different pharmacies and fortunately she's okay."

People with chronic conditions may be resistant to those trying to help them make a change.

"I remember a conversation with one of my teammates when she told me she was taking certain pills and I could see her, I could see what she looked like, and I'm pretty sure they were like pills to help her to live [with her conditions]. And I offered to…next time we talk, let's just walk while we're talking. I mean to, to walk [and talk] or to walk the dog, it's like, no, just us walking while you're [here], she's like, oh no, I'm not going to do that."

Participants discussed trouble explaining or having people understand disabilities, especially "hidden" or less common disabilities.

"When doctors look at me, all they see is age since I'm [very young]. And since like, I'm so young, [and] I hate this phrase that the I've heard so many times, oh, 'you're too young to have all this wrong with you' when that doesn't even matter."

"Sometimes it's…you're born with it. Sometimes it's an accident that happens on later in life. There's no [difference] because…half the time people don't even know what I'm talking about, which means that if they don't know what I'm talking about, I'm not really going to trust them and they're just going to wing it. But them wining it, you know, it could hurt me more than I am."

"So when we go to [dance] competitions, people give her weird looks too. Cause they just saw her. If she's in a wheelchair, it's more dirty looks, than weird looks. More like 'why are you here?' rather than, 'oh that's so cool'. It's just kind of like why, why? And instead of celebrating the fact that you can do it."

Thinking back to the time before you or your family member developed the disease – what things, actions, or interventions might have prevented them from getting it in the first place?

Environment, diet, and genetics were all named as contributing factors to getting chronic diseases. Participants said that while chronic diseases have a genetic component and some have unknown causes, lifestyle can play a role in helping to prevent many diseases—eating well and exercising were mentioned, and there was also a discussion about stress and the harm that it can cause.

"My earliest memory is the asthma which I had struggled with my whole life only to, as an adult find out it's not hereditary [as I thought]. It is something you can grow out of if your parents aren't smoking or living in a house with black mold, smoking while she is pregnant and that in itself is a condition that actually then as I got older…I always brag that I never broke a bone. I did get a little bit better for a few years around middle school. I didn't need to have them [inhalers] there with me every day. Then, I found out what cigarettes are. I had seen them everywhere. So it was just natural for me to pick that up. And I just quit about five years ago. I wish I quit [earlier] seeing [how I was] having asthma and high blood pressure and partying, not knowing what high blood pressure was. I just assumed it was the cocaine that was making me sick. Yeah, it's been a wild ride. I would have not done that for sure."

Education was mentioned as something that could help people make healthy changes.

"Classes like this one on education are very important, especially for our culture. … And by sharing—depression is something that has occurred in my family, so being aware, seeing that people in my family have suffered through that, being conscious of being more active and that it's okay, and to look for help, or talk with someone. But, education, like this class is what makes it easier."

6. Sometimes the neighborhood / area people live in can help them to be healthy, or make it hard to be healthy.

Being healthy can take a lot of personal effort—from finding free/low-cost opportunities for activity, learning how to eat/buy healthy food, getting to stores, taking the time to cook with fresh produce, and more. It also might require resources (time or money) or abilities (teach oneself about nutrition) that people might not have. Some changes that need to be made, like with the physical environment, may be out of participants' control.

What are the things around where you live that help you to be healthy?

Participants mostly thought of factors related to the physical environment, programs and resources, and community building/relationships when discussing what in the community helps them to be healthy.

PHYSICAL ENVIRONMENT:

Many participants discussed how they appreciate being outdoors and having the ability to exercise without the use of an indoor, dedicated gym space – though those spaces were appreciated by some participants as well. During the pandemic, opportunities to be outdoors has also taken on a larger stress management and social connection role as well. Easy access to fresh fruits and vegetables (farmers markets, the mobile food pantry, personal and community gardens) were also appreciated and similarly functioned as a coping mechanism in the face of COVID-19.

"The great thing that I love about Lansing is it literally, almost every neighborhood has a city park. It's either a big one, or a small one depending on which neighborhood you're in..."

"The number one thing [I've noticed] is community gardens. I've never seen one of them, never before [I moved here]."

"So when he [my son] came back to Alive [in Charlotte] that was like huge for him just physically, mentally. But that it was a risk too with the COVID. But those are the places they can help with mentally and physically."

"I live here in Eaton Rapids and I don't know, it's walkable and they all have the parks area we go to, and I really like Charlotte. They have the pool there and they have Al!ve...we have a health center here [in Eaton Rapids] but it's not very big."

"We have a nature center out there to take our kids down, go fishing."

PROGRAMS AND RESOURCES:

Participants appreciated programs that helped them to afford especially healthy food including: food distributions offered by various agencies, food stamps being accepted at farmers markets and nutrition education opportunities. Free and low-cost opportunities for physical activity, through programs and in the built environment, were also mentioned.

"I like how Charlotte and Eaton Rapids have the farmer's markets and WIC gives us farmer's market bucks in the summer. And then if you have the EBT like double it or whatever, I wish that Potterville and Bellevue had farmer's markets where they're actually, they're not like food. They're not farmer's markets. Like the ones that are here."

"I live on the east side and so Allen Neighborhood Center is my neighborhood center and Allen Neighborhood Center is one of the exceptional neighborhood centers. We have we have the community gardens in our area. We have a number of those of the center services. We have the food distributions. We also have the, the walking [trail] that you can do at the local - I think it is Foster Park. You can walk two days a week, if you walk five miles, you actually can get coupons to use at the farmer's market."

"Here in Eaton Rapids that VFW home place. We'd have like a workout park like right by the ball fields, because my son played baseball [there for years]. And they actually practice there. And the younger kids would play on this little workout park where like everything has station and it showed you what to do, like a ninja deal. I wish like our county parks had like that option too..."

"That would be excellent. It would be a big draw. Fitzgerald Park. That's a big park, but then it costs to go there, it costs to go to all these parks. If you're [in your] county of residence it should be free. I'm sorry. I mean, I can't even for him to go to Potter Park Zoo, it's $10. It's ridiculous."

COMMUNITY, RELATIONSHIPS, SOCIAL INTERACTIONS:

Talking and bonding with others in the community and mutual respect were named as conducive to good health. An undercurrent of several of the focus groups is the role that social support, in any capacity, is extremely beneficial to mental health and to a sense of community. As society at large becomes more connected through social media, new resources and connections can emerge.

"I live in Bellevue. It's a small town and pretty much knows each other...I just love the small town feel."

"And they're like, we don't even understand why people won't show up to get the free stuff [from the food pantry]. It's like, you don't have a relationship with them. And so they see you as somebody that's judging, even though you're handing it to them, or when you deliver the food, you just leave it on the doorstep and run like, do you want your food left on the porch? No. When I did the mobile food pantry here in Lansing, we, as our fraternity, we had a certain number of houses [we went to]. ...We had conversations, they were happy whenever we came and they were looking forward to it. And so, I think that if we do things like [like that] they have to be local enough that the people know and trust are going to stamp the approval and, and to just trust the people and be honest. [They need to] know that they're human, just like all of us, it's just their life is just maybe a little different."

"I've actually gravitated to like people that are interested in meeting in person, because I went from going to the office, going to the law school to come home, all of those being separate spaces to all of them being one [virtual environment] overnight. And that was

really hard to get accustomed to. And I'm like super outgoing and social. So like I need those interactions. So like that, like my you know, some, you know, a select handful of people from my community has been really just amazing as far as having that mental outlet."

"Facebook for [my daughter's condition], has been a great resource for us to ask questions [to others like us]. Like, is this normal?"

"I would messenger, Facebook messenger with people or use WhatsApp. So I could see people in person and we chat or we'd be knitting, we'd be crafting or something at the same time, even though we're not in the same room…that's why I was telling people to try and do stuff like that. Cause it makes a difference."

"I find that through COVID things like the networking group I belong to on Facebook, there's a 517 living page that those community pages have become extremely important because otherwise there wasn't a way to get that [important] information out."

What are the things around where you live that make it harder to be healthy?

Conditions affecting the physical environment, programs and resources, community and relationships, safety, housing, substances, and health care were all discussed.

PHYSICAL ENVIRONMENT:

Participants in different groups discussed a lack of safe places for physical activity (including unsafe/not complete sidewalks, lack of nearby parks or parks that are not maintained, no nearby low-cost exercise options, and no indoor options (for when weather is bad). Many discussed the food desert effect, where places to buy healthy, less expensive foods are harder to access (especially regarding distance and transportation) or fewer in number and places that don't have healthy food options and/or that are more expensive are closer or greater in number.

"My house is close to a park. In that park, they don't mow the lawn. The grass is knee-high. How can you run in there? How can you go for a walk there? You can't. You have to walk on the concrete, on the streets."

"They don't clean or put enough garbage cans [at the parks] so people throw trash there, and they don't mow the lawn."

"There are more marijuana stores than parks. To me, that affects us a lot."

"[Hills and parks] have been closed where kids used to go sledding, and now, they can't. You have to pay to get to those places. It is not fair. What else can you do in winter but to go sledding and play outside with snow? They just can't. They don't have the parks for them."

"They should make as many sports fields for kids as possible, they have to exercise. What's the point of having a physical activity device [indoors] instead of them going out to play, run, and exercise?"

"[I wish I could go to] the gym, but I can't afford to go to Alive because I don't make any money. I know. I wish they had…a sliding scale or anything. Like they don't have an assistance if you're low income. You have to pay the $40 a month…" "What gets me is the added childcare. So it's not just that I'm paying the gym and I have to pay the kid fee every month for them to go into the [gym]…Just forget it. I'm going to walk."

"It wasn't a problem in my current area, but where I grew up, it was three or four miles to the nearest grocery store. And it's like, this sucks. And there's a lot of places like that, where there is little access to the healthier foods and to the fresh foods."

"If [you] want to go to Quality Dairy, fine that's like a mile walk, hike yourself up there. But all of they have ice cream and pop and chips, and maybe they have bananas, maybe they had apples. But you couldn't get anything walk anywhere closer. It was always, we're going to go buy groceries for two weeks because Meijer's four miles away."

"Well, and it's, if [healthy food is] not costly in money, it's costly in time because it takes time to make all that stuff."

PROGRAMS AND RESOURCES:

Even with assistance programs, some people still can't afford the food they need (healthy food is often more expensive), and some food assistance don't give out very healthy food.

"Yesterday on Facebook [there was a discussion] about giving away seconds for free or the ones that have blemishes for free to people. And I said, well, you know, people who need food deserve firsts. I see this all the time. When you go to a food bank [the food is] expired or this and that. And it's like, you don't just donate expired food. These are still people, I'm still a person who needs to eat and I deserve to eat food that's healthy. The food that they give us from commodities from the food bank…beef stew has over 1600 milligrams over 1,600 milligrams of salt, sodium per serving, per serving! They're [giving] these to the people in low income housing. This is all connected to health. You're giving it to people in low-income housing and elderly. So they're just, and this is horrible food to give people in these situations."

"Yeah, we can [get some nutrition education/ skills] through like the MSU thing [SNAP-ed]. I mean, they don't even have home-[economics] here anymore. Right. They have a health class that they can take a new kid and learn about this and that. And that's through the gym teacher."

SAFETY:

In several groups, a lack of safety was noted, especially in the more densely populated areas. Participants said that nearby parks and neighborhoods were unsafe (due to drugs and drug paraphernalia, fast traffic, finding bullet casings on the sidewalk, etc.).

"…as long as you're not on Grand River and you stand a good chance to not get run over. So you stay away from certain places after dark especially the Fox Island, which we call 'Stop and Rob'."

"What you said about getting run over? I live in the middle of nowhere and when the gym was closed, I was running and walking outside a lot. But like their cars go like 60 plus on a road. That made it really dangerous … it's snowing outside and there are cars going like 60 miles an hour, like right towards [me]."

"I feel like since people started driving again, there's been a lot more careless drivers. People not running red lights. Yeah. Those a lot more hurry to get nowhere than there used to be. Or there's no consideration for others. No, zero, zero."

"I wish there wasn't gun violence and that people… knew that they could reach out. I think

a lot of these zombies that I see walking around shot up and way riding on the sidewalk …no one's told them there's another option."

"It is discouraging to find so many needles and not have a way to dispose them."

HOUSING:

Affordable housing was seen as a challenge. Section 8 housing is seen as hard to find. Even for existing housing, maintenance may not be done or landlords may not address pressing issues including some that can affect the health of their tenants.

"The lacks of housing, apartment for section eight and all that stuff and seniors, I feel like all the community pages, everyday people looking for an apartment. And it stinks to be in that situation."

"[People] may not have the things that allow you to breath healthy. My neighbor, they haven't had an AC for two weeks. I mean, I don't know if it's the landlord's responsibility to provide an air condition, but it was hot and they have two kids and they've been in the house for two weeks [with no air conditioning]."

7. We are interested in making our community a healthier place for everyone to live now, and after the pandemic ends. Are there any concrete steps we could take to make that happen? If anything we possible, what would help your family be healthier?

For the most part, participants reiterated statements that had made earlier in the discussions and did not have many concrete examples to share. The few that were shared centered on a solitary point-of-contact for services and information (e.g. not having 2-1-1 route you to different departments or people). There was some discussion in the Disability & Recovery group about frustration with enforcement of handicap parking spaces and elimination or moving those spaces to make places for curbside services.

"The one thing, if we could just right now eliminate some of the diversification [of contact points], unify crap, stop making people go to 17 places to get one vein of information."

"They need an education campaign about the abuse of handicap parking, just because you have your disabled grandmother in the car and you're, and you're parking there while you, you you're able body self, runs into Meijer to get a few things. That doesn't mean that mean you need a space."

"...Or are you guys blocking the curb cuts while they go into deliver a package and the loose drive spaces, what was I'm out? Parking spaces, motorcycles, or bicycles, or small cars. They are there for people to get in and out of vehicles. And for people who have ramps that need them to be dropped. And the fact that nobody enforces these parking [laws]."

"...enforce [the parking laws]. When was the last time you saw someone get a ticket outside Michigan State University?"

"[In] the age of now you can pick up your groceries, they take it all the spaces that are right in front of the door and they've turned them into [non-handicap] parking spaces. So if you have a paid job or you're getting stuff delivered or whatever, you can park in the spaces that would normally be right in front of the door. So today I parked in [front of] Home Depot, I parked in a space that was for somebody getting a delivery. And the girl said, are you here for deliveries? I said "handicap" She said, oh, okay. Thank you."

8. Is there any other thought you would like to leave us with? Anything else you would like us to know?

Overall there were no large common threads or shared thoughts that were not expressed in other questions for the focus groups. Participants returned to themes and comments made in previous sections, expanding in detail slightly. Other miscellaneous comments made throughout that were important are also noted here.

TRANSPORTATION:

The impact of COVID-19 on what was already perceived as limited transportation options in rural Eaton and Ingham counties was noted briefly in regard to accessing care.

"Linden transportation, Eatran stopped and people who don't have a license and can't get [where they need to go]. They're dependent on their family..."

"They lost employees too...because schools shut down. That was their biggest [client pool]. They were doing a lot of driving kids to school."

IMPORTANCE OF AFFORDABLE HEALTHCARE, NOT JUST ACCESS TO CARE:

Though it was noted at several points during multiple focus groups, the importance of being able to afford healthcare – especially prescriptions can make a difference.

"[Make] Healthcare more accessible with lower the prices of like drugs, I mean prescription drugs. For myself, I had I think they've increased for...about 60% over the last two, three months. I mean, I pay out of pocket. Not a lot of money. Two months was [decently priced], I think that would help us with a lot of people on a fixed income have to pick between eating or medication and things like insulin, things like that."

MISC.:

One participant noted the difficulty in large scale change, noting that at times, the issues they discussed in the group seem too hard to address for just one group of people.

"...when I think of what can be done post pandemic, whenever that is, when I think of that, I feel like it feels too big because a lot of the issues that have been exposed are systemic and feel like, um, hard to capture just for like one group of people."

But despite that, focusing on smaller and more achievable change and relationship building can also create a sense of impact and that things are moving in the right direction.

"I think what you guys are talking about [with community] relationships is really important. So I think like 'doctors and donuts' or something...being able to connect with your doctors and stuff like that. Like what if there was a space for people to like talk with their [male friends], with their medical providers, just like on a relationship, like type level...then I thought about counseling. What if there was a group counseling session, like a healing circle that met weekly...something that could build relationships...I know that building relationships isn't going to solve everything."

Other participants had noticed the challenges presented by students returning to in-person learning environments from virtual schooling.

"It was like they were different [people than before] and that took more [time and effort] to just get them rolling. But for those who were virtual all last year, and that was stepping through those school doors. It's gonna look a lot different for [those] students. You have kindergarteners [coming in] and I was the one in first grade and it might be the first time they were like stepping into the building. Even our son was in eighth grade, but now he's stepping into ninth grade. So certain ages weren't as affected, I think. But I think certain age groups are really gonna have to be supported this school year."

"I hope they have those counselors on deck for all those needs."

In summary, focus group participants shared a variety of helpful insights, experiences, opinions and information with us. Much of the overall discussion was directly influenced by the COVID-19 pandemic. People's experience accessing services and resources has changed considerably in the last 18 months and the overall health landscape in the Capital Area has shifted considerably as everyone has adjusted to life during the pandemic. Despite the considerable recent changes, there continue to be challenges in the area regarding access to affordable care and a shortage of healthcare providers of all types - especially providers of color, or providers who speak languages other than English, and specialists. Mental health has been a growing concern, but has taken on new importance in the face of the pandemic as social isolation and disconnect has increased. Even though participants recognize the societal importance of mental health care, they feel there is still a stigma attached to discussing mental health in general.

The following themes emerged across a variety of questions and among many of the focus groups. They represent additional dimensions to perceptions about health in our communities.

MENTAL HEALTH

Anxiety, depression, suicide, and general stress were identified by participants as major mental health challenges. Some of these were attributed specifically to the COVID-19 pandemic and associated social-behavioral (e.g. social distancing, isolating from friends/family) and economic changes. Participants stated that addressing mental health is made more challenging by stigma and lack of affordable and convenient/quick mental health services.

"I know a lot of people my age [my early-30s] and especially around here are struggling with the same financial challenges and having access to mental health care alone."

"...my first [child] is going off to school and I did okay with that, and then probably the worst thing was packing up that little COVID bag. Like in case he got sick. So that was [when] it finally hit me, you know, that this [situation] was different..."

"...there is still a lot of stigma, um, in certain communities around getting health care, especially mental health care."

MENTAL HEALTH COPING STRATEGIES

Many participants relied on or turned to outdoor and exercise leisure activities for coping with mental health challenges, especially since the COVID-19 pandemic began. These included gardening, biking, visiting nature exhibits, and walking or running. Participants also mentioned using other leisure activities for coping with mental health, including watching television or movies, reading books, and conversations with family and friends.

"It helped a lot because there's, for me, at least gardening is something where I'm able to just go and relax. So that helped tremendously was having those outdoor options."

"I know that being connected to the right people around you is crucial..."

"...mental health wise, not working has been the biggest blessing. I hated my job. I hated my team. I hated my company...I can't stand them. So being let go [and] having a couple health challenges, not a big deal because I wasn't working there anymore."

"It's just been really nice to see the reconnection of people kind of gravitate back to more like some of the nuclear family, a little bit [of] people understanding the value of support in the face of everyday life and stuff. You forget how important those things are..."

CHRONIC DISEASE

Participants noted that insurance status, finances, and healthcare affordability were persistent barriers to chronic disease treatment and management. Some participants noted the difficulty accepting the reality of chronic disease and how it impacts them now and may in the future as well. A couple participants mentioned that their difficulty accepting the reality of having a chronic disease diagnosis made them hesitant to seek care and get the condition(s) under control.

"When you are low income and you are trying to survive at the clinic, having to start over every time you change your doctor and answer all those depressing questions and your life history is a little bit frustrating...I guess I understand why they have us repeat the story over and over, probably to make sure we're trying to get better."

"I am struggling with the reality of my situation...I will need a double kidney transplant...and when they tell me that I'm like 'no, that's not real.' But, the symptoms are still there, right?"

"My grandfather sat around and [he] had cancer, and knew he was sick. He would just always do what he did – his best to avoid going to the doctor as long as he can mask the pain [because of the cost]."

"...the challenge of not being able to have prescriptions just updated was the biggest [issue]. Having to see a physician and looking at a $200 office visit and going again, you do know I've been on this prescription for 17 years. Like I swear to God, I don't need to see you just write the script [and] go away."

BARRIERS IN THE BUILT ENVIRONMENT

Several participants noted a lack of transit methods, including: clean, safe, walkable and widespread sidewalks; affordable and reliable public transportation, such as buses, trains, or rideshares, especially in rural or remote parts of the county. A number of participants expressed a desire to have more local opportunities in the community for everyone to gain skills that can increase self-sufficiency such as: growing fresh food(s), financial education/literacy, and starting or developing a business were a few of the ideas mentioned. Participants were very interested in creating, maintaining, and improving community spaces, including gardens, parks, afterschool and recreational/hobby spaces.

"I don't walk alone at night. I don't put myself in situations where I could be in danger on purpose. It is discouraging to find so many needles and not have a way to dispose of them."

"It frustrates me that my parents live in a township that has no support for transportation at all...if you had to pay $8 every time you got in your car just to make it [to a] routine [appointment] appointment and could only go to one spot, you wouldn't do it."

"I can honestly tell you, my parents had the opposite experience [of being able to walk safely in their area]. My parents live in a rural part of [the] County and they are not aging as gracefully as I would prefer. So every time my dad gets in the car to drive them somewhere, I kind of worry that at some point something's going to go sideways. They're too far from most things to consider it [an easy drive]. It's 20 minutes to get into town. If they had a medical emergency, it takes the ambulance 20 to 30

minutes to [get to them]. So I can say, because of how involved I am with their world…that my world compared to theirs, if roles were reversed, it would be a much better situation. They would be much safer in my environment then than they are in theirs."

"The city [of Lansing] needs to fix the sidewalk and clear the damn sidewalks during the winter because trying to maneuver, my son and a wheelchair, or my mom who uses a Walker, trying to get to the bus stop is almost impossible. And we're not talking about the neighborhood sidewalks where people are supposed to clear them, everything we're talking about. [It's the]City owned sidewalks."

"[I wish there was more] locally grown food. It's really hard. I guess [maybe] not hard for most people that are low income that do qualify for food stamps. Cause the Allen [Neighborhood Center] and a couple of other markets, you can trade your EBT card for coins. So that's cool. But most of the people that I know still don't know how to plant seeds. That bothers me."

A SUPPORTIVE AND HEALTHY COMMUNITY

Participants suggested a centralized place for finding and sharing information, as well as more diverse communications methods. Concrete suggestions included: a personal care coordinator for those seeking social/human services or chronic disease management; and an increase in Youth programs aimed at keeping kids in a productive environment if their parents are working or unable to be home before or after school.

"Youth programs would be helpful if you could just find a way to reach them through [their] screens and get them involved [early in their lives]. I know there's a few different programs that are trying really, really hard to involve the youth. But parents are having to work more. So, there's no one to take them to the programs or to supervise [them]."

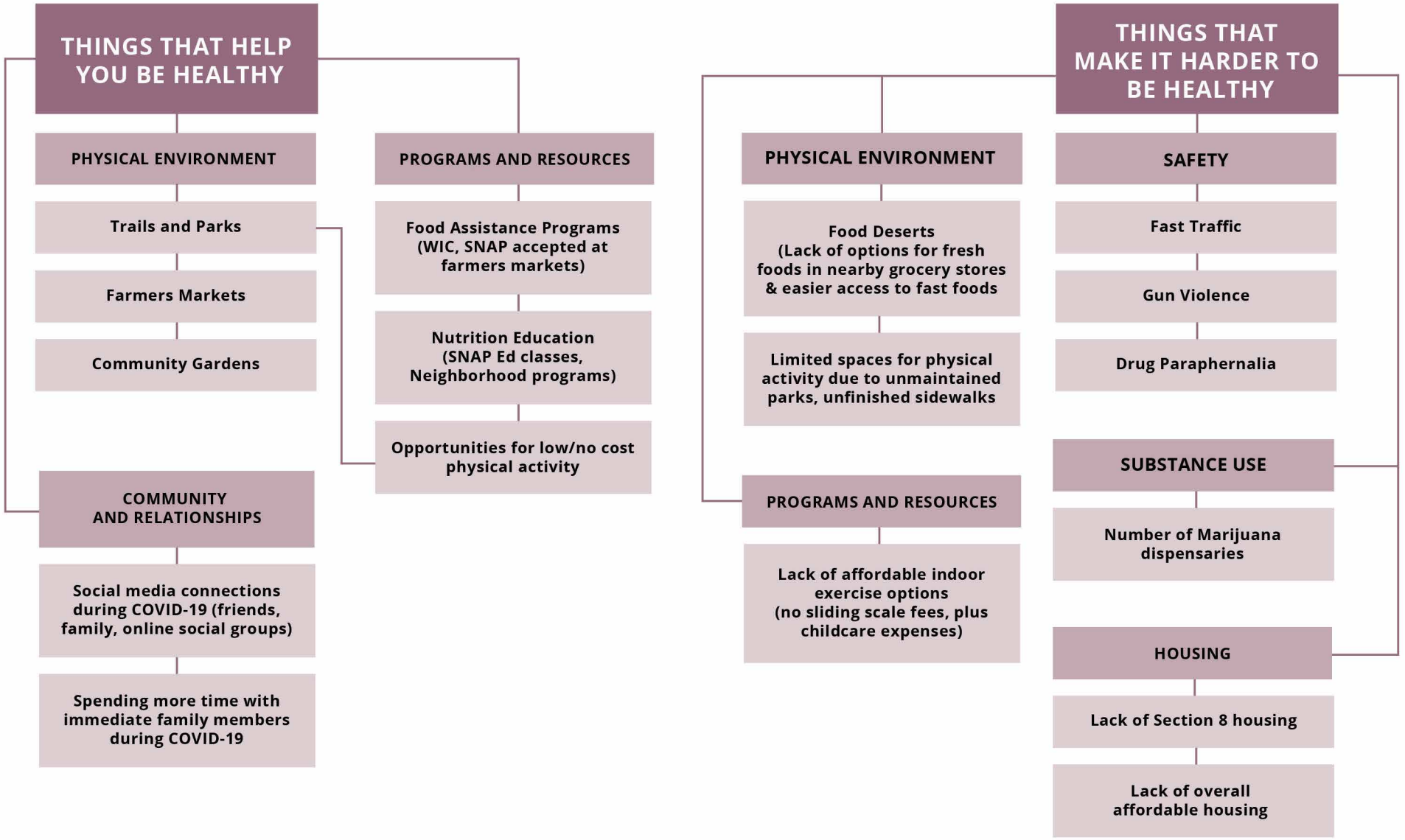
"So there's no central spot for people [to get information]. There's no one place to be able to say this is [what I need]. And I use my parents as an example because I'm very involved in their care, but trying to call senior services. They have the area agency on aging, they have seven or eight different, different programs and facilities for people that are aging and no one of those is the central point of contact. And that's the way things are for everything. It doesn't matter what you have. It doesn't matter if you're aging or you're a cat or, you know, whatever. Like there's just not one central spot…I probably call five different places just to refill the prescription I've been on for 17 years."

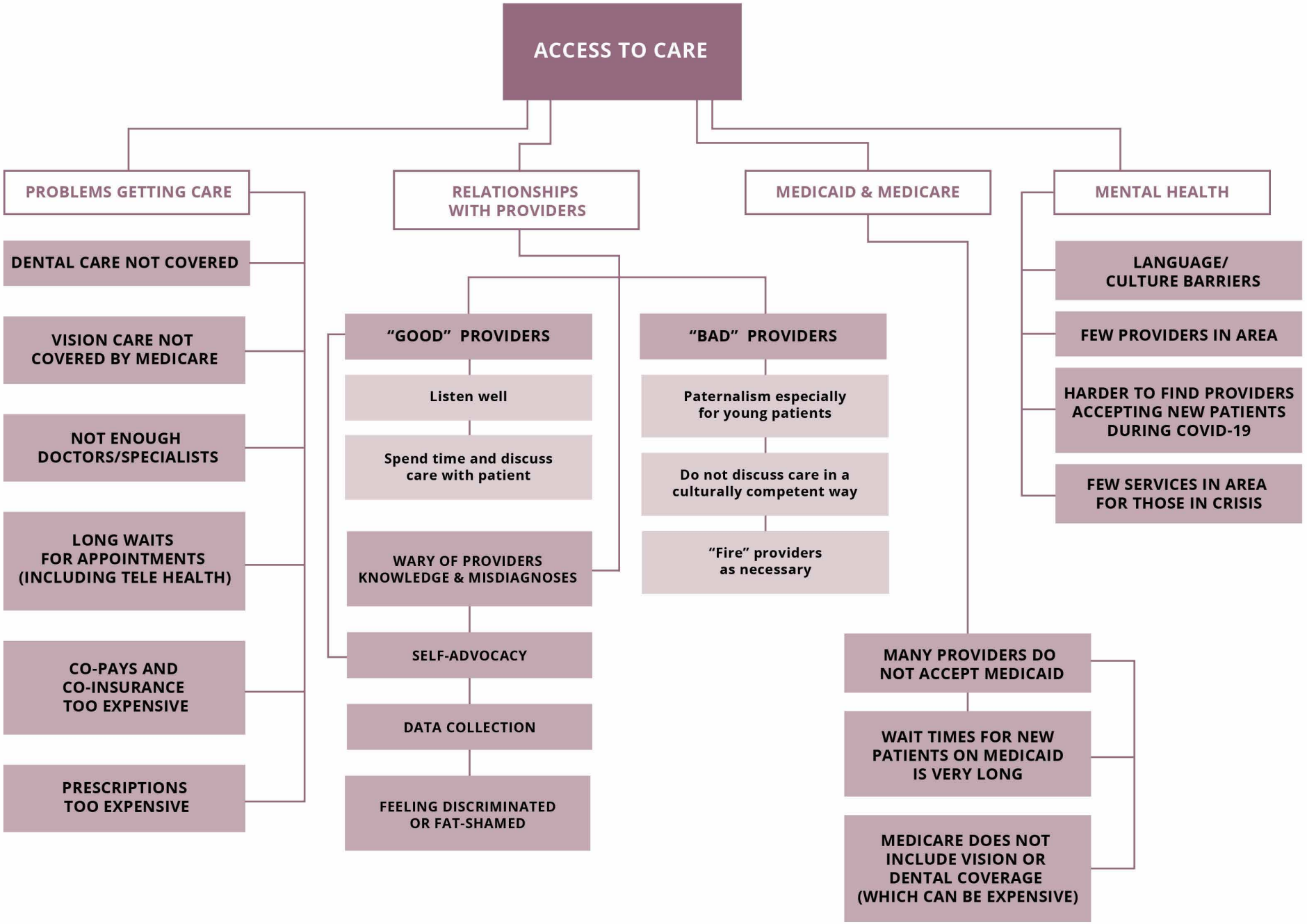
"I'm incredibly thankful that Meridian Township has a senior program where their police department will do routine check-ins for registered and elderly adults…"

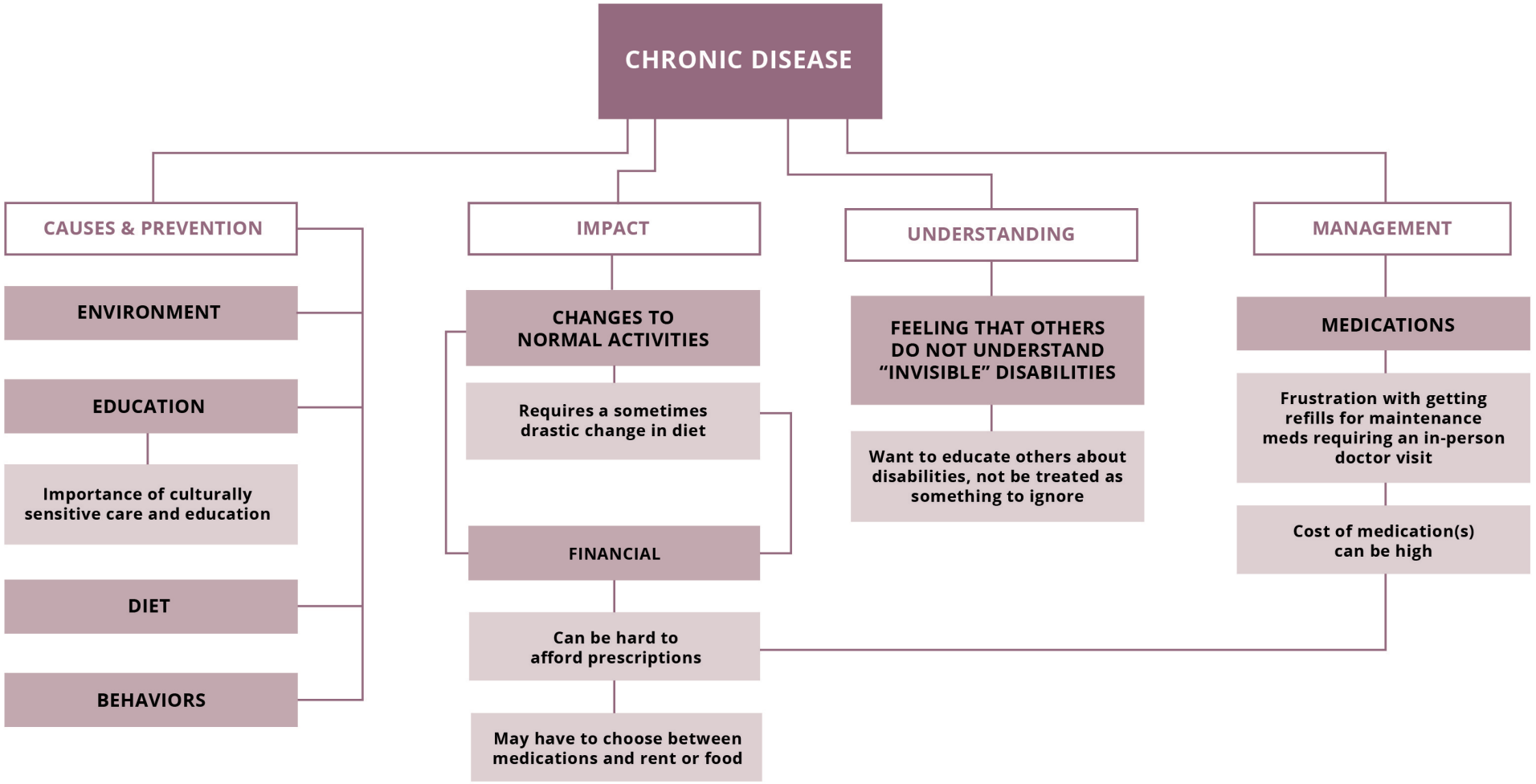
"…wouldn't it be cool as a working parent, if you could register your family, your address with, with the township and say, I work, could you check in on the kids"

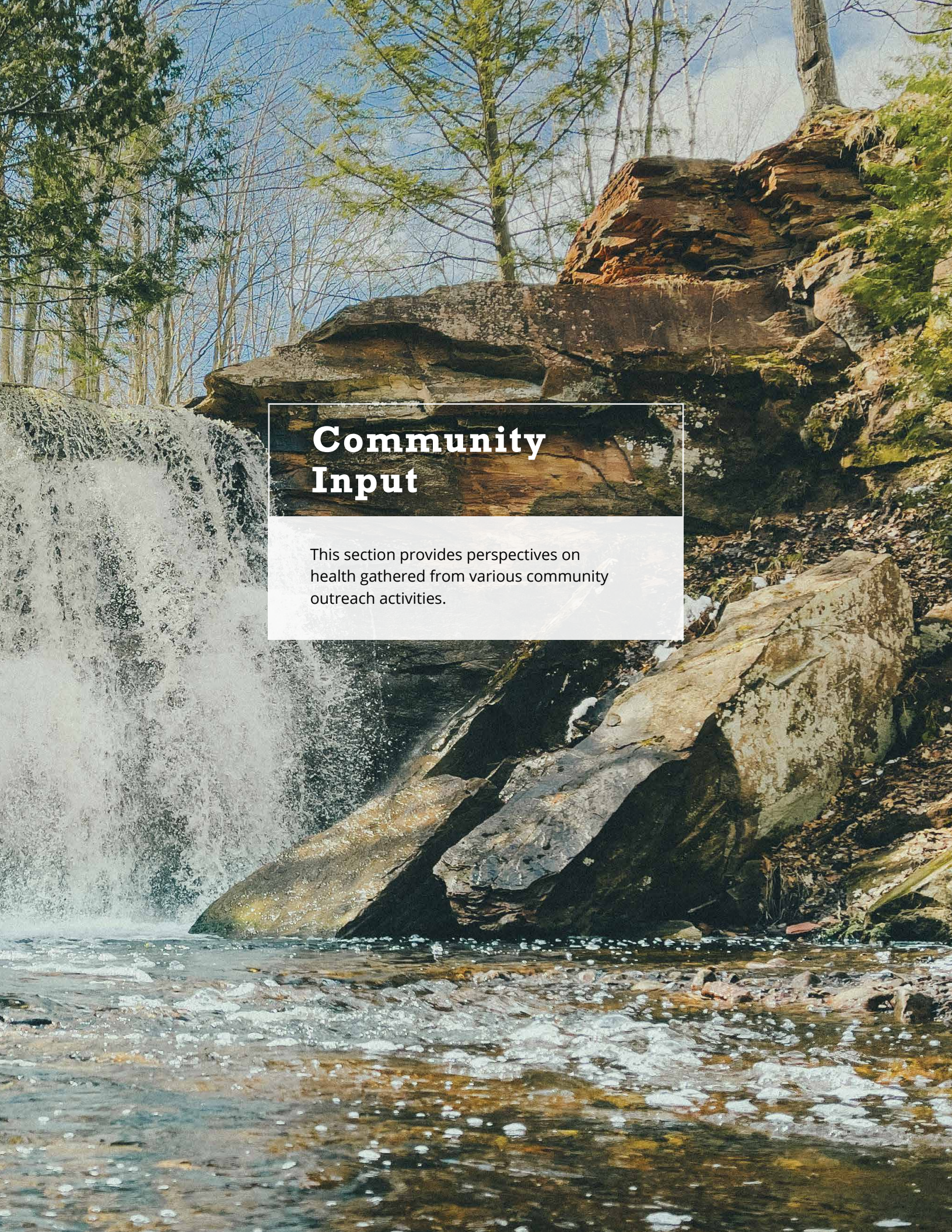
"[It would be] be fabulous if there was a care coordinator that you could go in, they do know your whole story. And if you're having a day where you do need pain management you [can just] call that person. They say, we'll have the pain manager call you in 20 minutes. You answered the phone and life goes on."

"It's like [we can use] this social media type of stuff, Facebook or anything…it seems like the way you set up kind of list of residents that need [help] with different activities. [Say you need help] on Saturday. And [someone has] some extra time to have them go help. …You know how this community yesterday has bigger projects, three or four or five people show up just throwing a half hour, hour here or two hours there. Somebody else donate something. Projects offers to people really quickly and just spreading the good feel without taking anything away from anybody…And just little things, little stuff you just don't think about the arm strength [for older residents]. You have to lift something off the top shelf. It's the kinds of things that you don't think about [that can make a big difference]."


THINGS THAT HELP YOU BE HEALTHY
PHYSICAL ENVIRONMENT
Trails and Parks
Farmers Markets
Community Gardens
PROGRAMS AND RESOURCES
Food Assistance Programs (WIC, SNAP accepted at farmers markets)
Nutrition Education (SNAP Ed classes, Neighborhood programs)
Opportunities for low/no cost physical activity
COMMUNITY AND RELATIONSHIPS
Social media connections during COVID-19 (friends, family, online social groups)
Spending more time with immediate family members during COVID-19
THINGS THAT MAKE IT HARDER TO BE HEALTHY
PHYSICAL ENVIRONMENT
Food Deserts (Lack of options for fresh foods in nearby grocery stores & easier access to fast foods
Limited spaces for physical activity due to unmaintained parks, unfinished sidewalks
PROGRAMS AND RESOURCES
Lack of affordable indoor exercise options (no sliding scale fees, plus childcare expenses)
SAFETY
Fast Traffic
Gun Violence
Drug Paraphernalia
SUBSTANCE USE
Number of Marijuana dispensaries
HOUSING
Lack of Section 8 housing
Lack of overall affordable housing


ACCESS TO CARE
PROBLEMS GETTING CARE
DENTAL CARE NOT COVERED
VISION CARE NOT COVERED BY MEDICARE
NOT ENOUGH DOCTORS/SPECIALISTS
LONG WAITS FOR APPOINTMENTS (INCLUDING TELE HEALTH)
CO-PAYS AND CO-INSURANCE TOO EXPENSIVE
PRESCRIPTIONS TOO EXPENSIVE
RELATIONSHIPS WITH PROVIDERS
"GOOD" PROVIDERS
Listen well
Spend time and discuss care with patient
"BAD" PROVIDERS
Paternalism especially for young patients
Do not discuss care in a culturally competent way
"Fire" providers as necessary
WARY OF PROVIDERS KNOWLEDGE & MISDIAGNOSES
SELF-ADVOCACY
DATA COLLECTION
FEELING DISCRIMINATED OR FAT-SHAMED
MEDICAID & MEDICARE
MANY PROVIDERS DO NOT ACCEPT MEDICAID
WAIT TIMES FOR NEW PATIENTS ON MEDICAID IS VERY LONG
MEDICARE DOES NOT INCLUDE VISION OR DENTAL COVERAGE (WHICH CAN BE EXPENSIVE)
MENTAL HEALTH
LANGUAGE/ CULTURE BARRIERS
FEW PROVIDERS IN AREA
HARDER TO FIND PROVIDERS ACCEPTING NEW PATIENTS DURING COVID-19
FEW SERVICES IN AREA FOR THOSE IN CRISIS


CHRONIC DISEASE
CAUSES & PREVENTION
ENVIRONMENT
EDUCATION
Importance of culturally sensitive care and education
DIET
BEHAVIORS
IMPACT
CHANGES TO NORMAL ACTIVITIES
Requires a sometimes drastic change in diet
FINANCIAL
Can be hard to afford prescriptions
May have to choose between medications and rent or food
UNDERSTANDING
FEELING THAT OTHERS DO NOT UNDERSTAND "INVISIBLE" DISABILITIES
Want to educate others about disabilities, not be treated as something to ignore
MANAGEMENT
MEDICATIONS
Frustration with getting refills for maintenance meds requiring an in-person doctor visit
Cost of medication(s) can be high



Community Input

This section provides perspectives on health gathered from various community outreach activities.

Community Survey

The Healthy! Capital Counties Workgroup sought to provide an opportunity for the community to give their input about the state of health in the tri-county area. To make participation as easy as possible, an online survey was created that asked about the defining characteristics of a healthy community, the most important health problems in their county of residence and county of employment, impacts of COVID-19, access to health resources, social needs, and health care barriers.

The community survey was available from February 26th 2021 to May 31, 2021 to people who lived or worked in the tri-county area. The 17-question survey asked participants about what they thought the characteristics of a healthy community were; what were the substantial health problems in their community; addressing social needs in health care; barriers to receiving quality healthcare; and their ability to access health and community resources. Participation was solicited via the following methods:

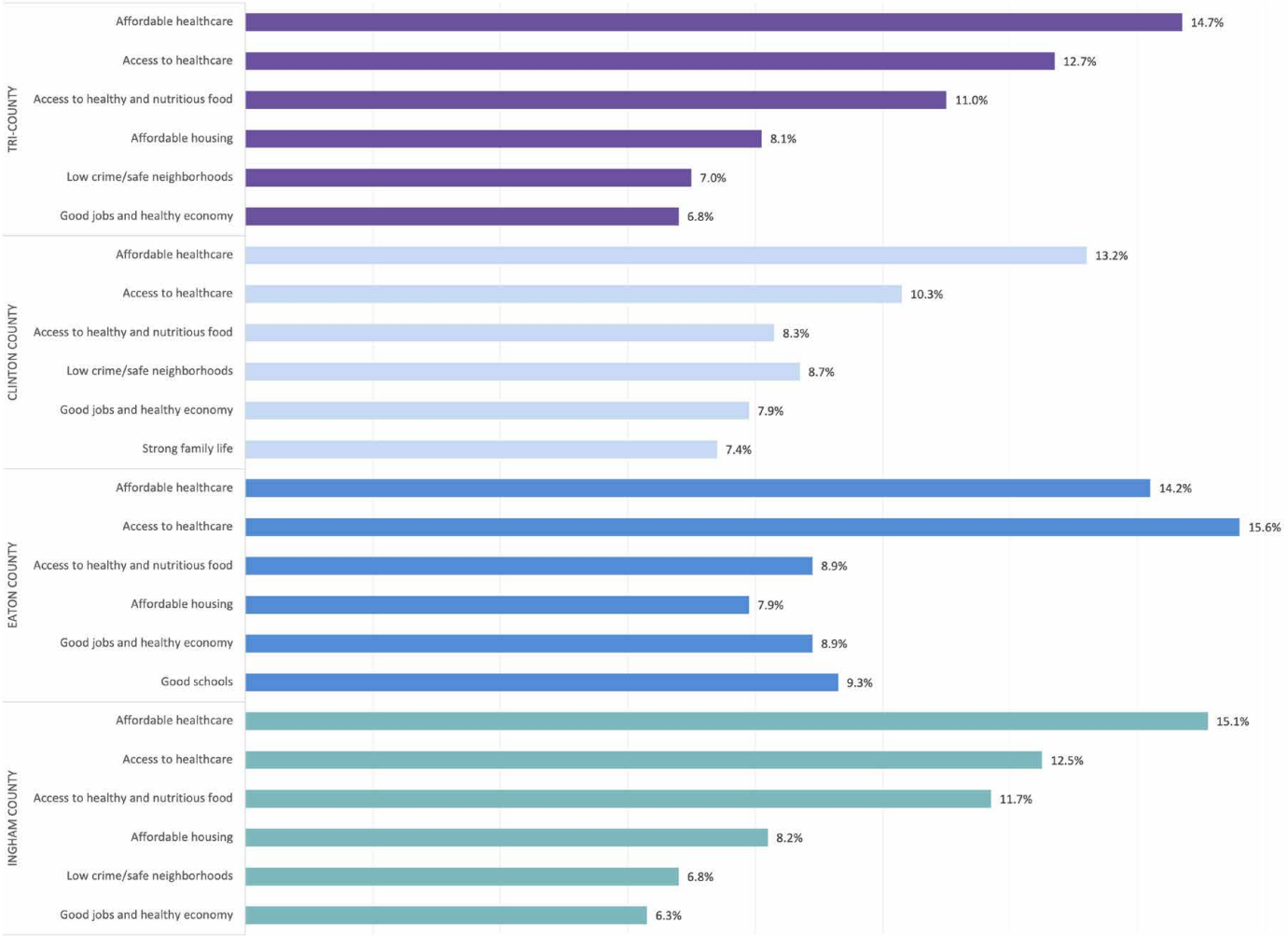
- Posting on the Healthy! Capital Counties website – healthycapitalcounties.org;
- Email invitation to the Healthy! Capital Counties list serve;
- Email and personal invitations to various partner agencies and coalitions within Clinton, Eaton, and Ingham counties;
- Facebook posts on health department and hospital partner websites;
- Boosted Facebook advertisements within the tri-county area;
- Printed handouts at various coalition meetings, community events, and health department locations including mass vaccinations clinics.

PARTICIPANT DEMOGRAPHICS

1014 responses were collected and 979 of those were from those who lived or worked in Clinton, Eaton, and Ingham counties; other results were excluded from this analysis. 96.6% of respondents reported living in Clinton, Eaton, or Ingham counties;

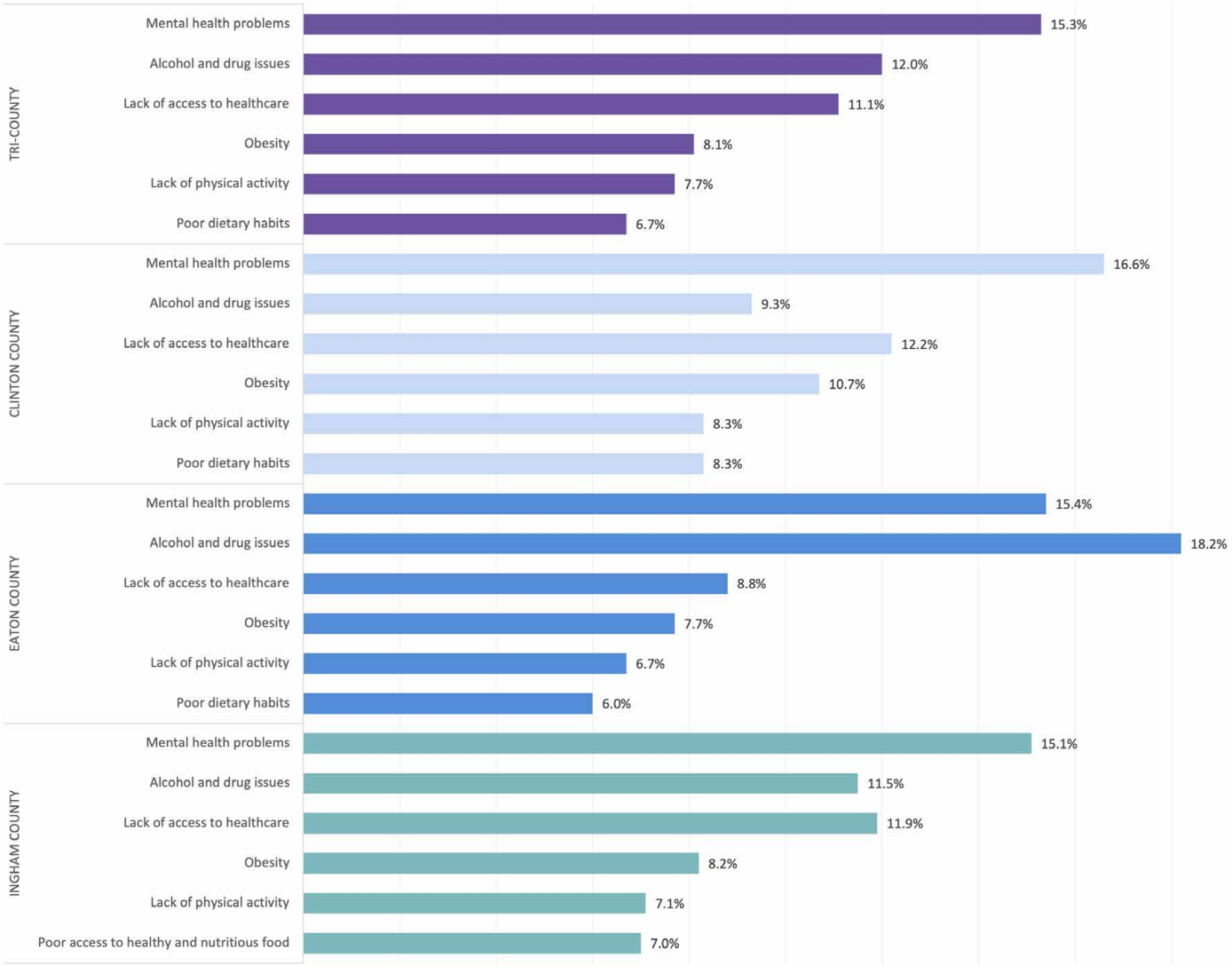
WHAT DO YOU THINK ARE THE THREE MOST SUBSTANTIAL FACTORS THAT DEFINE A "HEALTHY COMMUNITY"?

'Affordable healthcare' and 'access to healthcare' top the list of substantial factors that defined a healthy community for all three counties in the Capital Area. The third most substantial factor varied among the three counties. In Clinton County 'Low crime and safe neighborhoods' was the third choice. Eaton County chose 'Good Schools', while Ingham County listed 'Access to health and nutritious foods' as their third choice.



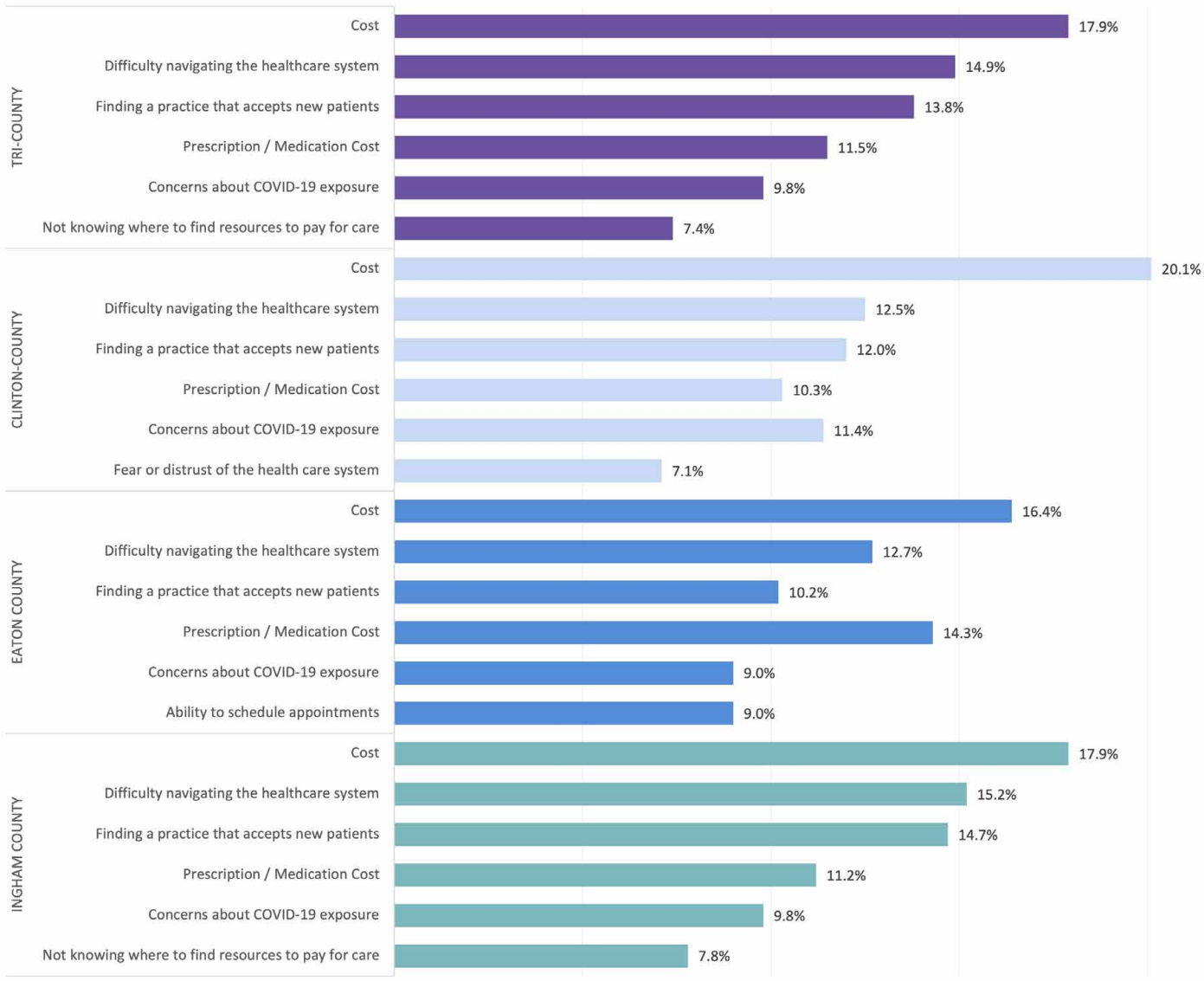
IN THE COUNTY YOU LIVE IN, WHAT DO YOU THINK ARE THE THREE MOST SUBSTANTIAL PROBLEMS THAT IMPACT HEALTH?

When considering the three most substantial problems that impact health, counties had varying answers. Eaton County listed 'Alcohol and drug problems' as the biggest issue, followed by 'Mental health problems' and 'Lack of access to healthcare'. Clinton County had 'Mental health problems' as the top concern, followed by "Lack of access to healthcare' and 'Obesity'. Ingham County also had "Mental health problems' as a top concern followed by 'Lack of access to healthcare' and 'alcohol and drug issues'



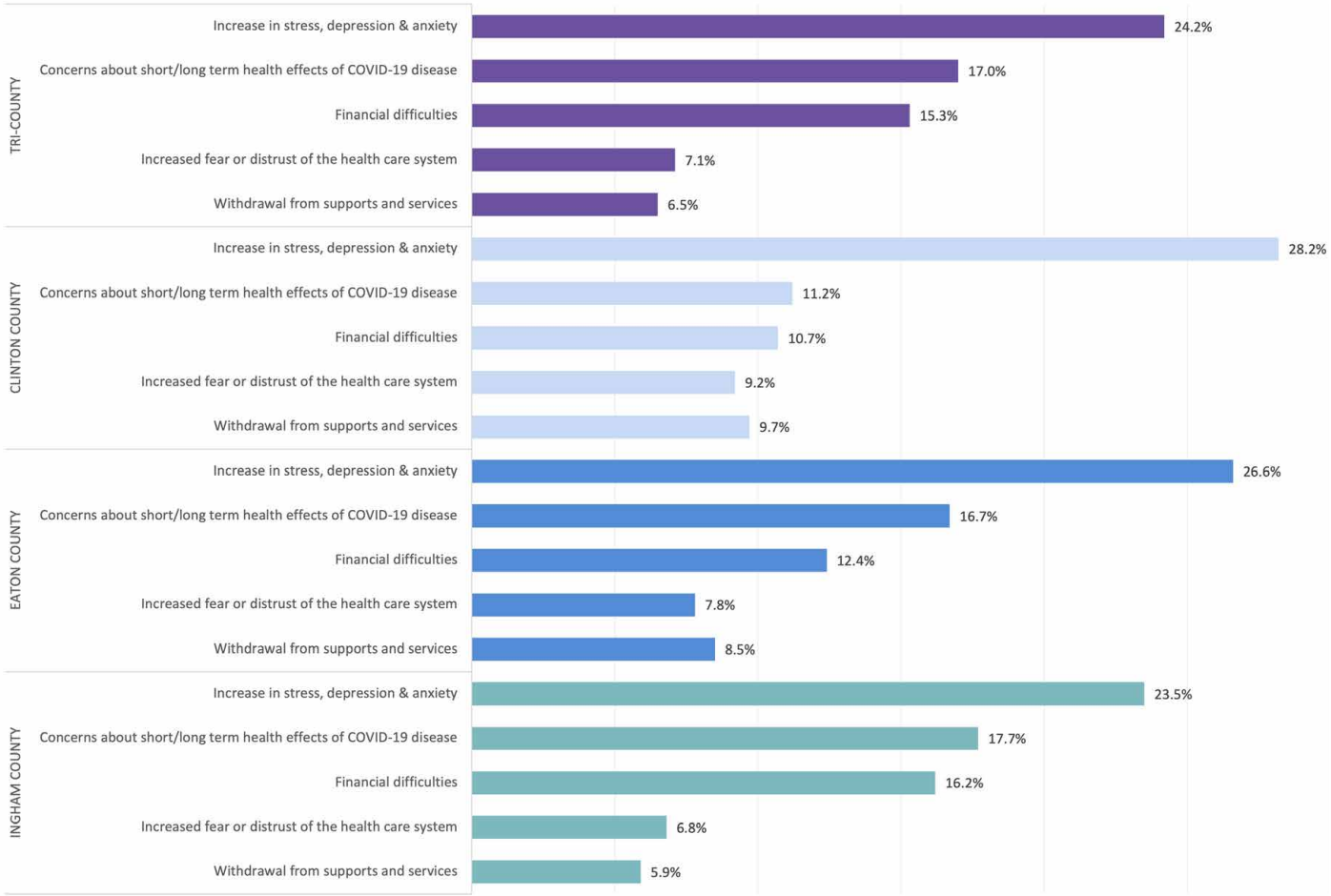
WHAT DO YOU FEEL ARE THE TOP THREE BARRIERS TO GETTING QUALITY HEALTHCARE IN THE COMMUNITY IN WHICH YOU LIVE?

The most commonly identified hurdle to obtaining health care was the cost of care. Difficulty navigating the healthcare system and finding a practice accepting new patients were also common concerns.



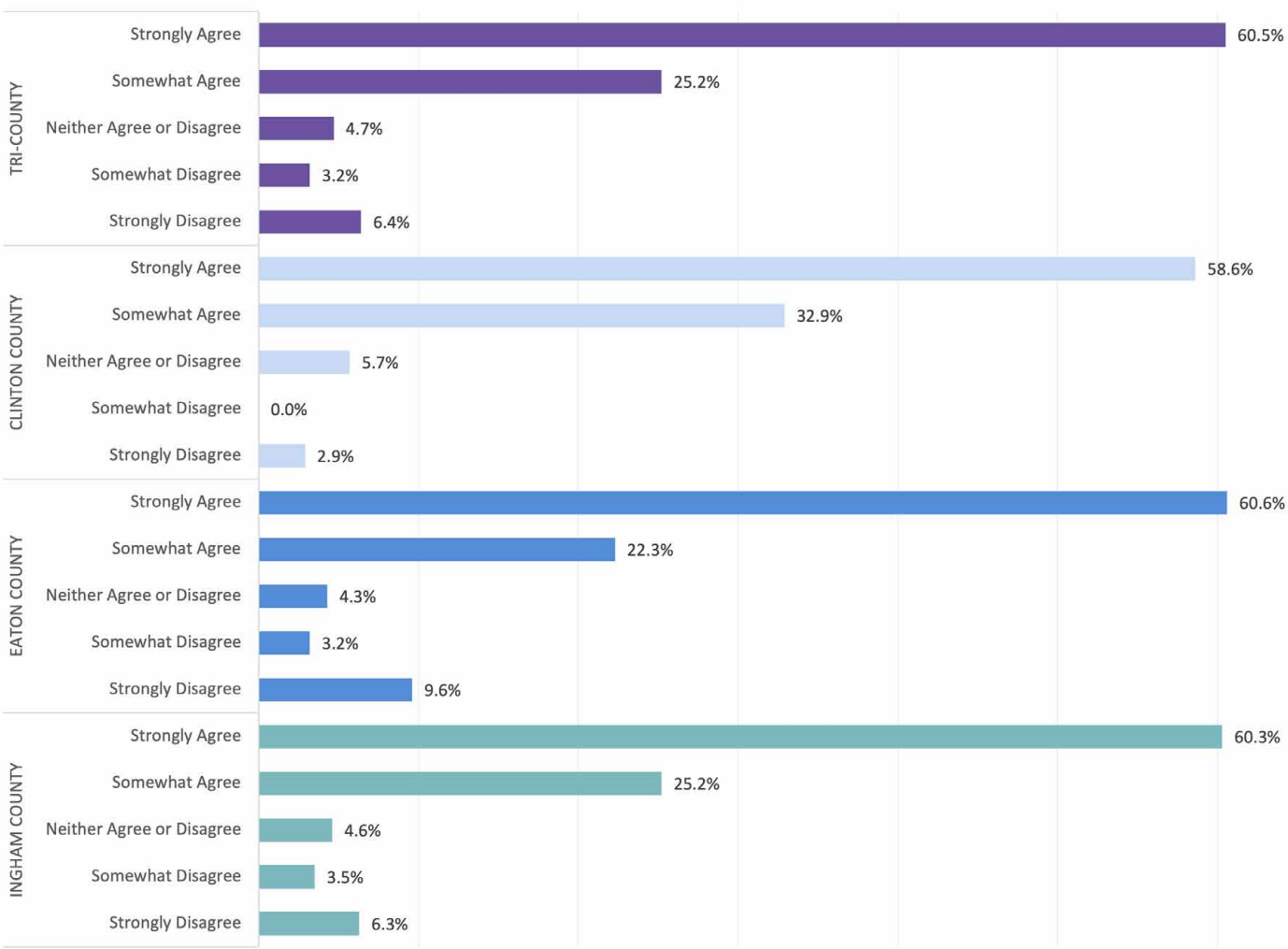
WHAT DO YOU THINK ARE THE THREE MOST IMPORTANT HEALTH-RELATED CONCERNS ASSOCIATED WITH THE COVID-19 PANDEMIC?

All three counties felt the most important health-related concern related to COVID-19 was an 'increase in stress, depression, and anxiety' followed by 'concerns about short/long term health effects of COVID-19' and 'financial difficulties'.



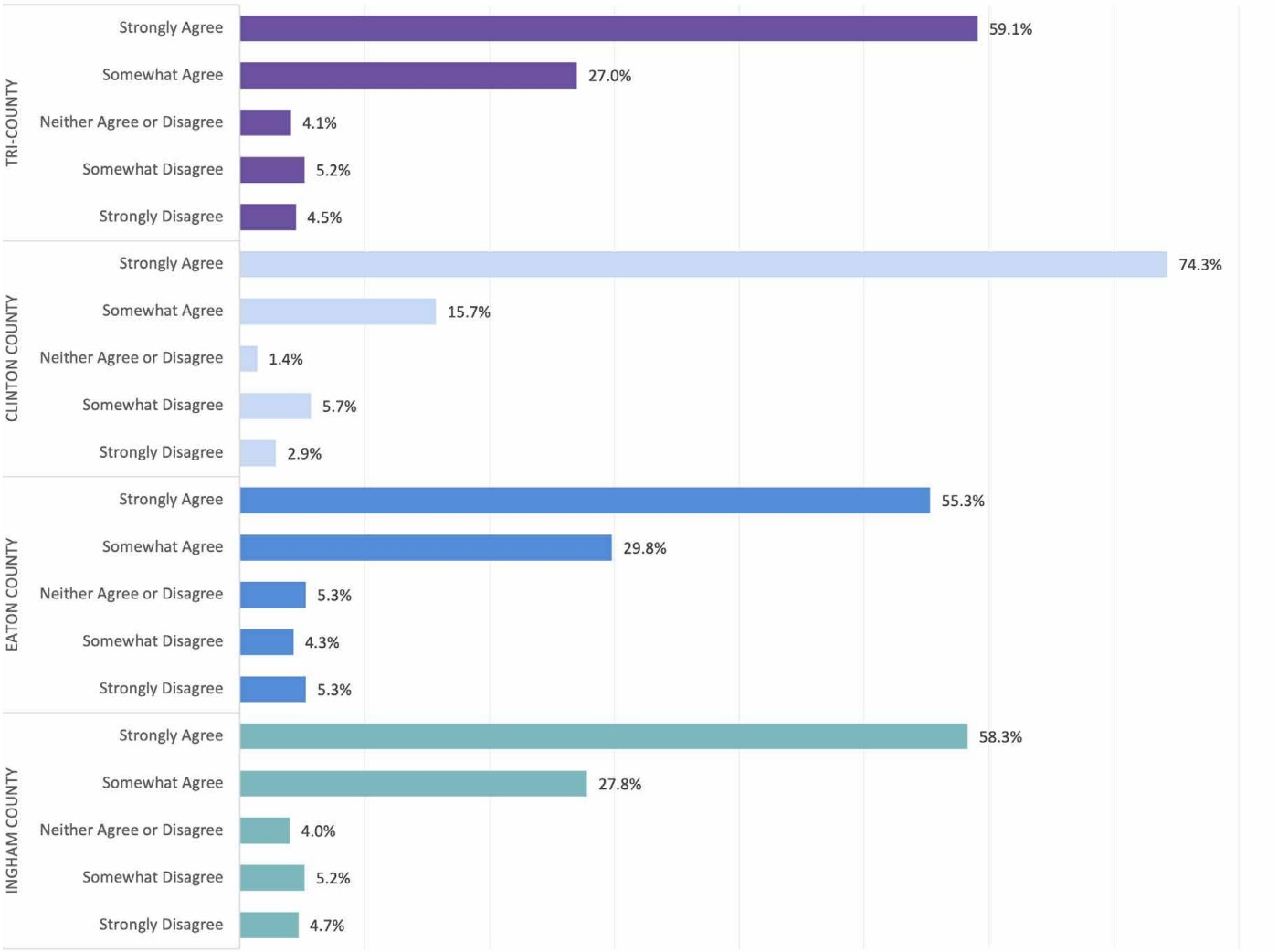
ADDRESSING SOCIAL NEEDS IS AS IMPORTANT AS ADDRESSING MEDICAL NEEDS TO IMPROVE COMMUNITY HEALTH

There was widespread agreement in the Capital Area community that addressing the social issues affecting people is as important as addressing their medical needs. Over 80% of respondents in all counties agreed with this sentiment.



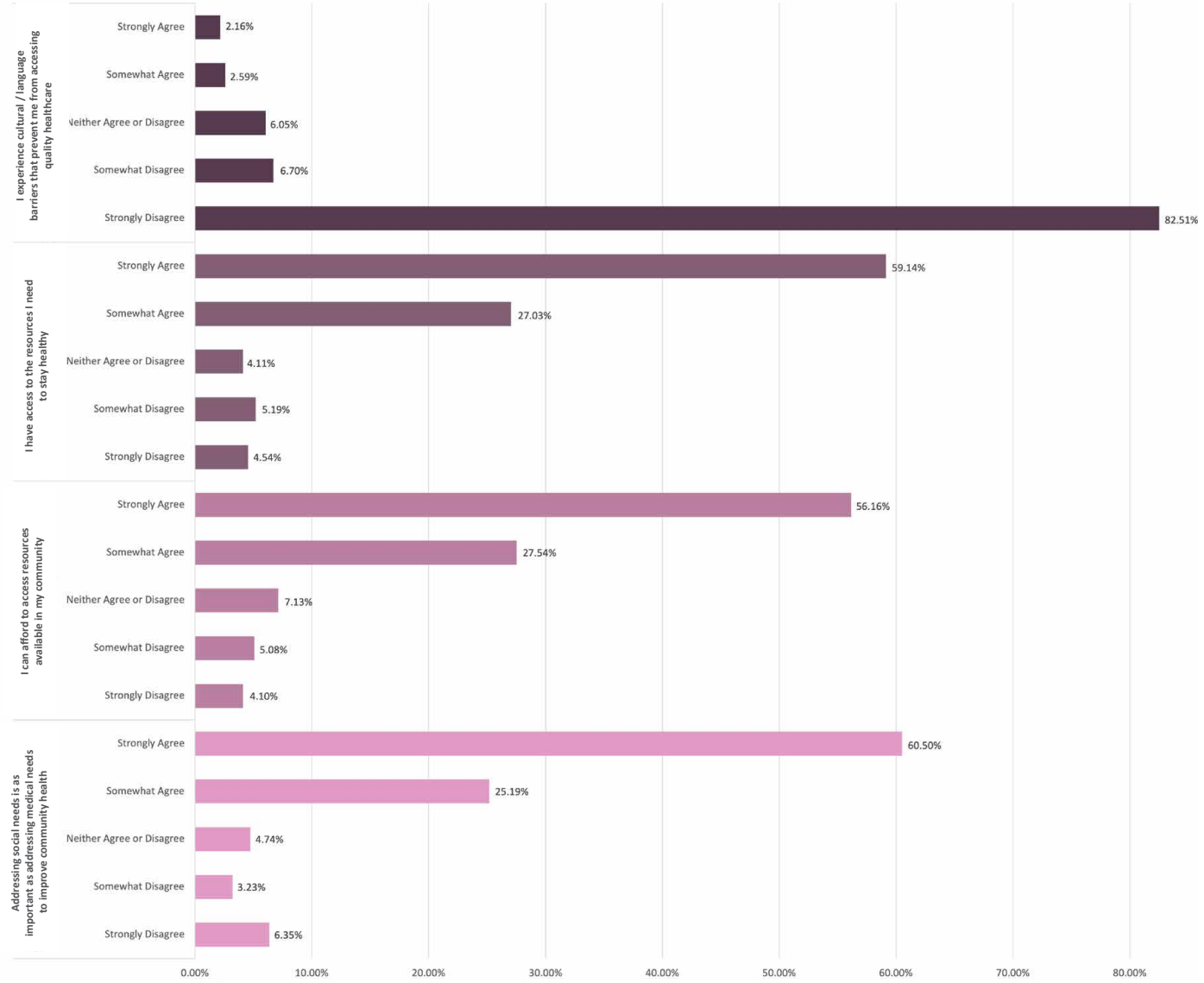
I HAVE ACCESS TO THE RESOURCES I NEED TO STAY HEALTHY

Although most participants of the survey agreed that they do have access to the resources they feel they need to stay healthy, fewer Eaton County and Ingham residents strongly agreed with that statement compared to Clinton County residents.



PLEASE INDICATE YOUR LEVEL OF AGREEMENT WITH THE FOLLOWING STATEMENTS:

Most residents (83.7%) in the tri-county area strongly agreed or somewhat agreed with the statement "I can afford to access resources available in my community".



Provider Survey

A specific effort was made to gain insight from local health care providers about the health of the community. Health care providers within the three hospital systems were encouraged to participate in an online survey that asked about the characteristics of a healthy community, the most important health problems in their county of employment, factors affecting patient health including COVID-19, referrals to other community resources, social needs of patents, and health care barriers.

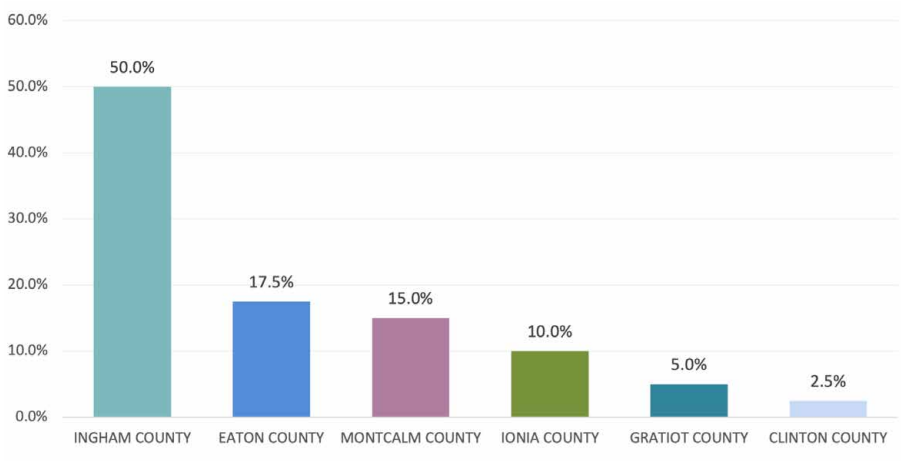
Health care providers were invited to complete the online survey via communication from their hospital system. The provider survey was available from March 1, 2021 to May 31, 2021 and was open to providers working at Sparrow, McLaren Greater Lansing, or Eaton Rapids Medical Center (ERMC). The 15 question survey asked providers about:

- characteristics of a health community;
- observed barriers keeping patients from progressing toward their health goals;
- observed barriers they see to patients accessing health care; and
- which community resources, if any, they refer their patients to
- COVID-19 specific issues and concerns.

Forty providers responded to this survey. It is common for providers can be affiliated with multiple hospitals, but they were instructed to complete the survey only once. Nearly half of respondents were affiliated with Edward W. Sparrow Hospital (aka Sparrow Main) while almost 18% were affiliated with McLaren Greater Lansing and 15% were with Eaton Rapids Medical Center.

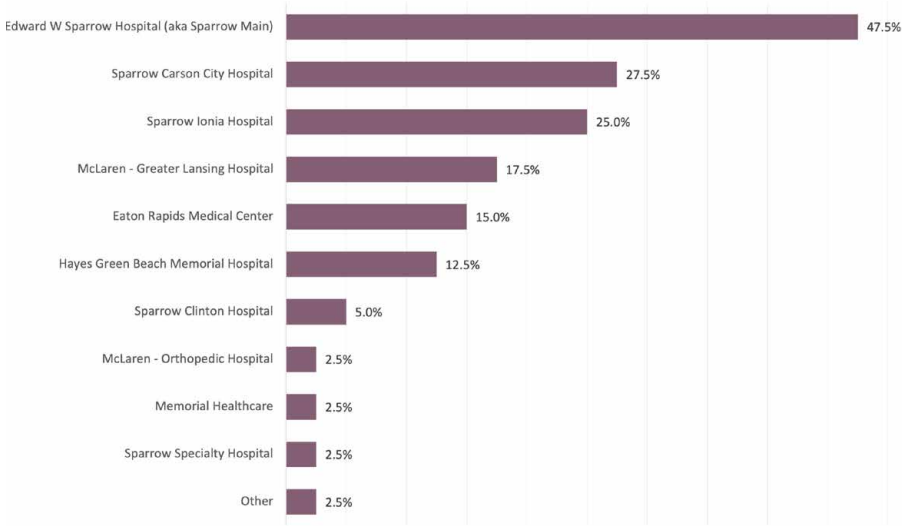
IN WHAT COUNTY DO YOU PRACTICE MOST OFTEN?

Half of all respondents stated they practice in Ingham County. Eaton County had 17.5% of respondents practice in its jurisdiction and Clinton had 2.5% of responses. Most of the participants were affiliated Sparrow Main, McLaren Greater Lansing and Eaton Rapids Medical Center.



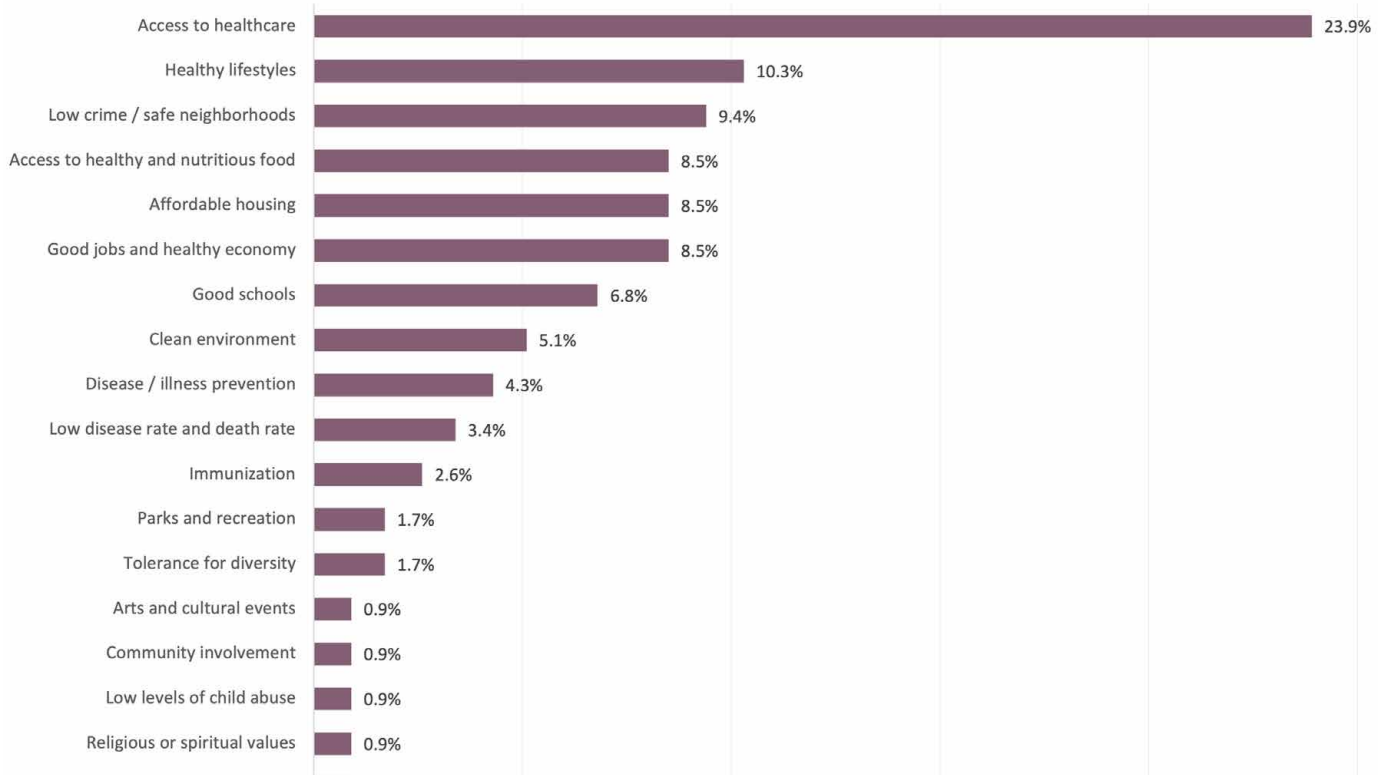
WHAT HOSPITALS ARE YOU AFFILIATED WITH?

Half of all respondents stated they practice in Ingham County. Eaton County had 17.5% of respondents practice in its jurisdiction and Clinton had 2.5% of responses. Most of the participants were affiliated Sparrow Main, McLaren Greater Lansing and Eaton Rapids Medical Center.



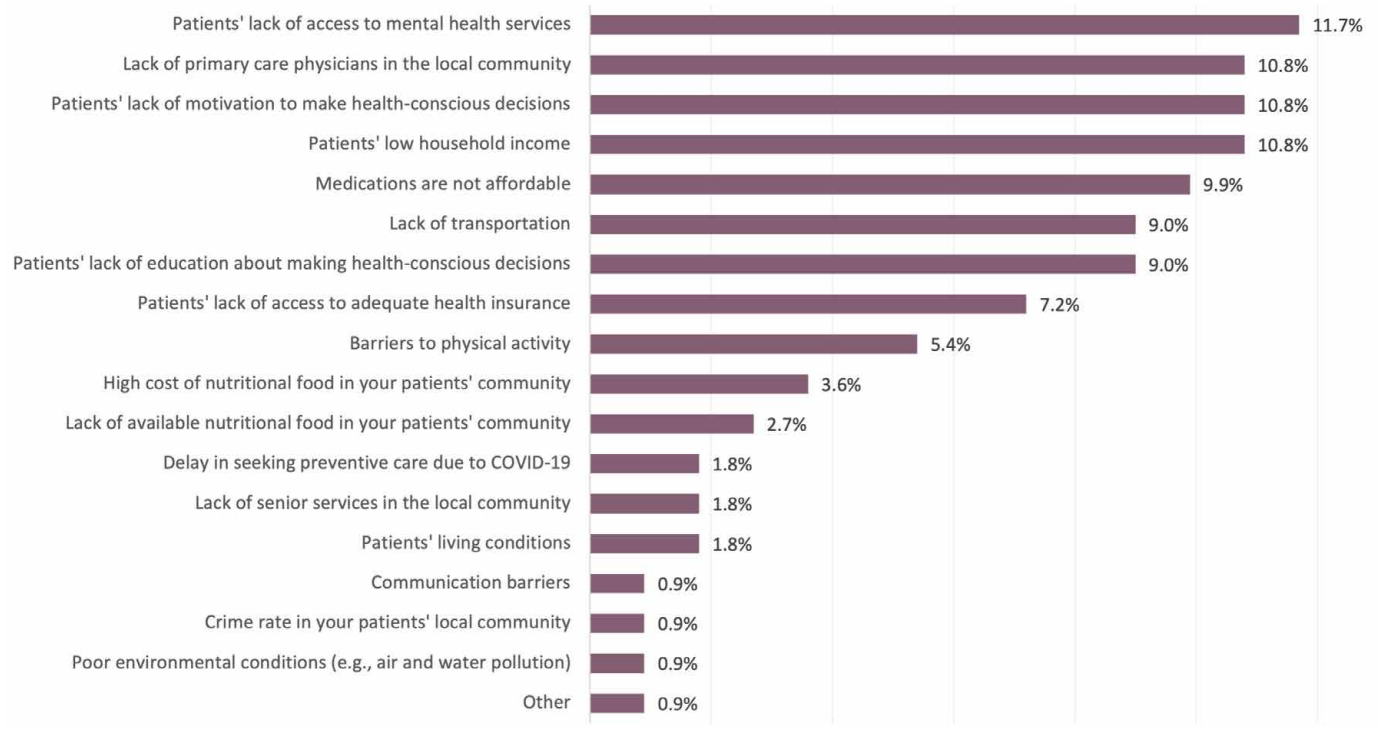
WHAT DO YOU BELIEVE ARE THE THREE MOST IMPORTANT FACTORS THAT DEFINE A "HEALTHY COMMUNITY"?

Most providers believe that 'Access to healthcare' followed by 'Healthy lifestyle' and 'low crime / safe neighborhoods' were factors that define a healthy community.



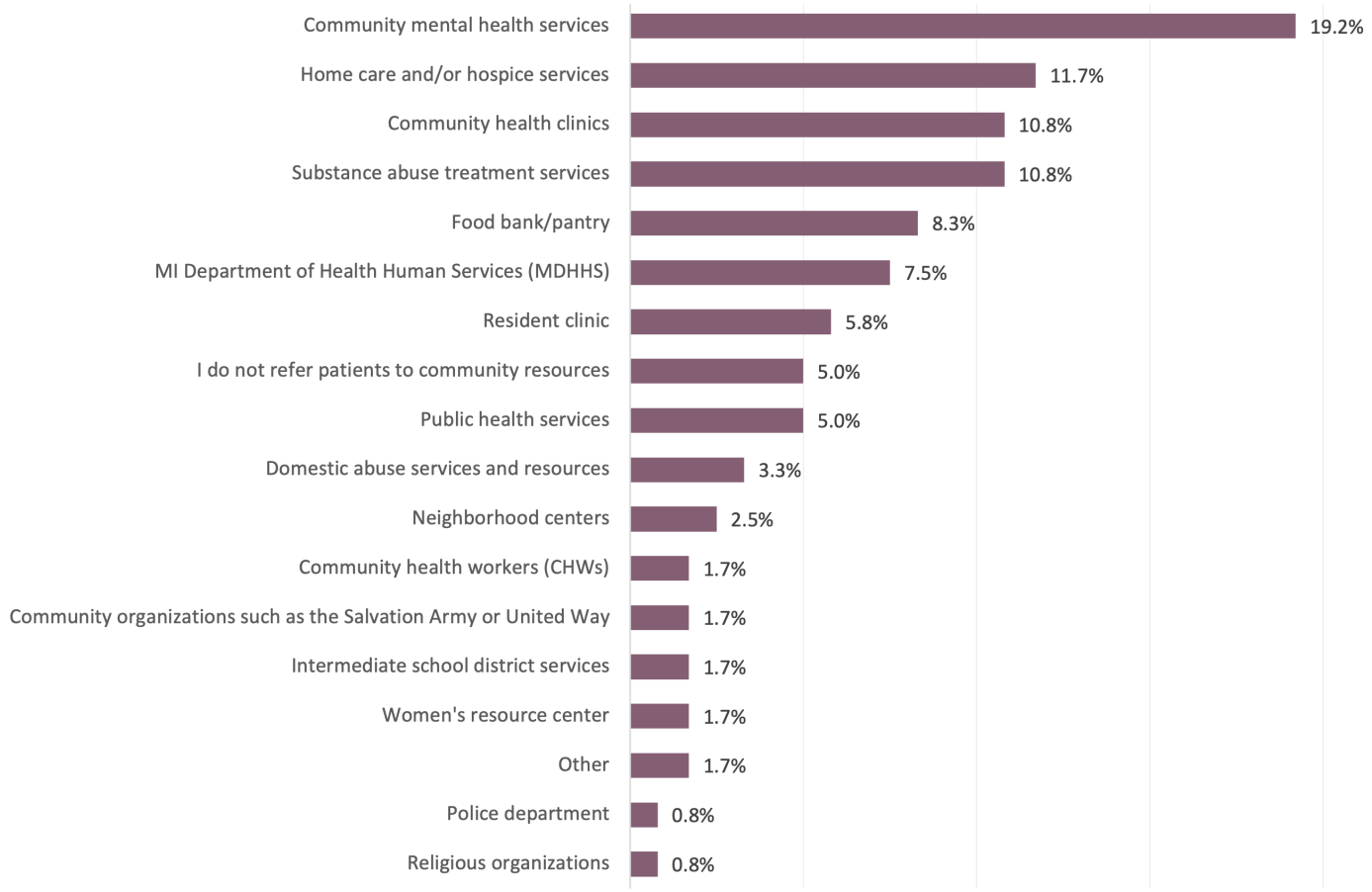
WHAT DO YOU BELIEVE ARE THE TOP THREE FACTORS THAT NEGATIVELY IMPACT YOUR PATIENTS' HEALTH?

When asked to list the top three factors that negatively impact a patient's health, most providers indicated that a 'Lack of access to mental health services' was the biggest issue. After that three factors had the same percentage of responses. Those were 'Patients' low household income', 'lack of motivation to make health-conscious decisions' and 'Lack of primary care physicians in local community'.



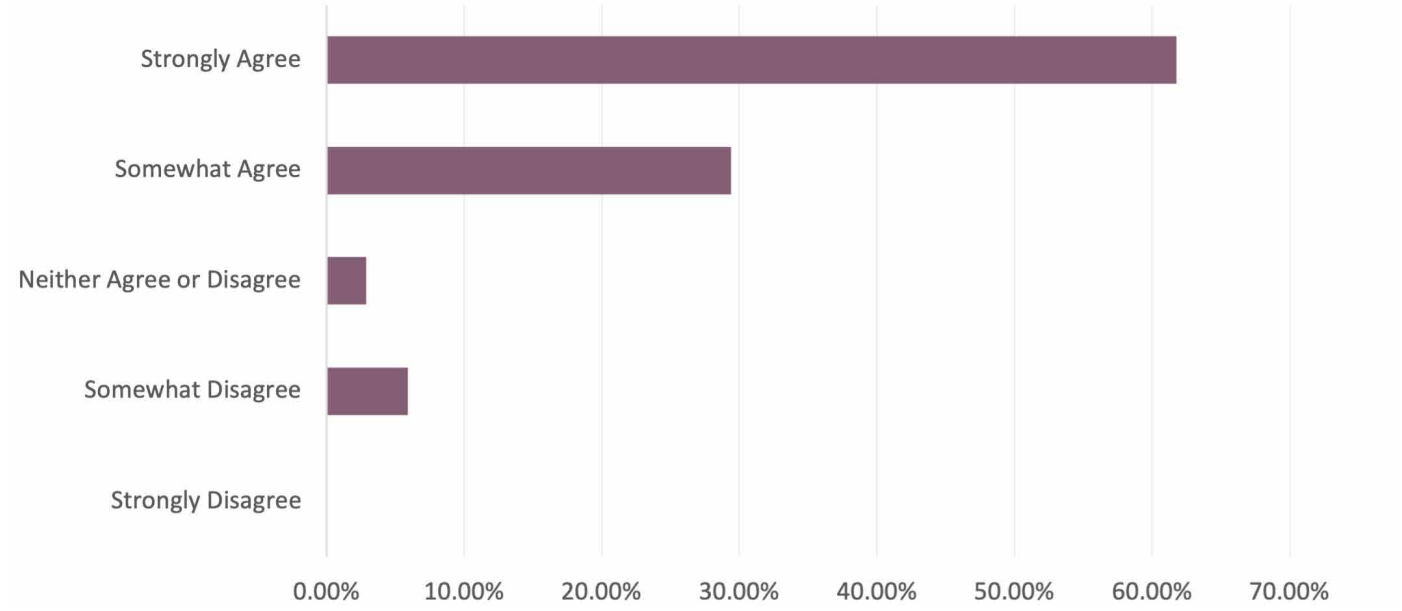
TO WHAT, IF ANY, COMMUNITY RESOURCES DO YOU ROUTINELY REFER PATIENTS TO HELP ADDRESS UNMET NEEDS?

In order to address unmet needs, most providers (65.7%) referred their patients to community mental health services. Around 40% of providers commonly refer patients to community health clinics, substance abuse treatment services and home care/hospital services.



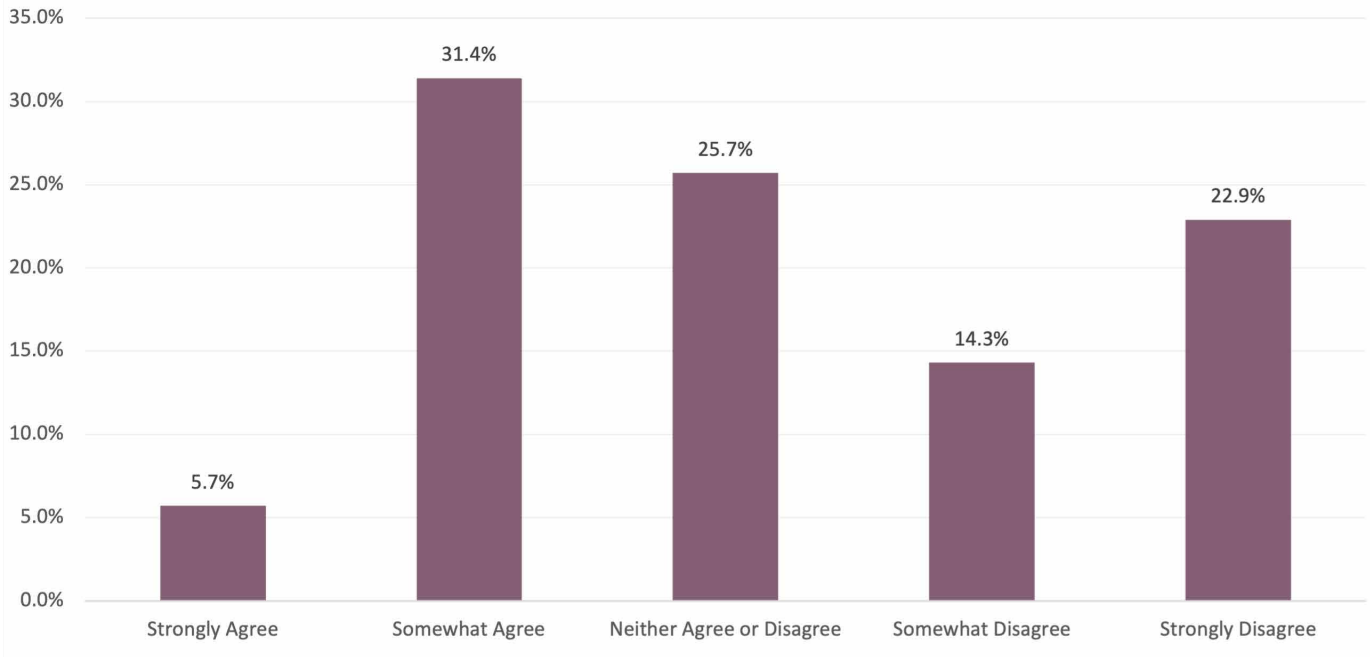
ADDRESSING SOCIAL NEEDS IS AS IMPORTANT AS MEDICAL

Most physicians strongly agreed that addressing the patient's social needs is as important as addressing their medical condition; however, not all physicians strongly agreed that they have the support to help their patients lead a healthier life. Most doctors admitted that their patients express health concerns that are related to social needs that is not within their sphere of influence. When asked if their patients had access to the resources they needed to stay healthy, few physicians reported that they strongly agreed with that statement; most somewhat disagreed or somewhat agreed with that statement. The majority of physicians strongly agreed or somewhat agreed that their patients' unmet social needs prevented them from being able to provide their patients quality healthcare. Most physicians somewhat agreed there are cultural and language barriers that get in the way of providing quality care.



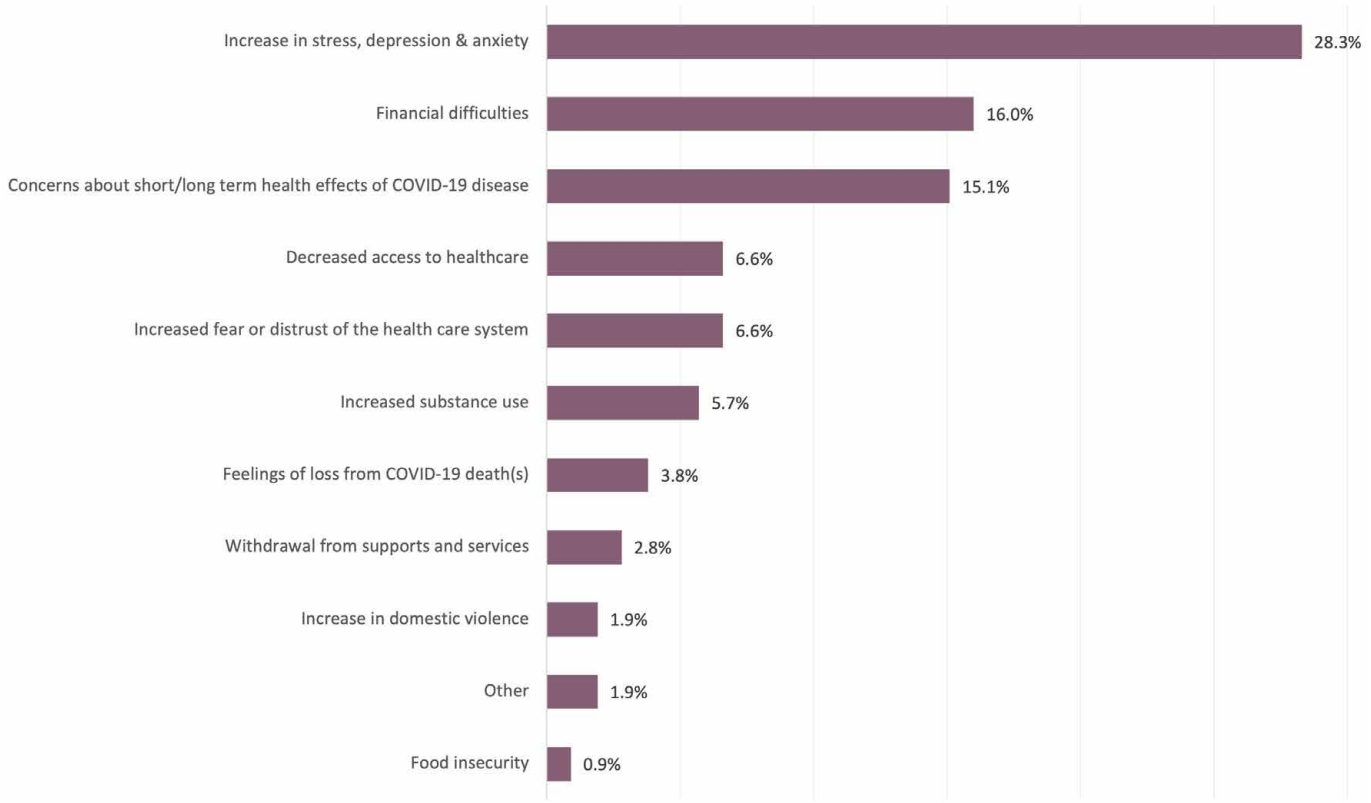
CULTURE/LANGUAGE BARRIERS GET IN THE WAY OF QUALITY HEALTHCARE SERVICE

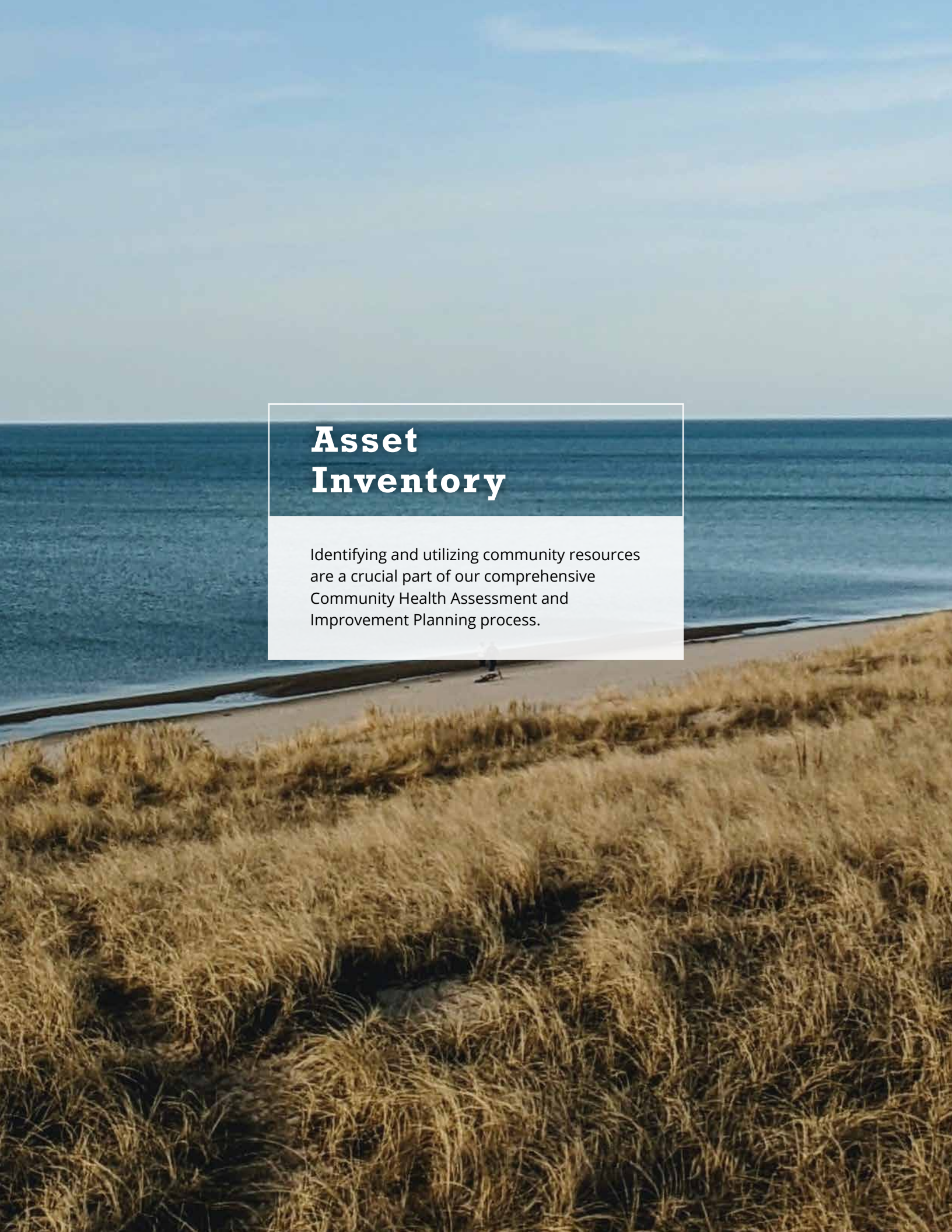
Most physicians somewhat agreed there are cultural and language barriers that get in the way of providing quality care.



IN YOUR OPINION, WHAT ARE THE THREE MOST IMPORTANT HEALTH-RELATED CONCERNS ASSOCIATED WITH THE COVID-19 PANDEMIC?

When asked the three most important health related concerns associated with the COVID-19 pandemic, 28.3% of respondents said 'increase in stress, depression and anxiety' while 16% said 'financial difficulties' and 15.1% said 'concerns about short and long term health effects of COVID-19 disease'.





Asset Inventory

Identifying and utilizing community resources are a crucial part of our comprehensive Community Health Assessment and Improvement Planning process.

Asset Inventory & Mapping

This asset inventory was originally compiled by the 2012 Community Advisory Committee on March 1, 2012 as part of the 2012 H!CC Community Health Needs Assessment. The asset inventory continues to be reviewed and updated in subsequent Healthy! Capital Counties cycles.

Attendees of the February 26, 2021 Stakeholder Input Meeting were asked to review the provided asset inventory and vote on which asset categories (and individual assets within a category) would be most useful to the assessment process if they could be geographically mapped within the Capital Region. From this asset prioritization process, the Stakeholder Committee chose health care system and mental health assets as well as food system assets to be included as mapping activities. Two asset separate, interactive maps have been included as products of this activity. The interactive Google Maps are currently available on the Healthy! Capital Counties website.

This inventory will be used as part of the community health improvement planning process to explore the breadth and depth of community assets and resources that may be mobilized to address community health needs.

WHAT IS AN ASSET?

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

INDIVIDUAL ASSETS

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

CITIZEN ASSETS

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

INSTITUTIONAL ASSETS

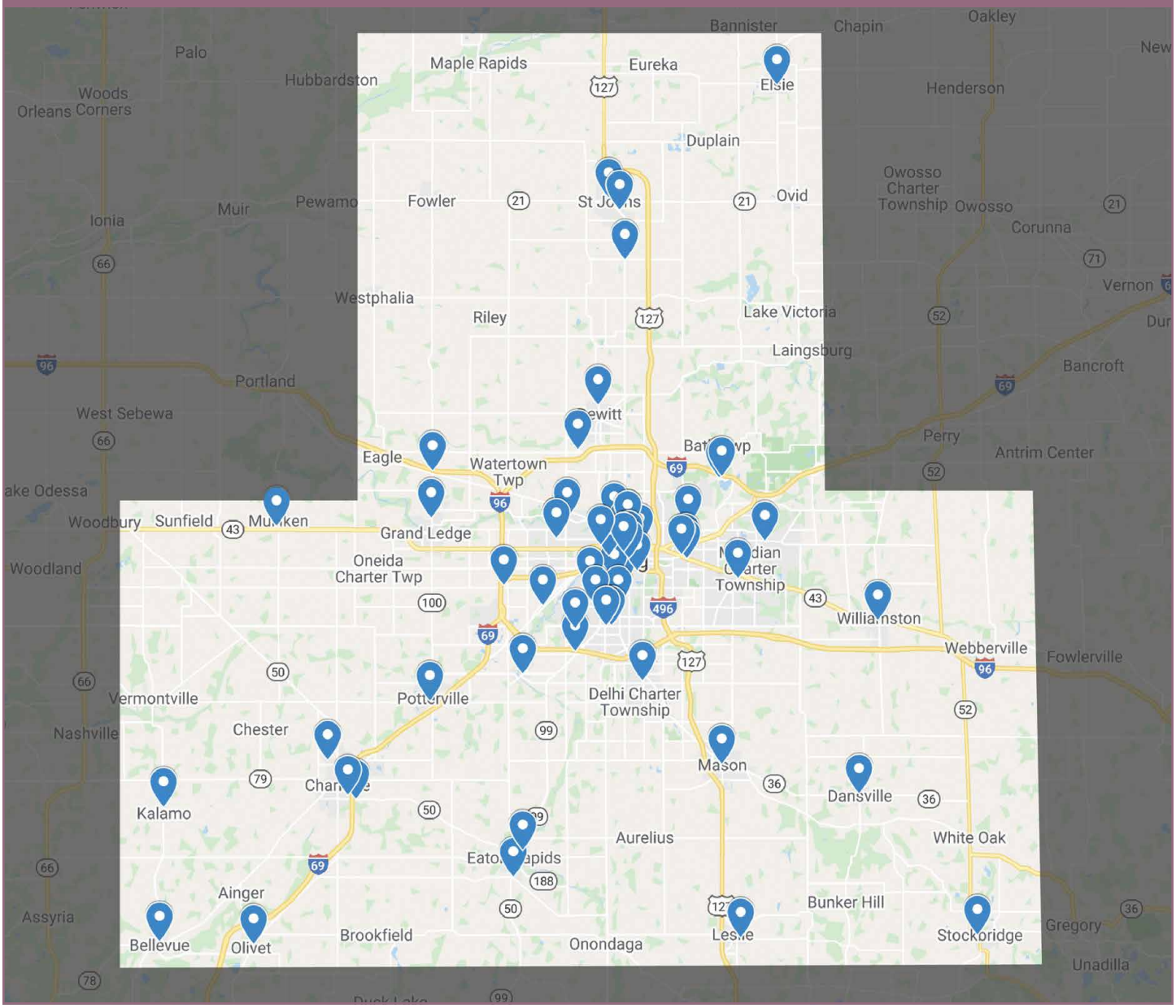
Assets held by institutions in the community. These are often well-established groups, employers, or governmental entities, and are both for-profit and not-for-profit organizations. Some institutions are comprised of groups of institutions — these are labeled ‘organizational’ assets.

2021 H!CC Asset Inventory

In an effort to streamline the asset inventory process for this cycle, a shorter list of assets was provided for discussion during the February 2021 meeting. Only assets with more than 5 votes from the previous cycle were included and an open discussion period was held to weight inclusion of other assets. In the end, the top choices were health system assets (including CMH and Substance Abuse Treatment and Recovery) and Food System Assets. Votes totals are not included as it was decided after the initial vote to combine mental health and health care system assets.

ASSET INVENTORY - HEALTHY! CAPITAL COUNTIES
HEALTH CARE SYSTEM ASSETS
Community Mental Health
Substance Abuse Treatment and Recovery Providers
Free Clinics
Hospitals
EDUCATION ASSETS
K-12 School Districts
HOUSING ASSETS
Homeless Prevention and Housing Organizations
FOOD SYSTEM ASSETS
Food Pantry/Bank/Commodities
PUBLIC SAFETY ASSETS
Domestic Violence & Crisis Response Orgs
EMPLOYMENT ASSETS
Unemployment and Job-placement Services
ORGANIZATIONAL ASSETS
Human Services Collaboratives

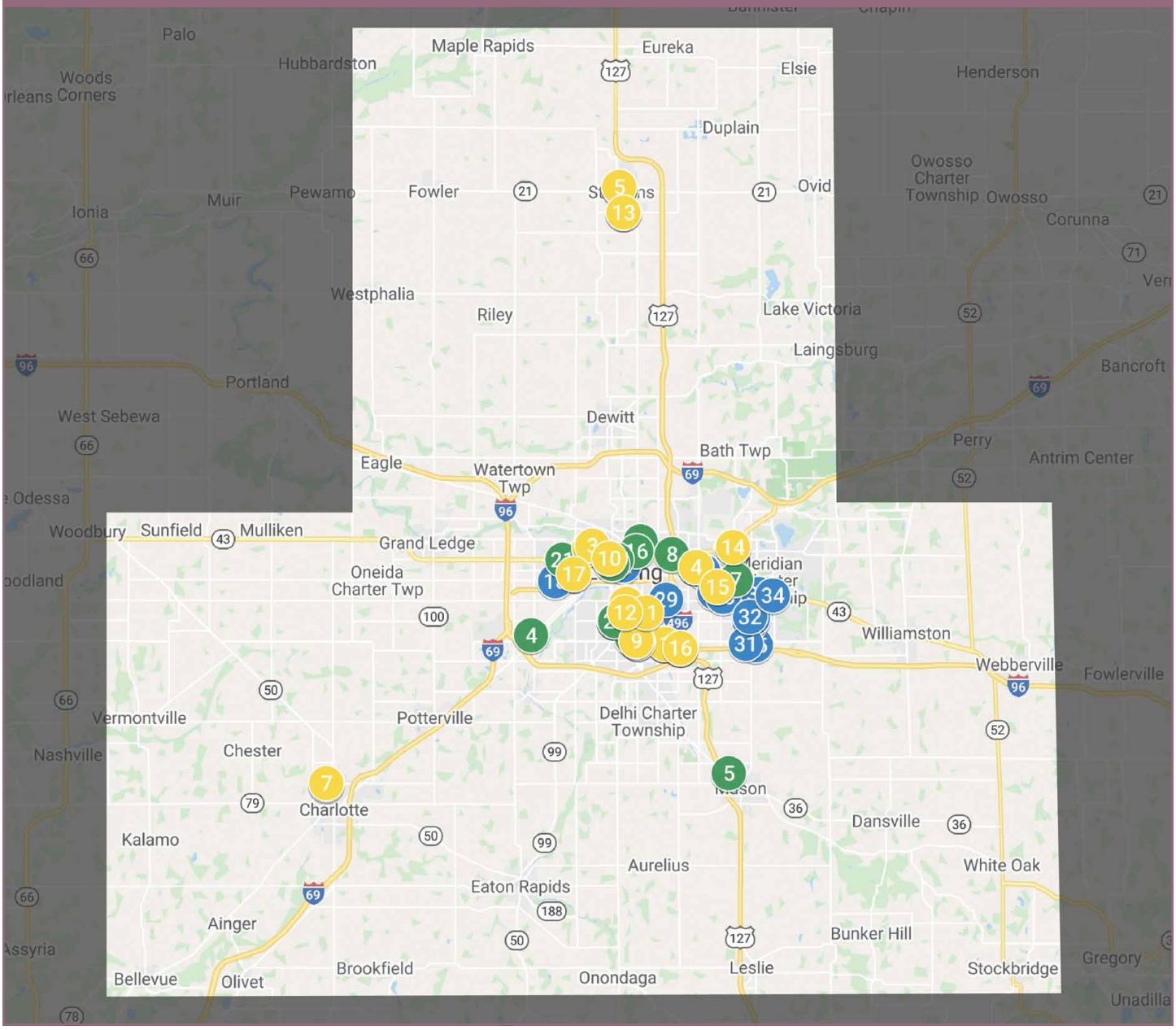
CAPITAL REGION FOOD PANTRIES/DISTRIBUTIONS



Food Pantry

To view a map of Food Pantries/Disributions across the region, **please visit this link.**

COMMUNITY HEALTH SERVICES



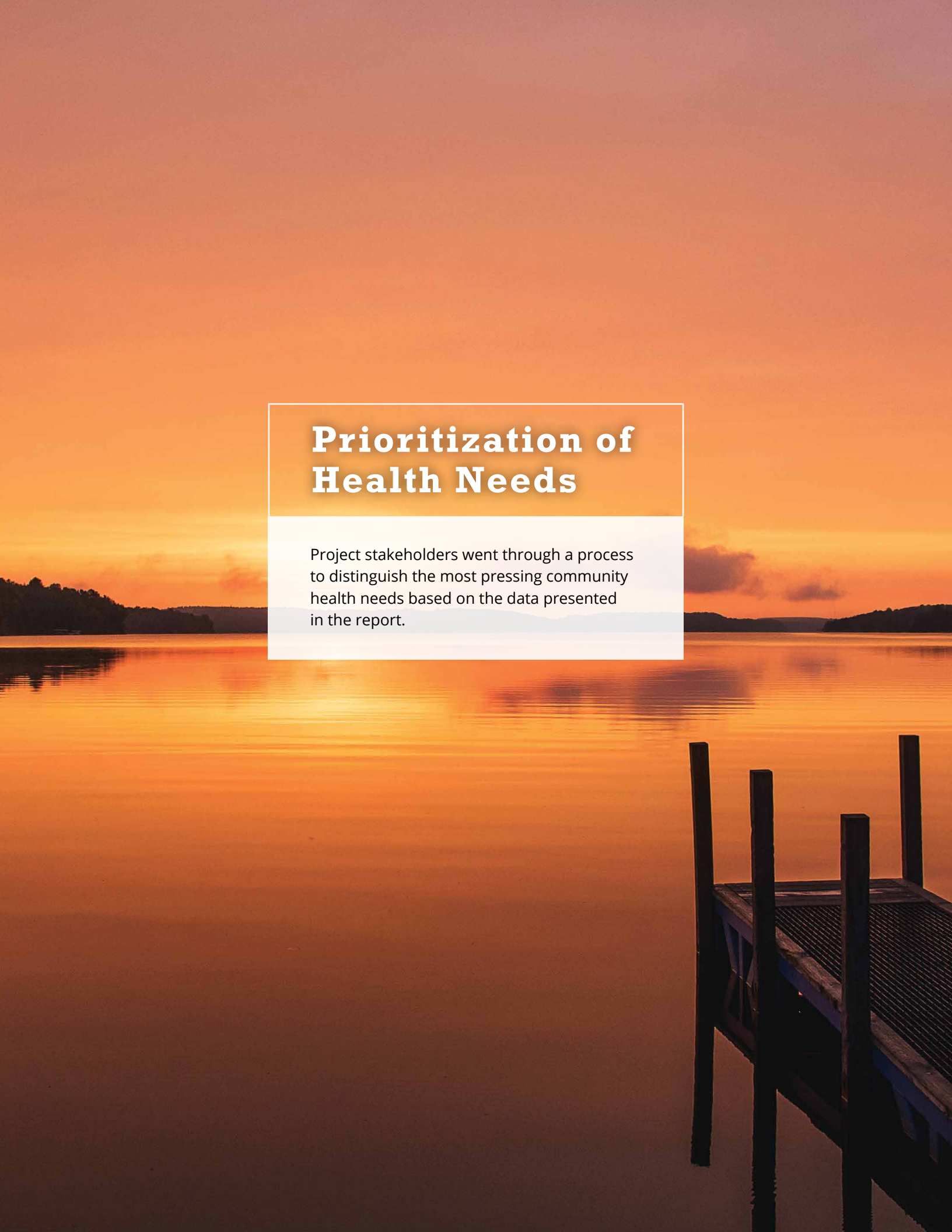
34 CAPITAL REGION BEHAVIORAL HEALTH SERVICES

23 DRUG AND ALCOHOL TREATMENT CENTERS

17 CAPITAL REGION MENTAL HEALTH TREATMENT SERVICES

Behavioral Health facilities are those that provide mental health services as well as substance use disorder services at one location. Mental health facilities are those provide services that are not related to substance use disorders.

To view a map of Community Health Services across the region, **please visit this link.**



Prioritization of Health Needs

Project stakeholders went through a process to distinguish the most pressing community health needs based on the data presented in the report.

Setting a Shared Course

PRIORITIZATION METHODOLOGY

The 2021 Healthy! Capital Counties Community Health Needs Assessment produced a variety of data from numerous sources about the health issues affecting the community. The report was used to identify health issues to prioritize by community stakeholders. The project workgroup and steering committee utilized the consensus criteria method, as outlined below:

- Identified the criteria to be considered when evaluating the issues;
- Selected weights for each criteria;
- Identified the issues to be evaluated, based upon the community profile and health needs assessment report;
- Engaged stakeholders in selecting the most important issues for each criteria; and
- Applied the weights to the stakeholder feedback (votes)

IDENTIFYING THE CRITERIA

Based upon previous experience garnered from the methods use in previous Healthy! Capital Counties Assessment cycles, BEDHD proposed using the same four criteria below for evaluating the issues to be prioritized in 2021. Those criteria were:

- Seriousness: How much of an impact does this have on people's health?
- Control: How much control do we have to affect the health issue?
- Capacity: What is our ability, as a community, to address the health issue?
- Catalytic: How much does this issue affect other health issues?

SELECTING THE WEIGHTS OF THE CRITERIA

In order to identify a broad spectrum of priorities that reflected the constellation of factors that influence health and the spheres of influence for current project partners, a two-tiered weighting system is suggested. This system involved identifying two sets of weights to apply to the voting results, one that would highlight upstream factors and one that would highlight downstream factors. If there was a discrepancy between the outcomes of the two weighting methods, then the results of the two methods would be combined into one list of priorities. Below are the weights agreed upon by the Healthy! Capital Counties workgroup:

CRITERIA AND DEFINITION	UPSTREAM WEIGHTS	DOWNSTREAM WEIGHTS
Seriousness (how serious is the health issue)	4	4
Control (how much control do we have to affect the health issue)	2	3
Capacity (what is our ability, as a community, to act on a particular health issue)	1	2
Catalytic (how much does this issue affect other health issues)	3	1

IDENTIFYING THE ISSUES TO BE EVALUATED

There were 31 quantitative data indicators in the report, which the workgroup agreed was too many to vote on during prioritization due to the limitation of a virtual prioritization event. Through group discussion and consensus, the workgroup and steering committee combined the quantitative indicators into the following set of 17 health issues:

- Financial Stability and Economic Mobility
- Affordable Housing
- Education
- Social Connection and Capital
- Accidental Injury & Mortality
- Health Care Access and Quality
- Environmental Quality
- Built Environment
- Obesity
- Tobacco Use
- Behavioral Health
- Physical Activity
- Nutrition
- Communicable Diseases
- Maternal and Child Health
- Chronic Disease
- Community Safety

ENGAGING STAKEHOLDERS IN SELECTING PRIORITIES

All project partners were encouraged to invite key stakeholders and community partners to the prioritization event, during which the health issues would be prioritized. Invitees largely overlapped with those attending the data party as the events are related with prioritization being informed by what is presented in the data party.

The meeting was advertised on the Barry-Eaton District Health Department website, Facebook page, via email to the project email listserv, local coalition meetings, and via project partner websites, Facebook pages, and other media.
At the event, project staff presented an overview of the Healthy! Capital Counties CHNA project to date, as well as highlights from the project's health needs assessment report.

To familiarize participants with data in the report, as well as enabling them to practice the prioritization of data, an exercise at was designed to familiarize any new participants with the data in the report and test the voting system. Participants were also provided with preparatory materials including data packets, worksheets and guides beforehand for those who wished to review them prior to the event. Participants were encouraged to consider these sets of measures through the lens of the four criteria (seriousness, control, capacity, and catalytic) that would later be used for prioritization.

In addition, an overview of other components of the report was presented, including focus group findings, results from the community and health care provider surveys, and asset mapping.

The list of the 17 issues to be prioritized was then provided and participants were asked to review these and ask questions prior to the voting process. Instructions were provided prior to the final voting activity. Participants were shown all 17 issues and 4 votes were held. Each vote centered on one of the four criteria listed above. Each vote was catalogued and then weighted. After all votes were held, there was a list of 5 priorities as seen below.

PRIORITIZATION VOTING RESULTS

UPSTREAM WEIGHTING

As described previously, two sets of weights were applied to the votes received. The first set of weights, for which the catalytic criteria was highly weighted, produced the following scores. The items with the lowest score is the highest priority due to the voting scheme used. The top five priorities that emerged were:

- Health Care Access & Quality
- Community Safety
- Behavioral Health
- Affordable Housing
- Education

	Seriousness (how serious is the health issue) weight= 1	**Control** (how much control do we have to affect the health issue) weight= 3	**Capacity** (what is our ability, as a community to act on a particular health issue) weight= 4	**Catalytic** (how much does this issue affect other health issues) weight= 2	**Weighted Score**
Health Care Access and Quality	1	3	4	2	10
Community Safety	5	6	8	10	29
Behavioral Health	2	9	12	8	31
Affordable Housing	3	12	20	4	39
Education	8	21	28	14	71
Chronic Disease	6	36	16	18	76
Social Connection and Capital	11	15	32	20	78
Physical Activity	9	27	24	30	90
Built Environment	14	18	44	16	92
Nutrition	10	30	40	12	92
Financial Stability and Economic Mobility	4	48	56	6	114
Maternal and Child Health	15	39	36	28	118
Environmental Quality	13	24	60	24	121
Communicable Diseases	12	33	48	32	125
Obesity	7	45	52	22	126
Tobacco	16	42	64	26	148
Accidental Injury	17	51	68	34	170

DOWNSTREAM WEIGHTING

The second set of weights was based upon the criteria being set low. This approach produced a second set of scores, listed below. The items with the lowest score is the highest priority due to the voting scheme used. The top priorities from this set were:

- Health Care Access & Quality
- Behavioral Health
- Affordable Housing
- Community Safety
- Education

	Seriousness (how serious is the health issue) weight= 1	**Control** (how much control do we have to affect the health issue) weight= 2	**Capacity** (what is our ability, as a community to act on a particular health issue) weight= 3	**Catalytic** (how much does this issue affect other health issues) weight= 4	**Weighted Score**
Health Care Access and Quality	1	2	3	4	10
Behavioral Health	2	6	9	16	33
Affordable Housing	3	8	15	8	34
Community Safety	5	4	6	20	35
Education	8	14	21	28	71
Chronic Disease	6	24	12	36	78
Nutrition	10	20	30	24	84
Social Connection and Capital	11	10	24	40	85
Financial Stability and Economic Mobility	4	32	42	12	90
Built Environment	14	12	33	32	91
Physical Activity	9	18	18	60	105
Obesity	7	30	39	44	120
Environmental Quality	13	16	45	48	122
Maternal and Child Health	15	26	27	56	124
Communicable Diseases	12	22	36	64	134
Tobacco	16	28	48	52	144
Accidental Injury	17	34	51	68	170

After the Upstream and Downstream votes were discussed among the group, the decision was made to include the top 4 priorities. The list below represents the chosen four priorities for the 2021 Healthy! Capital Counties Asessment.

FINAL LIST OF HEALTH PRIORITIES:

HEALTH CARE ACCESS AND QUALITY

COMMUNITY SAFETY

BEHAVIORAL HEALTH

AFFORDABLE HOUSING

Thank You


Barry-Eaton District
Health Department
Be Active • Be Safe • Be Healthy


Eaton Rapids
Medical Center


McLaren
GREATER LANSING


Ingham County
Health Department


Sparrow


Mid-Michigan District
HEALTH DEPARTMENT
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