Sparrow Carson Hospital

2019 Sparrow Carson Hospital Community Health Needs Assessment

Prepared by the Michigan Public Health Institute

Acknowledgements

This report was prepared with the assistance of Sparrow Carson Hospital and residents throughout Montcalm County who provided their time and insights in helping to identify the most important health needs, issues, and concerns throughout this region. This assessment would not have been possible without their participation.

We would like to thank the staff and leaders of the Healthy! Capital Counties coalition—for conducting the underlying community health needs assessment work upon which this report is based. Their knowledge and experience as public health officials provided a level of professionalism to their model for assessing community health needs and, subsequently, their identification and assessment of the importance of numerous proposed strategies for improving the health and well-being of all residents throughout our service area.

Sincerely,

William N. Roeser
Interim President and CEO
Sparrow Carson Hospital

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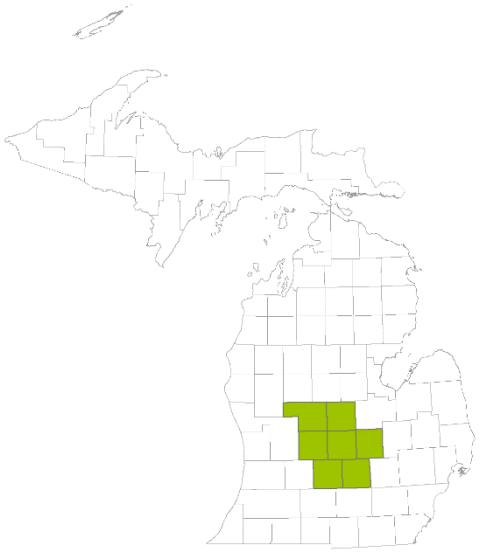
Introduction

Since 2010, Sparrow Health System has participated in a local collaborative effort called Healthy! Capital Counties. Healthy! Capital Counties aims to gather and present data that describes the health status of those living and working in the three county region surrounding Lansing, Michigan (Clinton, Eaton, and Ingham Counties). Sparrow Health System also partnered with the Ingham County Health Department and the Barry-Eaton District Health Department (two of the Healthy! Capital Counties partners) to compile quantitative health indicator data for the remaining counties within Sparrow Health System's service area (Gratiot, Shiawassee, Montcalm, and Ionia Counties). As part of their data gathering efforts, Healthy! Capital Counties conducted focus groups with medically underserved populations in addition to surveying community members and health care providers. To expand upon the information gathered by Healthy! Capital Counties, Sparrow Health System partnered with the Michigan Public Health Institute to conduct an additional four focus groups and thirteen key informant interviews with individuals who live and work in the region. The results of these efforts make up this Community Health Needs Assessment report. Community asset inventories and a description of the health needs prioritization process follow the presentation of the data. As a whole, this information will be used by Sparrow Health System to develop a set of specific actions to address the major health issues and concerns of the community, with the goal of improving the health status of the community at large and the individual health of local residents.

About Sparrow Health System

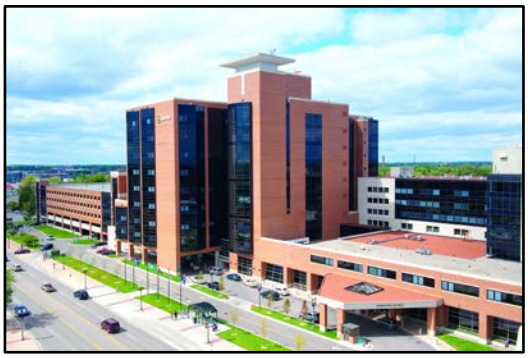


Sparrow Health System is Mid-Michigan's largest health system with five hospitals located throughout the region. Those hospitals are:

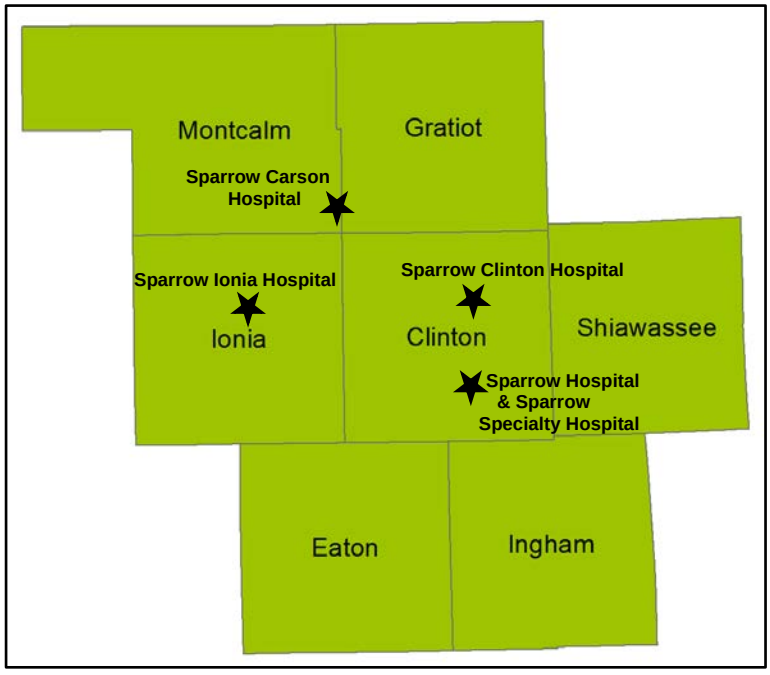
- Sparrow Hospital located in Lansing;
- Sparrow Specialty Hospital located in Lansing;
- Sparrow Carson Hospital located in Carson City;
- Sparrow Clinton Hospital located in St. Johns; and
- Sparrow Ionia Hospital located in Ionia.

Sparrow works toward its mission of improving the health of people in these communities by providing quality, compassionate care to every person, every time. Sparrow Health Systems' vision is to be recognized as a national leader in quality and patient experience.

Sparrow Hospital



Sparrow Hospital is located in downtown Lansing, Michigan. This location is the regional center for cancer, trauma, pediatrics, orthopedics, and neurological care. Sparrow Hospital also features neonatal and pediatric intensive care units, and a certified comprehensive stroke center. The Sparrow Herbert-Herman Cancer Center elevates the care provided to more than 300 patients per day, with linear accelerators, a Resource Center for patients, and much more. Sparrow and the Thoracic and Cardiovascular Institute (TCI), the region's largest cardiovascular group, have combined to provide the highest-quality care in mid-Michigan. Sparrow Hospital's Magnet designation by the American Nurses Credentialing Center recognizes the national level quality of its Nurses and is given to a small percentage of hospitals throughout the country. At Sparrow, patients have access to the only Level 1 Trauma Center in the area, and the Emergency Department is one of Michigan's largest and most advanced. Sparrow Hospital has 676 licensed beds and more than 900 physicians on its medical staff. Each year, nearly 4,000 babies are born at Sparrow Hospital, making it the premier birthing center in the region.



Sparrow Specialty Hospital

Sparrow Specialty Hospital is also located in downtown Lansing and provides long-term (extended, in patient) acute care services to medically complex and critically ill patients across Mid-Michigan. Since 2004, patients have come to Sparrow Specialty Hospital to get the time they need to heal from traumatic injuries and other serious conditions. Sparrow Specialty Hospital is a 30-bed acute care hospital specializing in patients who require a 25-day or longer length of stay in a hospital setting. It is fully accredited by the Healthcare Facilities Accreditation Program, an independent organization that accredits and certifies health care organizations and programs. Services at Sparrow Specialty Hospital include, but are not limited to: integrative services; occupational therapy; IV services; physical therapy; respiratory therapy; speech therapy; nutritional services; dialysis; lymphedema therapy; ventilator support; and specialized wound care.

Sparrow Carson Hospital

Sparrow Carson Hospital is located in Carson City, Michigan and is the newest hospital to join Sparrow Health System. This location is an acute care hospital equipped with 61 beds and 16 physicians. It has a Level III Emergency Department staffed and equipped to provide emergency care 24 hours a day, seven days a week with a physician on site at all times.

Sparrow Clinton Hospital

Sparrow Clinton Hospital is located in St. Johns, Michigan. This hospital provides acute and ambulatory care services to patients and has 25 licensed beds. In 2014, Sparrow Clinton Hospital opened a new state-of-the-art Emergency Services Department that serves over 13,000 patients each year.

Sparrow Ionia Hospital

Sparrow Ionia Hospital is located in Ionia, Michigan. The hospital was rebuilt in 2015, replacing the original building constructed in 1953. The all-new, state-of-the-art 65,000 square foot critical access hospital features 22 licensed beds. The hospital also offers outpatient services, including a Chemotherapy and Infusion Lab; General and Fluoroscopy Radiology; Nuclear Medicine; CT; Digital Mammography; Ultrasound and Bone Density; an Emergency Department with private patient rooms, triage area, and two trauma rooms; a Surgery Department with two operating rooms, administrative offices, and a board room; a cafeteria; and a community education center.

Partnership with Healthy! Capital Counties

Sparrow Health System participated in a collaborative effort called Healthy! Capital Counties, which aimed to gather and present data that would allow for a better understanding of the health status of those living and working in the three county region surrounding Lansing, Michigan (Clinton, Eaton, and Ingham Counties). Other Healthy! Capital Counties partners included:

- Eaton Rapids Medical Center;
- Hayes Green Beach Memorial Hospital;
- McLaren Greater Lansing;
- Barry-Eaton District Health Department;
- Ingham County Health Department; and
- Mid-Michigan District Health Department.

In addition, Sparrow Health System partnered with the Ingham County Health Department and the Barry-Eaton District Health Department to compile quantitative health indicator data for other counties within Sparrow Health System's service area (Gratiot, Shiawassee, Montcalm, and Ionia Counties). To supplement the qualitative data gathered by Healthy! Capital Counties, Sparrow Health System partnered with the Michigan Public Health Institute to conduct an additional four focus groups and thirteen key informant interviews.

Healthy! Capital Counties Vision

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

- in a physical, social, and cultural environment that supports health;
- in a safe, vibrant, and prosperous community that provides many opportunities to contribute and thrive; and
- With minimal barriers and adequate resources to reach their full potential.

Purpose

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

Healthy! Capital Counties Process

The Healthy! Capital Counties project began as a partnership between the four hospital systems and the three local health departments serving Ingham, Eaton, and Clinton Counties in December of 2010. The 2010 Patient Protection and Affordable Care Act requires non-profit hospitals to conduct or participate in a "community health needs assessment," partner with public health and the 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 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. Building on a regional history of cross-hospital system and cross-health department collaboration, the entities decided to partner collaboratively on this project to conserve and enhance the local capacity to do this work.

In 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 of 2012. The second round of the community health

improvement process began in October of 2014 and resulted in the 2015 Healthy! Capital Counties Community Health Profile and Needs Assessment, published in October of 2015. The third cycle of the Healthy! Capital Counties project began in August of 2017 and resulted in the 2018 Healthy! Capital Counties Community Health Profile and Needs Assessment.

COMMUNITY ENGAGEMENT

The Healthy! Capital Counties project is unique in its multi-agency, collaborative structure and its philosophical promise to integrate and apply a health equity perspective to its processes and data interpretations. Dennis Raphael (2004) defines health equity as the economic and social conditions that influence the health of individuals, communities, and jurisdictions as a whole.

The Healthy! Capital Counties project included one main workgroup, which consisted 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, Healthy! Capital Counties held six focus groups in various locations across the three county region to gather input from traditionally underserved populations. Online surveys were also distributed to both the community at large and the health care providers employed by the participating hospital systems to obtain perspective on the health issues and needs currently existing in the tri-county area.

Healthy! Capital Counties hosted three stakeholder meetings in November 2017, February 2018, and July 2018 to provide community organizations, partners, stakeholders, and the public the opportunity to provide feedback on several aspects of the project, including the quantitative indicator table, asset mapping, the focus group discussion guides, the community survey, and a preview of the findings from both the quantitative and qualitative data gathering efforts. A fourth stakeholder meeting was held in November 2018 during which numerous community representatives were engaged in the process of selecting community health priorities. Healthy! Capital Counties will develop the Community Health Improvement Plan based on these selected priorities.

HEALTHY! CAPITAL COUNTIES JURISDICTION

Many persons living in Clinton, Eaton, and Ingham Counties view themselves as residents of a greater “Capital Area,” which is centered around the urban core of Lansing/East Lansing. These capital counties include a wide variety of communities — from East Lansing, home to Michigan State University, to downtown neighborhoods in Lansing, to inner suburban communities surrounding the urban core, to small towns and villages scattered throughout the countryside. The hospital systems serving the area range from small community hospitals to large tertiary care centers. The need to establish a process that would simultaneously look broadly at the region as a whole and at the county level, while also viewing smaller communities more closely, was essential. The jurisdiction covered by the Healthy! Capital Counties Community Health Profile, which this report is based on, includes all of the residents living in Clinton, Eaton, and Ingham Counties.

MODEL

Healthy! Capital Counties used the Association for Community Health Improvement's model for their 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 their project as well as their timeframe. More information about the model can be found at 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;
- the participation of communities that are traditionally marginalized; and
- community engagement activities.

HOW DOES HEALTH HAPPEN?

Health can seem like a very fragile thing — one minute you have it, the next minute it is gone. Some people look to their genetics to explain their ill health, others think of their behaviors, and some feel that their very neighborhood makes it hard to be healthy. 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, such as a person's genes, can't be changed, while others, such as behavior, can.

The Healthy! Capital Counties Community Health Profile, which this report is based on, 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. To put it another way, the choices people make depend on the choices they have. The Community Health Profile, using information about health outcomes, behaviors, and 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, including 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 - which 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.

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*

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 measures presented in this report are those that have been shown to result in poor health outcomes. To put it bluntly, there is increasing evidence that inequality is making us sick.

Data Collection

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

PRIMARY DATA SOURCES

Several primary data sources were used in the development of this report: the Healthy! Capital Counties focus groups, Sparrow Health System focus groups and key informant interviews, the Capital Area Behavioral Risk Factor and Social Capital survey, and the Healthy! Capital Counties Community and Health Care Provider surveys.

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, Healthy! Capital Counties conducted a series of focus groups for the project. Six focus groups were held between March and May of 2018 and took place in various locations throughout the three-county focus area (Clinton, Eaton, and Ingham Counties). Groups that were actively solicited for input included:

- People with disabilities;
- People recovered/recovering from substance addiction;
- People who do not have health insurance;
- People who have low incomes or are unemployed;
- People who identify as Spanish-speaking Hispanic or Latino/a; and
- People who identify as persons of color.

Sparrow Health System Focus Groups: On behalf of Sparrow Health System, the Michigan Public Health Institute conducted four additional focus groups to expand upon the information gathered during the Healthy! Capital Counties focus groups. Focus groups were conducted in June and July of 2018, and topics covered included rural health and access to care.

Sparrow Health System Key Informant Interviews: In addition to the focus groups conducted on behalf of Sparrow Health System, the Michigan Public Health Institute also spoke with thirteen people who participated in key informant interviews. Key informant interviews were conducted by telephone between August and September of 2018.

Capital Area Behavioral Risk Factor & Social Capital Survey (BRFS): Since 2000, the Capital Area United Way, Barry-Eaton District Health Department, Ingham County Health Department, and Mid-Michigan District Health Department have conducted a telephone health survey of the adult population in their jurisdictions (Barry, Eaton, Ingham, Clinton, Gratiot, and Montcalm Counties) on various behaviors, medical conditions, and preventive health care practices. The survey was conducted using the Capital Area Behavioral Risk Factor & Social Capital survey instrument, which includes questions from the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System questionnaire as well as questions developed by the health departments to collect information of interest to the local community. During the 2014-2016 data collection cycle, a total of 3,613 adults in Clinton, Eaton, and Ingham counties responded to the landline/mobile phone survey. The overall survey response rate was 32.9%.

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 between April and June of 2018. 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 hospital systems participating in the H!CC collaborative.

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 to inform Congress of current trends in between the decennial census. The American Community Survey (ACS) is the response to that request. It is an ongoing statistical survey conducted by the U.S. Census Bureau which is sent to approximately 250,000 addresses monthly (or 3 million per year) to gather information about: demographics, family and relationships, income and benefits, and health insurance. In 2010, it replaced the long form of the decennial census.

Centers for Disease Control and Prevention (CDC): Prescription data comes from the QuintilesIMS Transactional Data Warehouse, which is based on a sample of approximately 59,000 retail (non-hospital) pharmacies that dispense roughly 88% of all retail prescriptions in the United States.

Federal Bureau of Investigation (FBI): The FBI Uniform Crime Reporting Program provides information on the rate of violent crimes.

Michigan Association of United Ways (MAUW): Since 2014, the Michigan Association of United Ways has 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.

Michigan Care Improvement Registry (MCIR): MCIR was created in 1998 to collect reliable childhood immunization information and make such data 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 evaluating program progress, and identifying emerging health issues and trends.

Michigan Profile for Healthy Youth (MiPHY) Survey (Michigan Department of Education and MDHHS): The Michigan Profile for Healthy Youth is an online student health survey, which provides information on adolescent 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 as well as violence.

National Environmental Public Health Tracking Network (NEPHTN): Coordinated by the Centers for Disease Control and Prevention, the NEPHTN brings together health and environmental data in one place, making it easier to analyze, interpret, and distribute information about the relationship between environmental exposures, hazards, and health outcomes.

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 as the interaction between these aspects, in order to identify causal relationships between food choice, diet quality, and access to healthy food.

Quantitative Data

This section contains all of the quantitative data gathered for the Community Health Needs Assessment. First, the data gathered by Healthy! Capital Counties is presented indicator-by-indicator. The table below depicts all of the domains, indicator groups, indicators, associated measures, and data sources for the Healthy! Capital Counties indicators. Each indicator is described in more depth on the pages following the table. Data for Shiawassee, Montcalm, Gratiot, and Ionia Counties have been provided by Ingham County Health Department staff and added to the information originally presented by Healthy! Capital Counties.

Citations

Healthy! Capital Counties 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, throughout this report.

SUMMARY OF THE HEALTHY! CAPITAL COUNTIES INDICATORS

Domain	Indicator Group	Indicator	Measures	Source
Opportunity Measures	Income	Income Distribution	Gini Coefficient for Income Inequality	ACS
Social, Economic, & Environmental Factors	Social & Economic Factors	Income	Percentage of Households below the ALICE Threshold	MAUW
		Education	Percentage of Adults ≥ 25 Years Old with a Bachelor's Degree or Higher	ACS
		Social Connection & Social Capital	Percentage of Adolescents Who Know an Adult in their Neighborhood They Could Talk to About Something Important	MiPHY
		Community Safety	Rate of Violent Crimes per 100,000 People	FBI
		Affordable Housing	Percentage of Households with Housing Costs greater than 30% of Income	ACS
		Quality of Primary Care	Ambulatory Care Sensitive (ACS) or Preventable Hospitalizations per 10,000 People per Year	MDHHS
	Environmental Factors	Environmental Quality-Indoor	Percentage of Children <6 Years Old with Elevated Blood Lead Levels (≥5ug/dL)	MDHHS
		Environmental Quality-Outdoor	Change in the Projected Number of Extreme Heat Days	NEPHTN
		Built Environment	Percentage of the Population Living in a Food Desert	USDA
Behaviors, Stress, & Physical Condition	Health Behaviors & Physical Condition	Obesity	Percentage of Adults who are Obese	BRFS
			Percentage of Adolescents who are Obese	MiPHY
		Tobacco Use	Percentage of Adults who Currently Smoke	BRFS
			Percentage of Adolescents who Smoked Cigarettes in the Past 30 Days	MiPHY
		Alcohol Use	Percentage of Adults who Reported Binge Drinking in the Past 30 Days	BRFS
			Percentage of Adolescents who Reported Binge Drinking in the Past 30 Days	MiPHY
		Substance Use	Number of Opioid Prescriptions Filled per 1,000 People	CDC

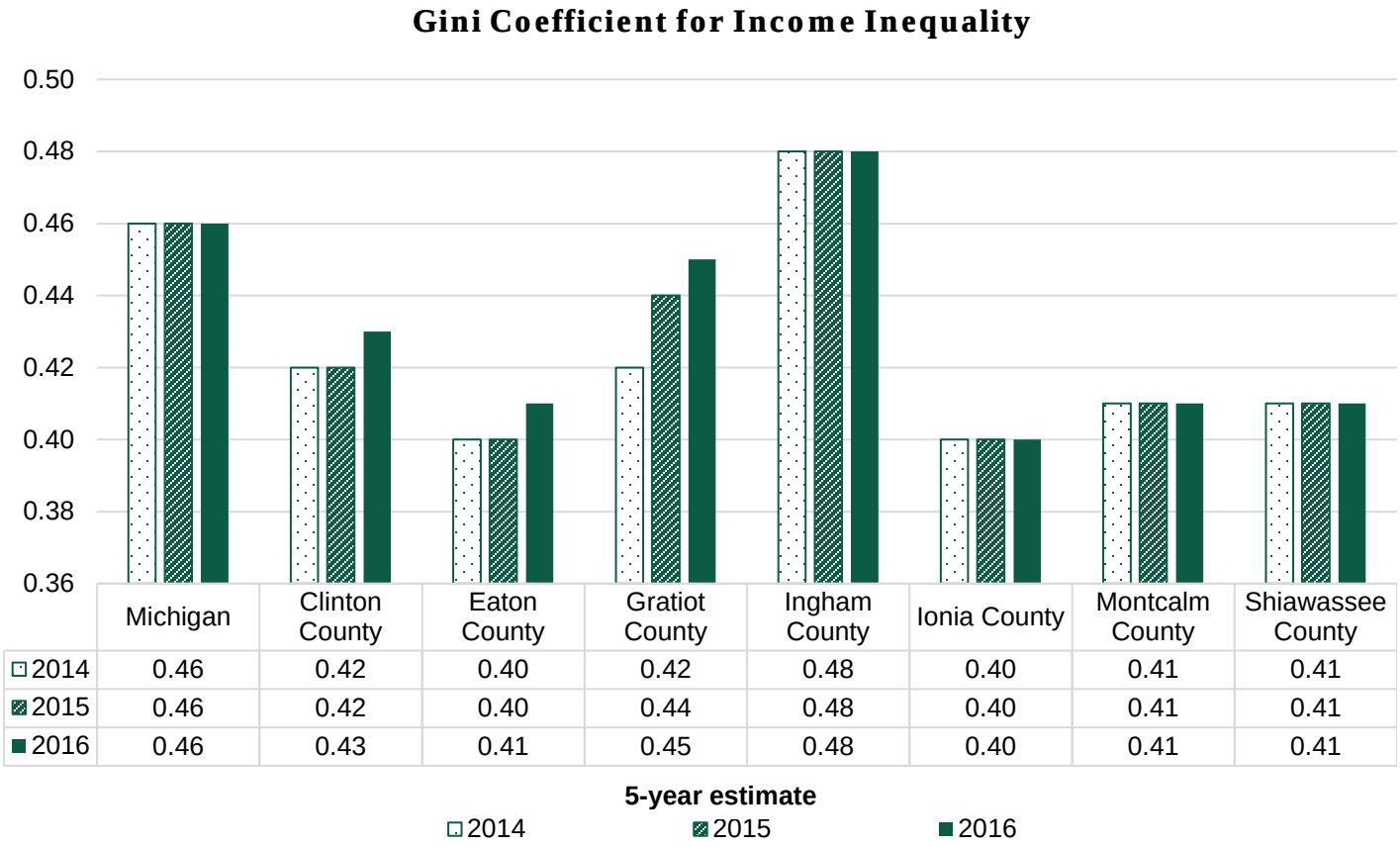
			Percentage of Adolescents who Took Painkillers without a Doctor's Prescription in the Past 30 days	MiPHY
		Physical Activity	Percentage of Adults who Report not Engaging in any Leisure Time Physical Activity	BRFS
			Percentage of Adolescents who Reported Physical Activity for ≥60 Minutes on ≥5 of the Past 7 Days	MiPHY
		Nutrition	Percentage of Adults who Consume ≥5 Servings of Fruits and Vegetables per Day	BRFS
			Percentage of Adolescents who Consume ≥5 Servings of Fruits and Vegetables per Day	MiPHY
	Clinical Care	Access to Primary Care and Health Insurance	Percentage of Adults with No Primary Care Provider	BRFS
			Percentage of Adults Ages 18-64 who are Uninsured	ACS
		Communicable Disease Prevention	Number of Non-Medical Immunization Waivers Granted per 1,000 Schoolchildren	MCIR
	Stress	Mental Health	Percentage of Adults who Reported Poor Mental Health	BRFS
			Percentage of Adolescents who Reported Symptoms of Depression in the Past Year	MiPHY
Health Outcomes	Illness (Morbidity)	Child Health	Asthma-Related Ambulatory Care Sensitive Hospitalizations per 10,000 Children <18 Years Old	MDHHS
		Chronic Disease	Diabetes-Related Ambulatory Care Sensitive Hospitalizations per 10,000 Adults	MDHHS
		Communicable Disease	Rate of Chlamydia Cases per 100,000 People	MDHHS
		Adult Health	Rate of Preventable Congestive Heart Failure-Related Hospitalizations per 10,000 Adults ≥ 65 Years Old	MDHHS
	Deaths (Mortality)	Overall Mortality	Life Expectancy (in years)	MDHHS; ACS
		Maternal & Child Health	Infant Deaths per 1,000 Live Births	MDHHS
		Chronic Disease	Age-Adjusted Rate of Death due to Diseases of the Heart per 100,000 People	MDHHS
		Safety Policies & Practices	Age-Adjusted Rate of Death due to Accidental Injury per 100,000 People	MDHHS

Income Distribution

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

Data Source: U.S. Census Bureau, American Community Survey

Years: 2010-2014, 2011-2015, and 2012-2016 American Community Survey 5-Year Estimates



	Michigan	Clinton County	Eaton County	Gratiot County	Ingham County	Ionia County	Montcalm County	Shiawassee County
2014	0.46	0.42	0.40	0.42	0.48	0.40	0.41	0.41
2015	0.46	0.42	0.40	0.44	0.48	0.40	0.41	0.41
2016	0.46	0.43	0.41	0.45	0.48	0.40	0.41	0.41

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 southern Africa and many South American countries, have generally poorer health outcomes than places with relatively low income inequality (Gini coefficients less than 0.35), such as Europe, Australia, Canada, and Scandinavia.

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

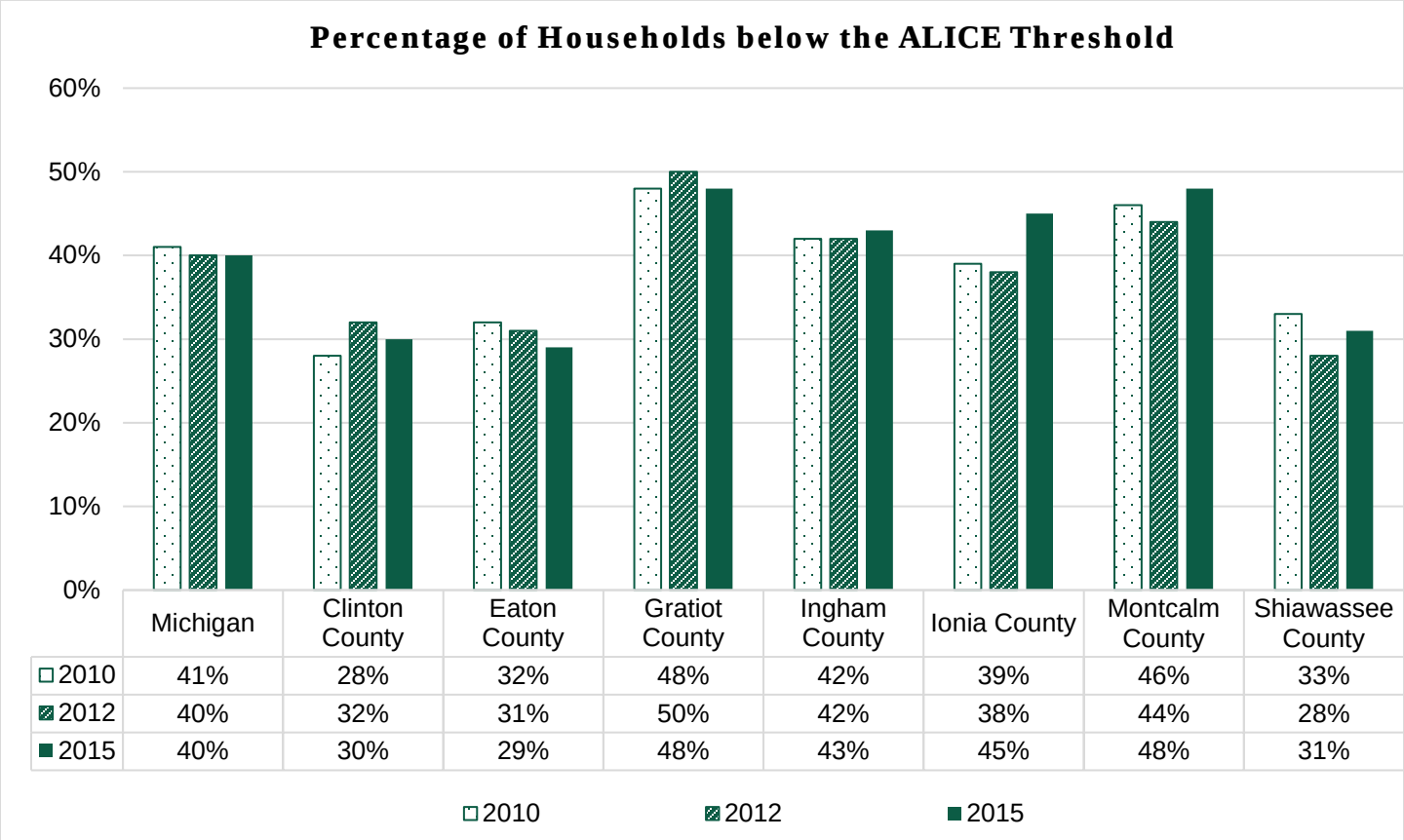
Income inequality may have negative consequences for the poor. The movement of high-income earners away from the low-income earners, for example, may leave low-income earners with relatively few jobs or reduce the extent to which the middle class and the rich confer positive effects on the poor, such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

Income

Measure: Percentage of Households below the ALICE Threshold

Data Source: 2017 United Ways of Michigan *ALICE Project* Report

Years: 2010, 2012, and 2015 Point-in-Time Data



	Michigan	Clinton County	Eaton County	Gratiot County	Ingham County	Ionia County	Montcalm County	Shiawassee County
2010	41%	28%	32%	48%	42%	39%	46%	33%
2012	40%	32%	31%	50%	42%	38%	44%	28%
2015	40%	30%	29%	48%	43%	45%	48%	31%

Reason for Measure: ALICE is an acronym that 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 ALICE threshold is the average income that a household needs to afford the basic necessities defined by the Household Survival Budget* for each county in Michigan. 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 for financial difficulties and poverty if they experience an unforeseen financial expense (e.g., a major car repair). Calculating the percentage 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.

**For example, in Clinton County in 2015, the Household Survival Budget was $55,080 annually ($4,590 monthly) for a family of four including an infant and a preschooler. In Ingham County, that same family of four would have to make $56,256 a year ($4,688 monthly) to afford basic necessities.*

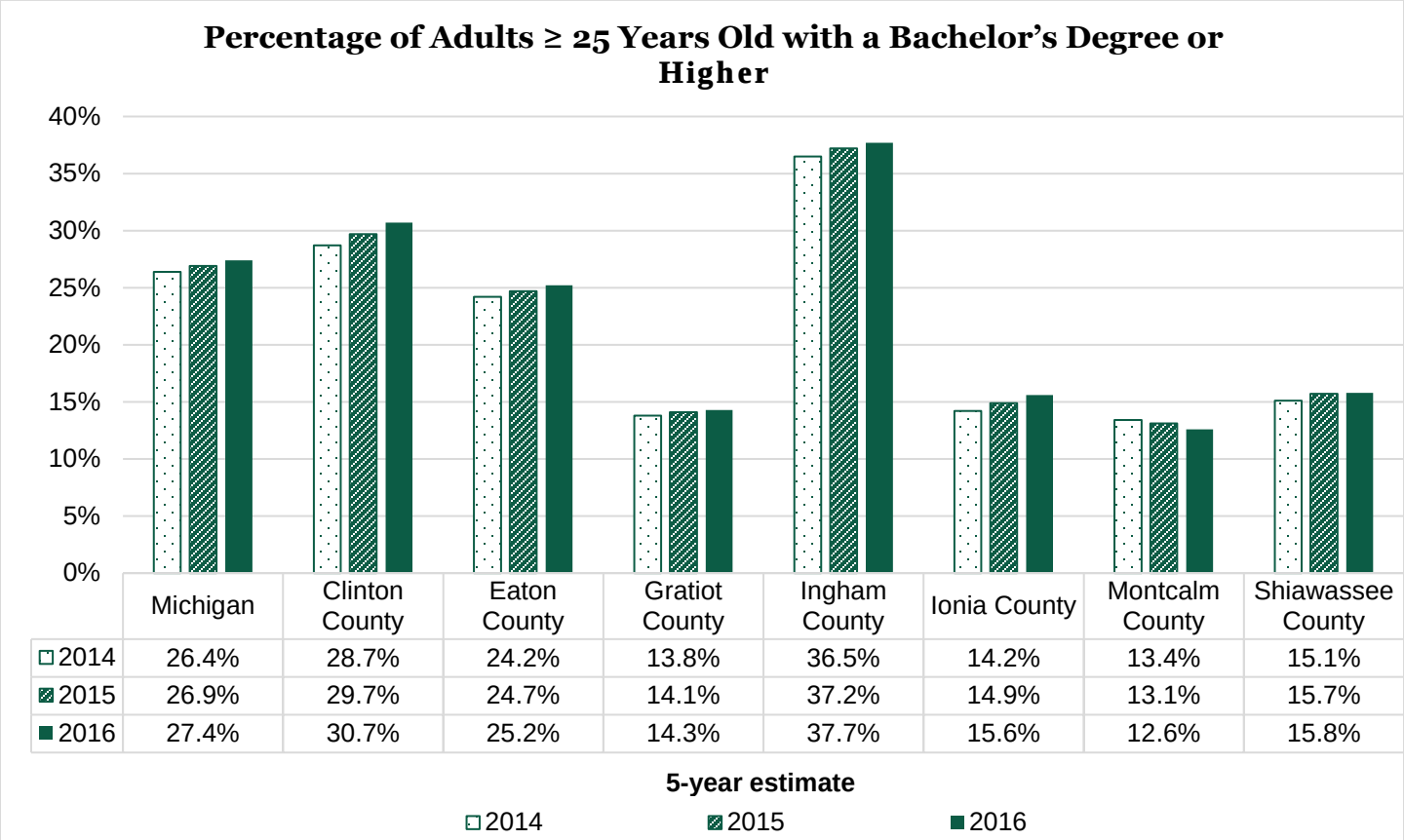
[+]Unless otherwise noted in this report, households below the Federal Poverty Level are included as part of the percentage of households with earnings below the ALICE threshold.

Education

Measure: The percentage of adults who are 25 years of age or older who have a Bachelor's Degree or higher.

Data Source: U.S. Census Bureau, American Community Survey

Years: 2010-2014, 2011-2015, and 2012-2016 American Community Survey 5-Year Estimates



	Michigan	Clinton County	Eaton County	Gratiot County	Ingham County	Ionia County	Montcalm County	Shiawassee County
2014	26.4%	28.7%	24.2%	13.8%	36.5%	14.2%	13.4%	15.1%
2015	26.9%	29.7%	24.7%	14.1%	37.2%	14.9%	13.1%	15.7%
2016	27.4%	30.7%	25.2%	14.3%	37.7%	15.6%	12.6%	15.8%

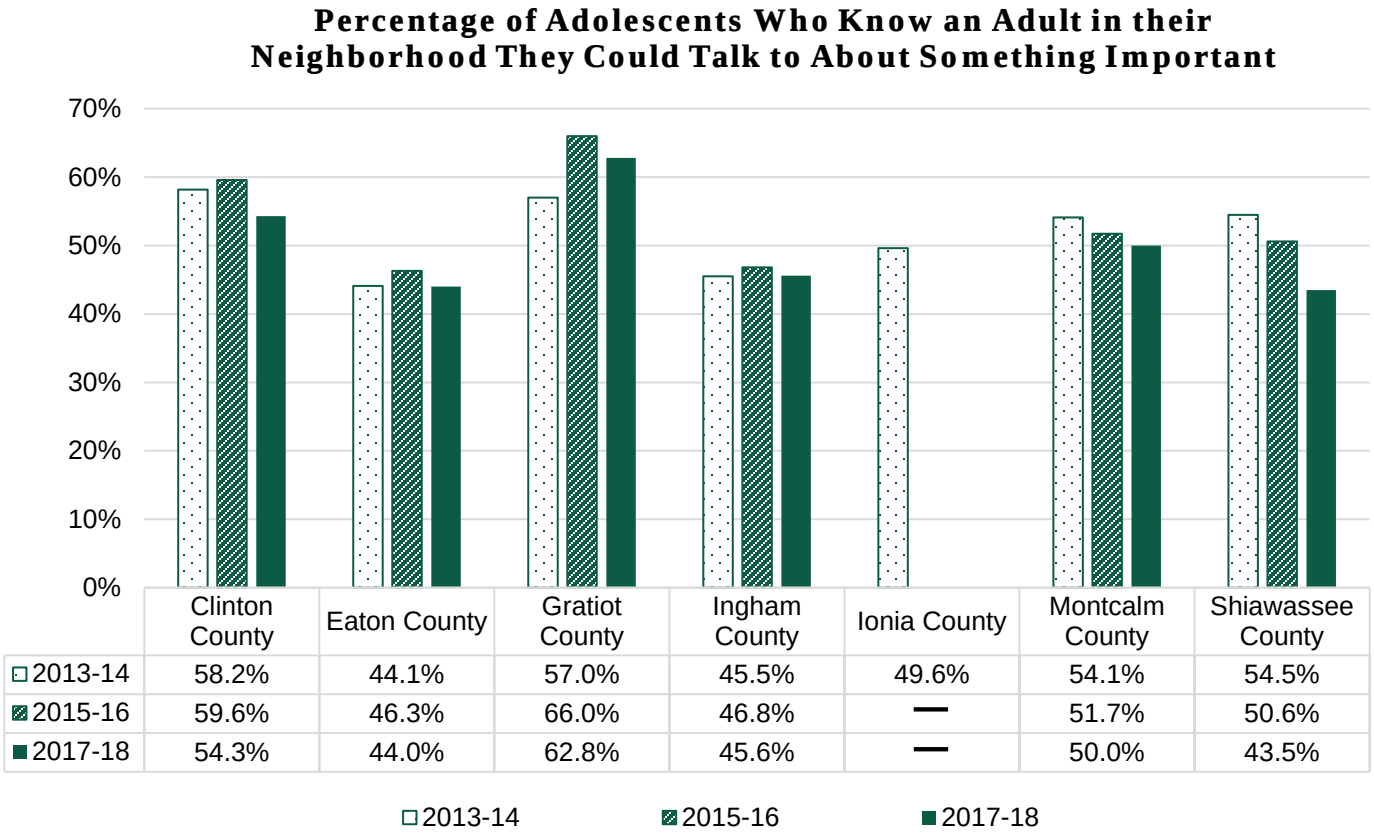
Reason for Measure: The relationship between higher education and improved health outcomes is well known, with years of formal education correlating strongly with improved work and economic opportunities, reduced psychosocial stress, and healthier lifestyles.[CHR] In other words, persons with more education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

Social Connection & Social Capital

Measure: The percentage of adolescents (9th and 11th grade students) that reported knowing an adult in their neighborhood that they could talk to about something important.

Data Source: Michigan Profile for Healthy Youth (MiPHY)

Years: 2013-2014, 2015-2016, and 2017-2018 academic years



	Clinton County	Eaton County	Gratiot County	Ingham County	Ionia County	Montcalm County	Shiawassee County
2013-14	58.2%	44.1%	57.0%	45.5%	49.6%	54.1%	54.5%
2015-16	59.6%	46.3%	66.0%	46.8%	—	51.7%	50.6%
2017-18	54.3%	44.0%	62.8%	45.6%	—	50.0%	43.5%

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, on 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 themselves. On the other hand, 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.

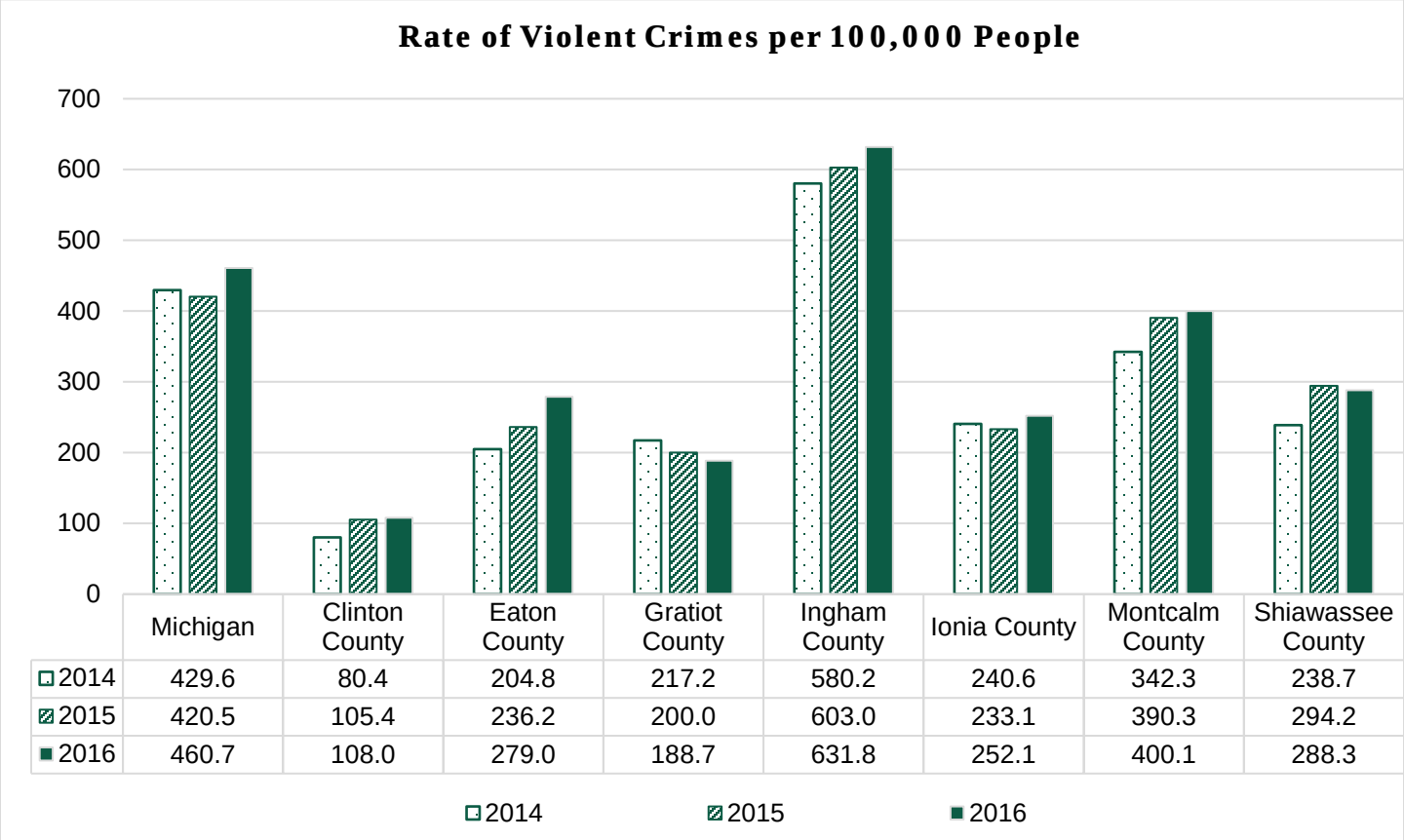
**Notes about this Measure: State-wide data is not available for this measure as this question was not asked on the Michigan Youth Risk Behavior Survey.*

Community Safety

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: FBI Uniform Crime Reporting Program

Years: 2014, 2015, and 2016



	Michigan	Clinton County	Eaton County	Gratiot County	Ingham County	Ionia County	Montcalm County	Shiawassee County
2014	429.6	80.4	204.8	217.2	580.2	240.6	342.3	238.7
2015	420.5	105.4	236.2	200.0	603.0	233.1	390.3	294.2
2016	460.7	108.0	279.0	188.7	631.8	252.1	400.1	288.3

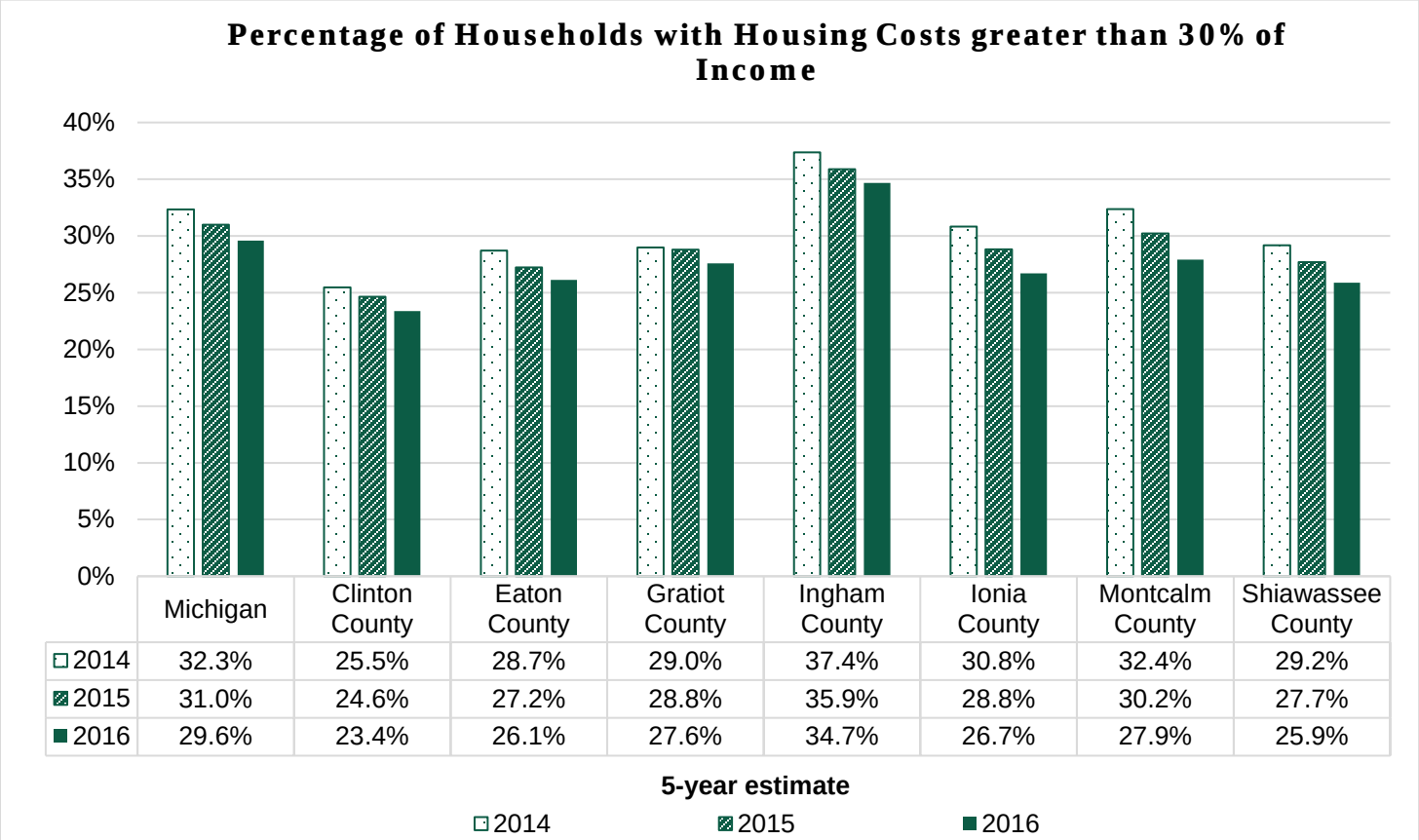
Reason for Measure: High levels of violent crime compromise physical safety and psychological well-being. Crime rates can also deter residents from pursuing healthy behaviors, such as exercising out-of-doors. Additionally, some evidence indicates that increased stress levels may contribute to obesity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

Affordable Housing

Measure: The percentage of households that spend 30 percent or more of their household income on housing costs.

Data Source: U.S. Census Bureau, American Community Survey

Years: 2010-2014, 2011-2015, and 2012-2016 American Community Survey 5-Year Estimates



	Michigan	Clinton County	Eaton County	Gratiot County	Ingham County	Ionia County	Montcalm County	Shiawassee County
2014	32.3%	25.5%	28.7%	29.0%	37.4%	30.8%	32.4%	29.2%
2015	31.0%	24.6%	27.2%	28.8%	35.9%	28.8%	30.2%	27.7%
2016	29.6%	23.4%	26.1%	27.6%	34.7%	26.7%	27.9%	25.9%

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

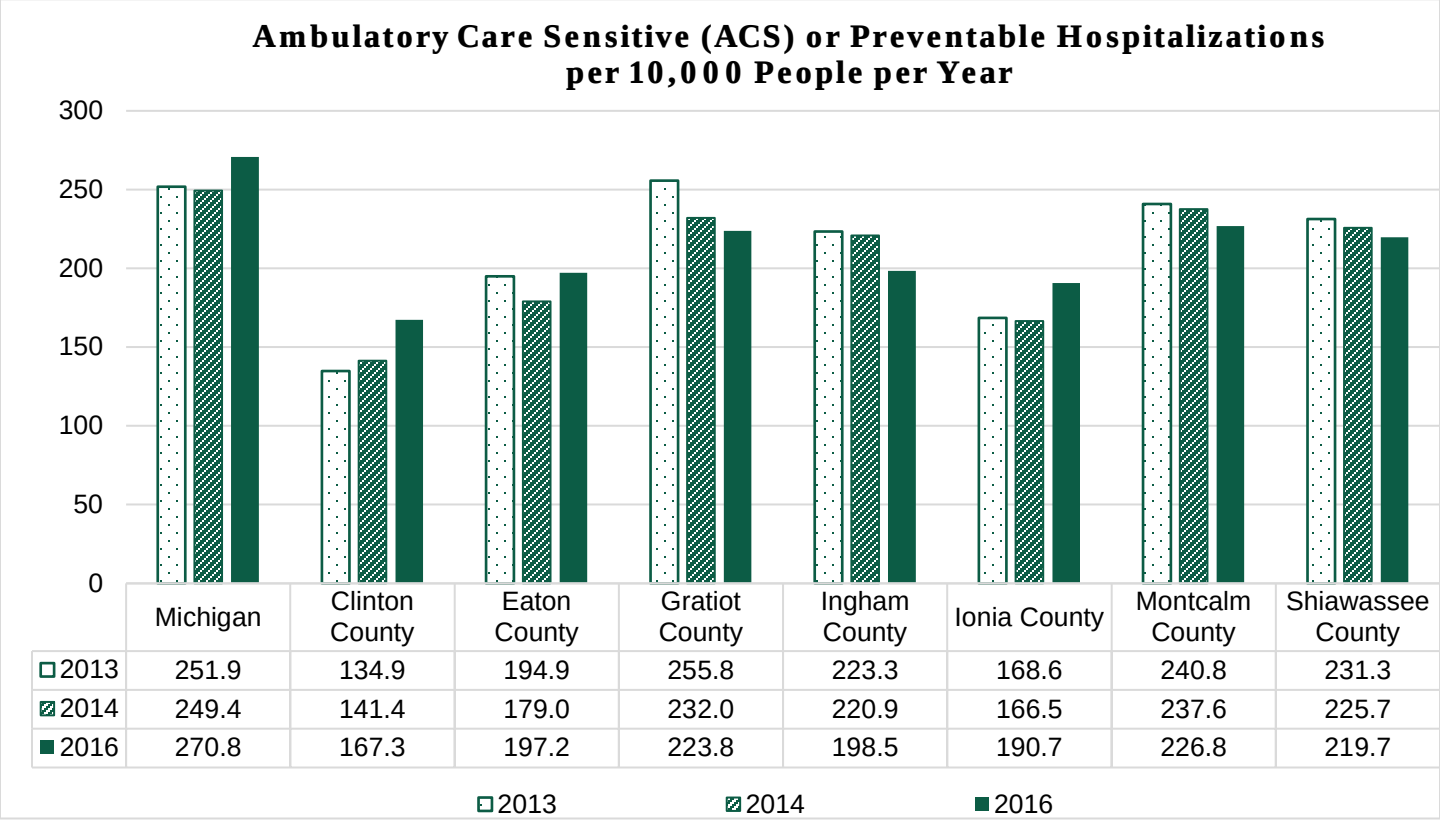
Source: http://www.nhc.org/media/documents/HousingandHealth1.pdf

Quality of Primary Care

Measure: The number of Ambulatory Care Sensitive (ACS) hospitalizations per 10,000 people per year. Ambulatory Care Sensitive hospitalizations are hospitalizations for conditions, such as asthma, diabetes or dehydration, where timely and effective ambulatory care can decrease hospitalizations by preventing the onset of an illness or condition, controlling an acute episode of an illness, or managing a chronic disease or condition. Ambulatory care is care provided in a primary care setting, such as a doctor's office, rather than in a hospital.

Data Source: Michigan Resident Inpatient Files created by the Michigan Department of Health and Human Services Division for Vital Records and Health Statistics using data from the Michigan Inpatient Database obtained with permission from the Michigan Health and Hospital Association Service Corporation.

Years: 2013, 2014, and 2016



	Michigan	Clinton County	Eaton County	Gratiot County	Ingham County	Ionia County	Montcalm County	Shiawassee County
2013	251.9	134.9	194.9	255.8	223.3	168.6	240.8	231.3
2014	249.4	141.4	179.0	232.0	220.9	166.5	237.6	225.7
2016	270.8	167.3	197.2	223.8	198.5	190.7	226.8	219.7

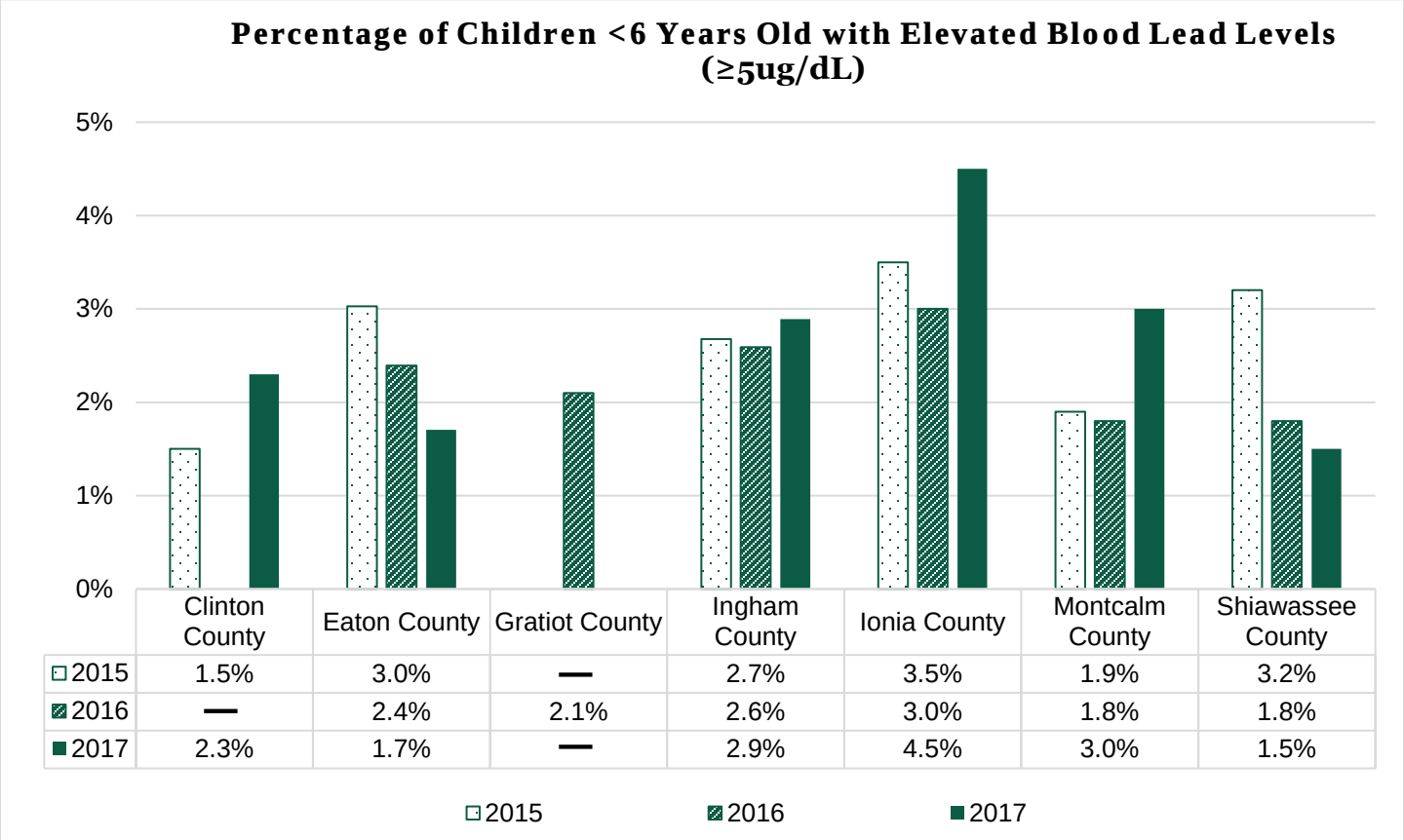
Reason for Measure: Ambulatory Care Sensitive conditions are illnesses that can often be managed effectively on an outpatient basis and generally do not result in hospitalization if managed properly. High rates of ACS hospitalizations in a community are an indicator of a lack of (or failure of) prevention efforts, a primary care resource shortage, poor performance of primary health care delivery systems, or other factors that create barriers to obtaining timely and effective ambulatory care.[MDHHS]

Environmental Quality – Indoor

Measure: The percentage of children less than six years of age who had their blood tested for lead with elevated blood lead levels (EBLL) ≥5ug/dL (highest venous or capillary blood lead level).

Data Source: Michigan Department of Health and Human Services, Childhood Lead Poisoning and Prevention Program

Years: 2015, 2016, and 2017



	Clinton County	Eaton County	Gratiot County	Ingham County	Ionia County	Montcalm County	Shiawassee County
2015	1.5%	3.0%	—	2.7%	3.5%	1.9%	3.2%
2016	—	2.4%	2.1%	2.6%	3.0%	1.8%	1.8%
2017	2.3%	1.7%	—	2.9%	4.5%	3.0%	1.5%

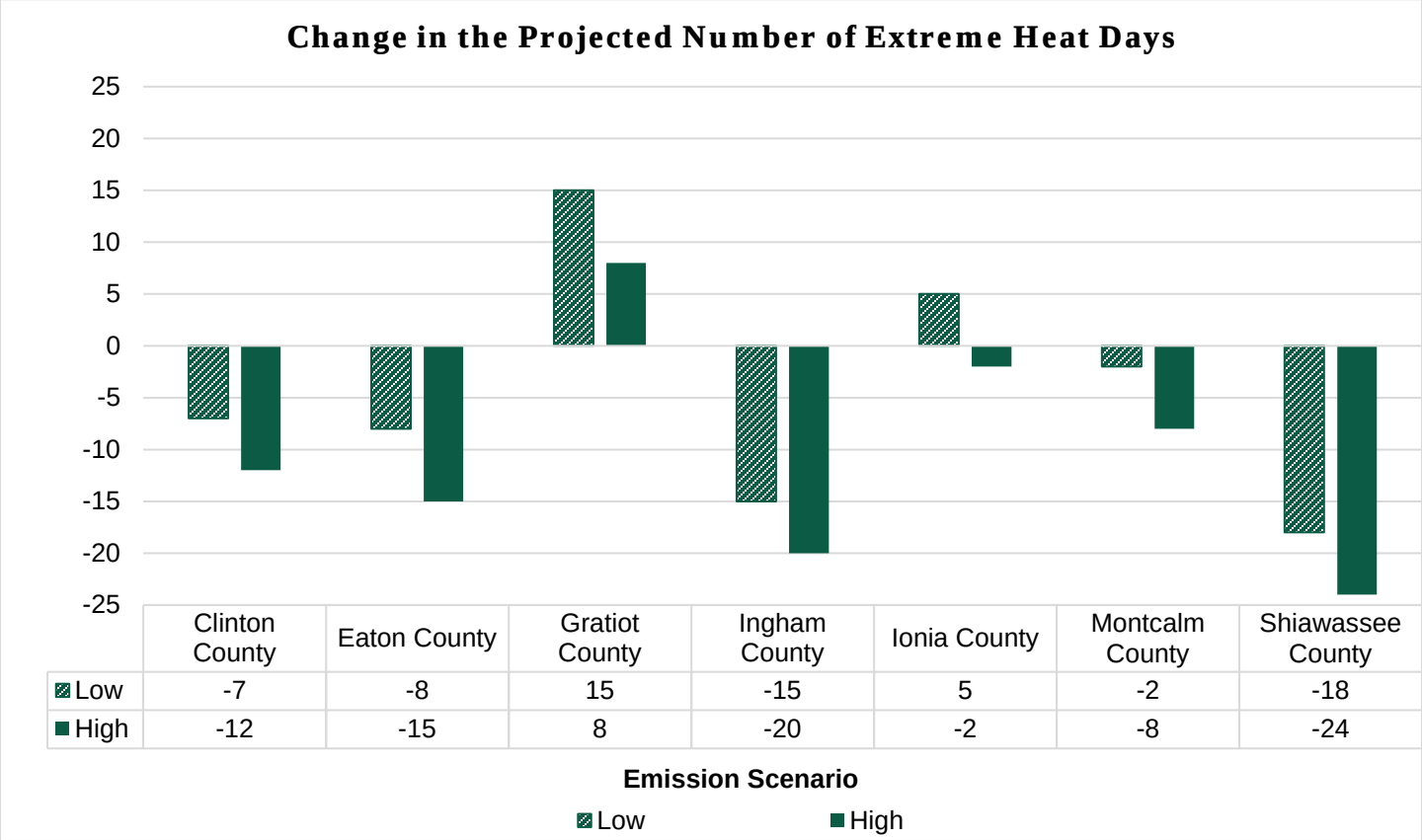
Reason for Measure: Lead exposure among children continues to be an important public health problem. Children living in older housing that may still contain lead-based paint are at highest risk. The adverse health effects of childhood lead exposure are numerous and well documented, including cognitive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

Environmental Quality – Outdoor

Measure: Change in the projected number of extreme heat days (those with temperatures above 90°F), which equals the projected number of extreme heat days during the years 2020-2025 minus the projected number of extreme heat days during the years 2010-2015. The Intergovernmental Panel on Climate Change (IPCC) developed four scenarios based on economic development, economic growth, technological change, and population growth. These scenarios are used to describe the different inputs that could affect climate change. The low emission and high mission scenarios represent the best and worst case scenarios of the four, respectively.

Data Source: National Environmental Public Health Tracking Network

Years: 2010-2015 and 2020-2025



	Clinton County	Eaton County	Gratiot County	Ingham County	Ionia County	Montcalm County	Shiawassee County
Low	-7	-8	15	-15	5	-2	-18
High	-12	-15	8	-20	-2	-8	-24

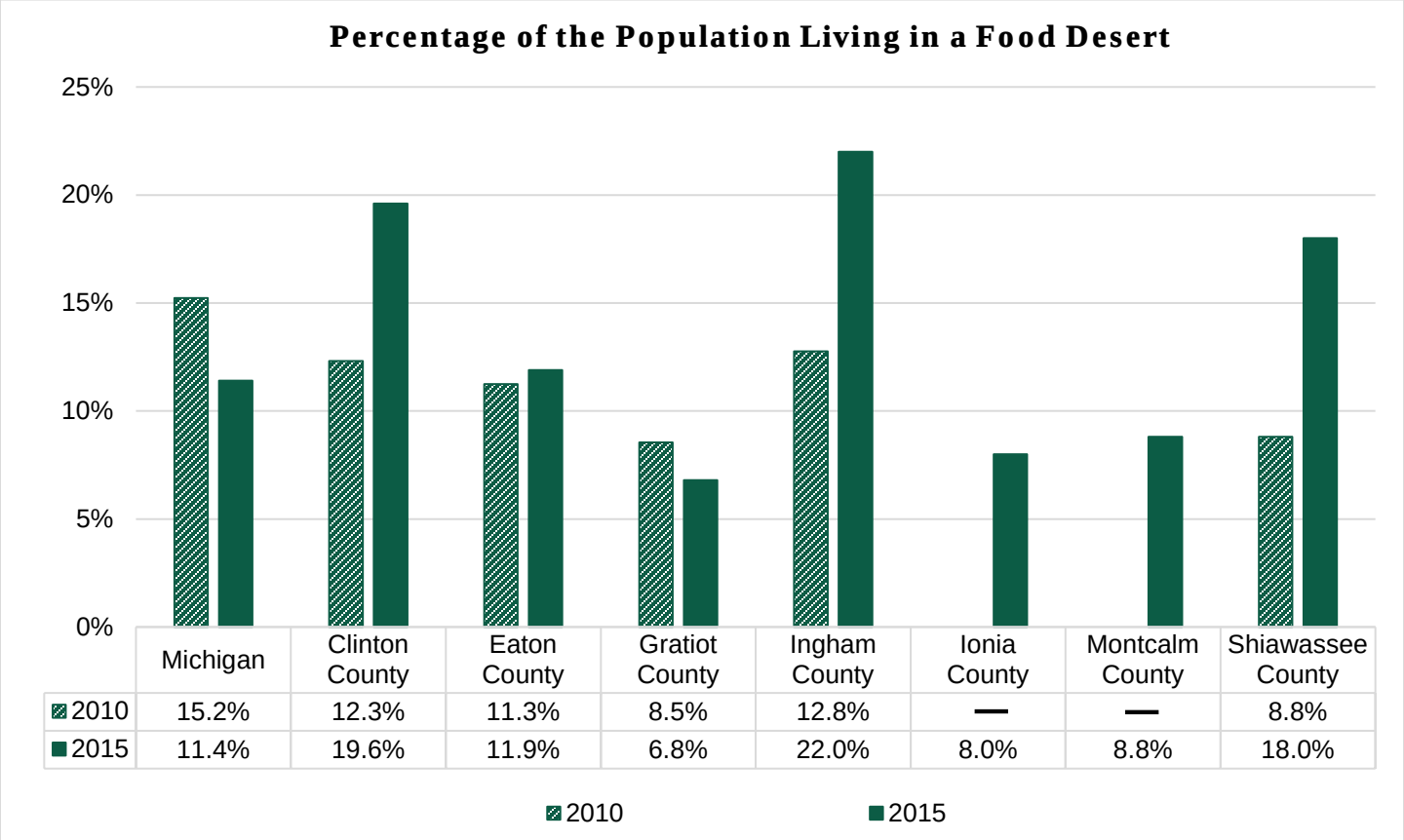
Reason for Measure: In most of the United States, an extreme heat day is a day of high heat and humidity with temperatures above 90 degrees Fahrenheit. On an extreme heat day, evaporation is slowed, and the body must work harder to maintain a normal temperature. Heat-related illnesses (i.e. heat exhaustion or heat stroke) could occur quickly, without warning, and affect anyone. Older adults, children, and sick or overweight individuals are particularly vulnerable to heat-related illnesses. Extreme heat days have gained notoriety recently because of 1) school and other facility closures due to the inability of aging cooling systems, if one exists, to keep up with the increased demand, and 2) blackouts, when the electrical grid becomes temporarily overwhelmed.

Built Environment

Measure: The percentage of the population that lives in a USDA-defined food desert. A food desert is a census tract that is low-income (the poverty rate is greater than 20 percent or median income is less than 80 percent of the statewide median income) and where a substantial number or share of people have limited access to food, which is defined as living more than one mile (in an urban area) or more than 10 miles (in a rural area) away from a grocery store or supermarket.

Data Source: United States Department of Agriculture, Economic Research Service, Food Access Research Atlas

Years: 2010 and 2015



	Michigan	Clinton County	Eaton County	Gratiot County	Ingham County	Ionia County	Montcalm County	Shiawassee County
2010	15.2%	12.3%	11.3%	8.5%	12.8%	—	—	8.8%
2015	11.4%	19.6%	11.9%	6.8%	22.0%	8.0%	8.8%	18.0%

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 less healthy foods.

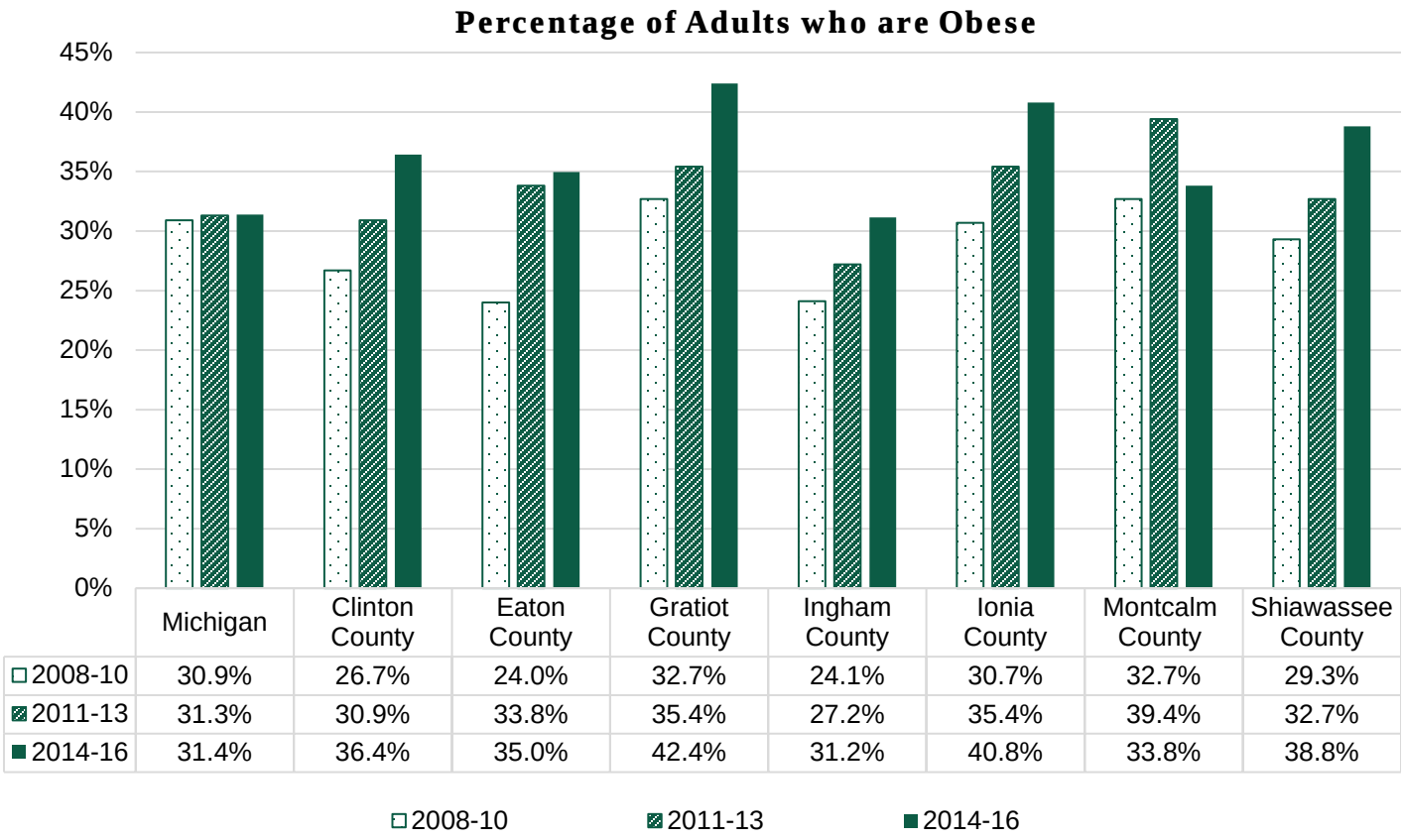
Obesity (Adults)

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 & Social Capital Survey

Years: 2008-2010, 2011-2013, and 2014-2016



	Michigan	Clinton County	Eaton County	Gratiot County	Ingham County	Ionia County	Montcalm County	Shiawassee County
2008-10	30.9%	26.7%	24.0%	32.7%	24.1%	30.7%	32.7%	29.3%
2011-13	31.3%	30.9%	33.8%	35.4%	27.2%	35.4%	39.4%	32.7%
2014-16	31.4%	36.4%	35.0%	42.4%	31.2%	40.8%	33.8%	38.8%

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

Obesity (Adolescents)

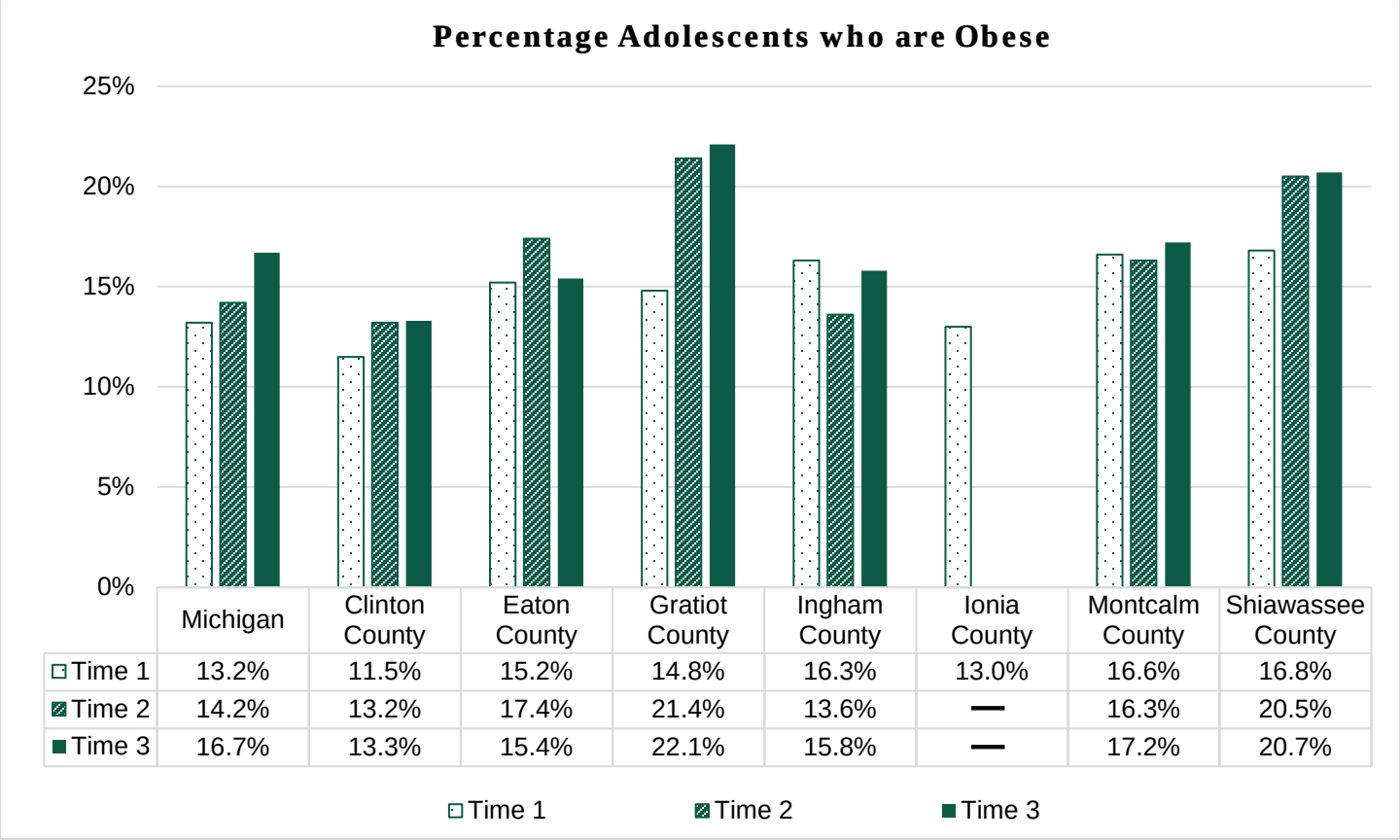
Measure: Adolescent obesity prevalence represents the percentage of students who are obese (at or above the 95th percentile for BMI by age and sex). BMI is calculated from the individual's self-reported height and weight. BMI is defined as weight in kg divided by height in meters, squared.

Data Source:

Michigan Profile for Healthy Youth (MiPHY): the percentage for students in the 9th and 11th grades
Michigan Youth Risk Behavior Survey (MI YRBS): the percentage for students in the 9th through 12th grades

Years:

MiPHY: 2013-2014 (Time 1), 2015-2016 (Time 2), and 2017-2018 (Time 3) academic years
MI YRBS: 2012-2013 (Time 1), 2014-2015 (Time 2), and 2016-2017 (Time 3) academic years
**The MI YRBS and the MiPHY are administered in alternate academic years.*



	Michigan	Clinton County	Eaton County	Gratiot County	Ingham County	Ionia County	Montcalm County	Shiawassee County
Time 1	13.2%	11.5%	15.2%	14.8%	16.3%	13.0%	16.6%	16.8%
Time 2	14.2%	13.2%	17.4%	21.4%	13.6%	—	16.3%	20.5%
Time 3	16.7%	13.3%	15.4%	22.1%	15.8%	—	17.2%	20.7%

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

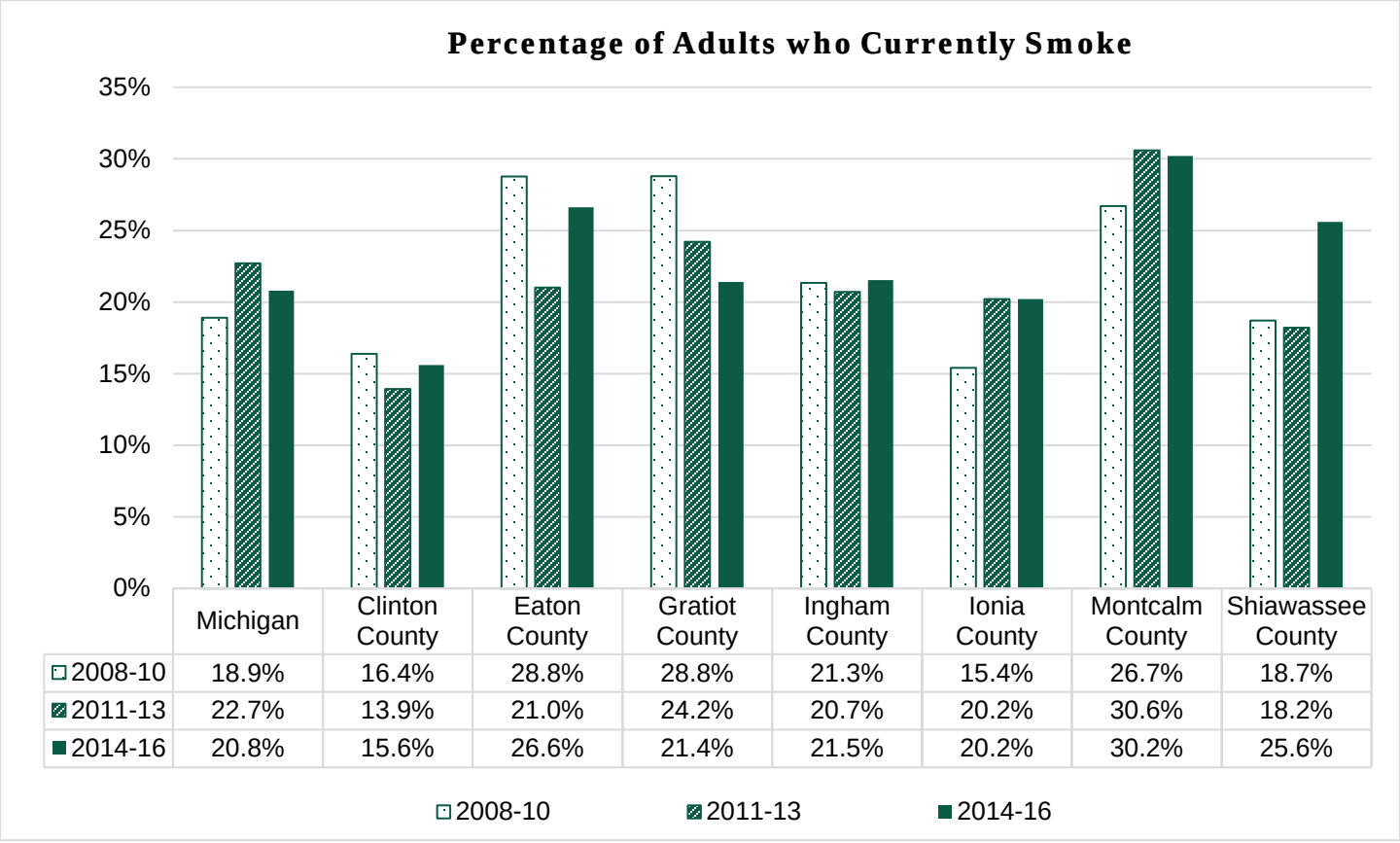
Potential long-term health effects of childhood obesity include a high probability of adult obesity, heart disease, type 2 diabetes, stroke, several types of cancer, and osteoarthritis. One study showed that children who became obese as early as age two were more likely to be obese as adults. Being overweight or obese is associated with increased risk for many types of cancer, including cancer of the breast, colon, endometrium, esophagus, kidney, pancreas, gall bladder, thyroid, ovary, cervix, and prostate, as well as multiple myeloma and Hodgkin's lymphoma.[CDC]

Tobacco Use (Adults)

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

Data Source:
Michigan Behavioral Risk Factor Surveillance System
Capital Area Behavioral Risk Factor & Social Capital Survey

Years: 2008-2010, 2011-2013, and 2014-2016



	Michigan	Clinton County	Eaton County	Gratiot County	Ingham County	Ionia County	Montcalm County	Shiawassee County
2008-10	18.9%	16.4%	28.8%	28.8%	21.3%	15.4%	26.7%	18.7%
2011-13	22.7%	13.9%	21.0%	24.2%	20.7%	20.2%	30.6%	18.2%
2014-16	20.8%	15.6%	26.6%	21.4%	21.5%	20.2%	30.2%	25.6%

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 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 effectiveness of existing programs.[CHR]

Tobacco Use (Adolescents)

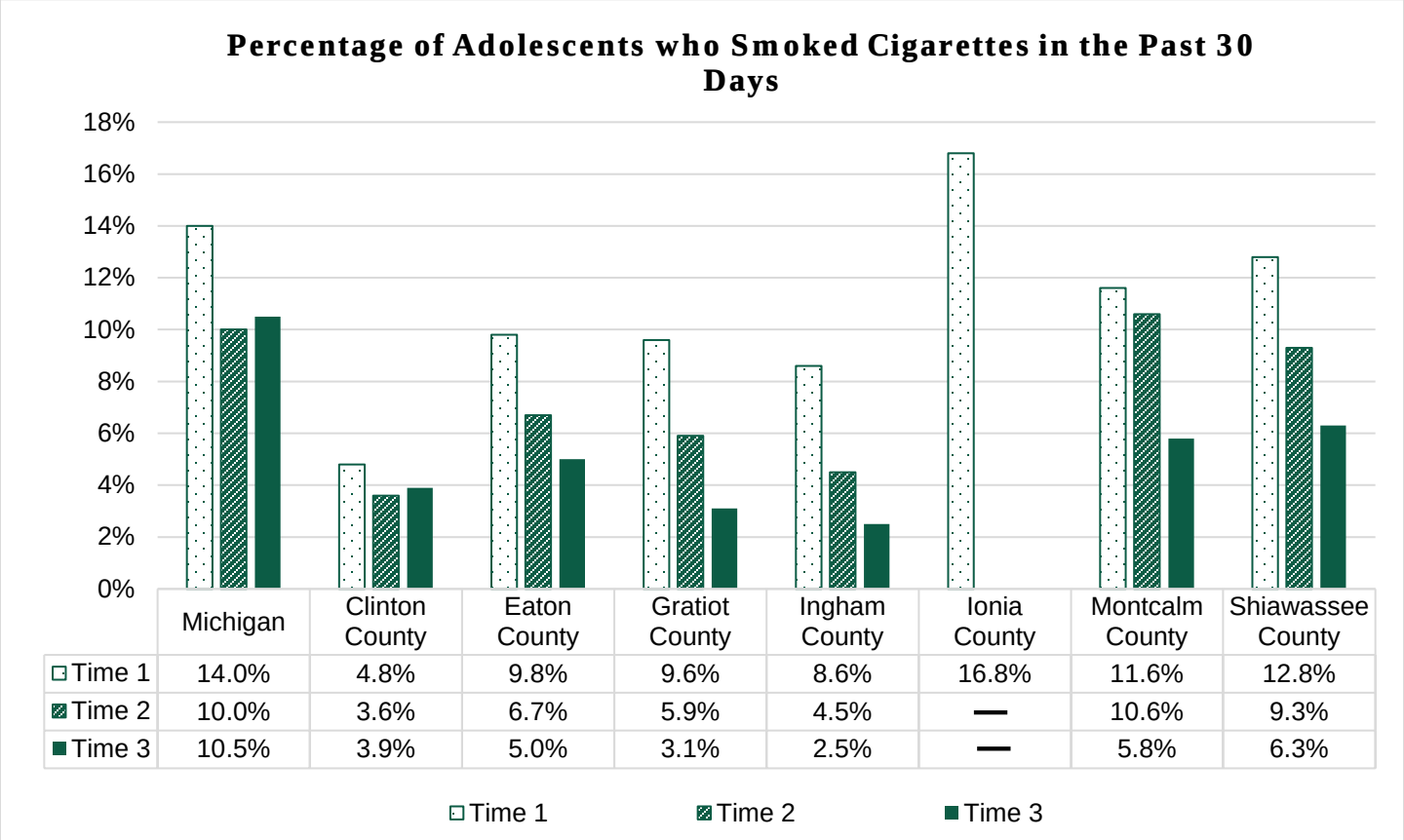
Measure: Adolescent smoking prevalence represents the percentage of students who smoked cigarettes on one or more of the past 30 days.

Data Source:

Michigan Profile for Healthy Youth (MiPHY): the percentage for students in the 9th and 11th grades
Michigan Youth Risk Behavior Survey (MI YRBS): the percentage for students in the 9th through 12th grades

Years:

MiPHY: 2013-2014 (Time 1), 2015-2016 (Time 2), and 2017-2018 (Time 3) academic years
MI YRBS: 2012-2013 (Time 1), 2014-2015 (Time 2), and 2016-2017 (Time 3) academic years
**The MI YRBS and the MiPHY are administered in alternate academic years.*



	Michigan	Clinton County	Eaton County	Gratiot County	Ingham County	Ionia County	Montcalm County	Shiawassee County
Time 1	14.0%	4.8%	9.8%	9.6%	8.6%	16.8%	11.6%	12.8%
Time 2	10.0%	3.6%	6.7%	5.9%	4.5%	—	10.6%	9.3%
Time 3	10.5%	3.9%	5.0%	3.1%	2.5%	—	5.8%	6.3%

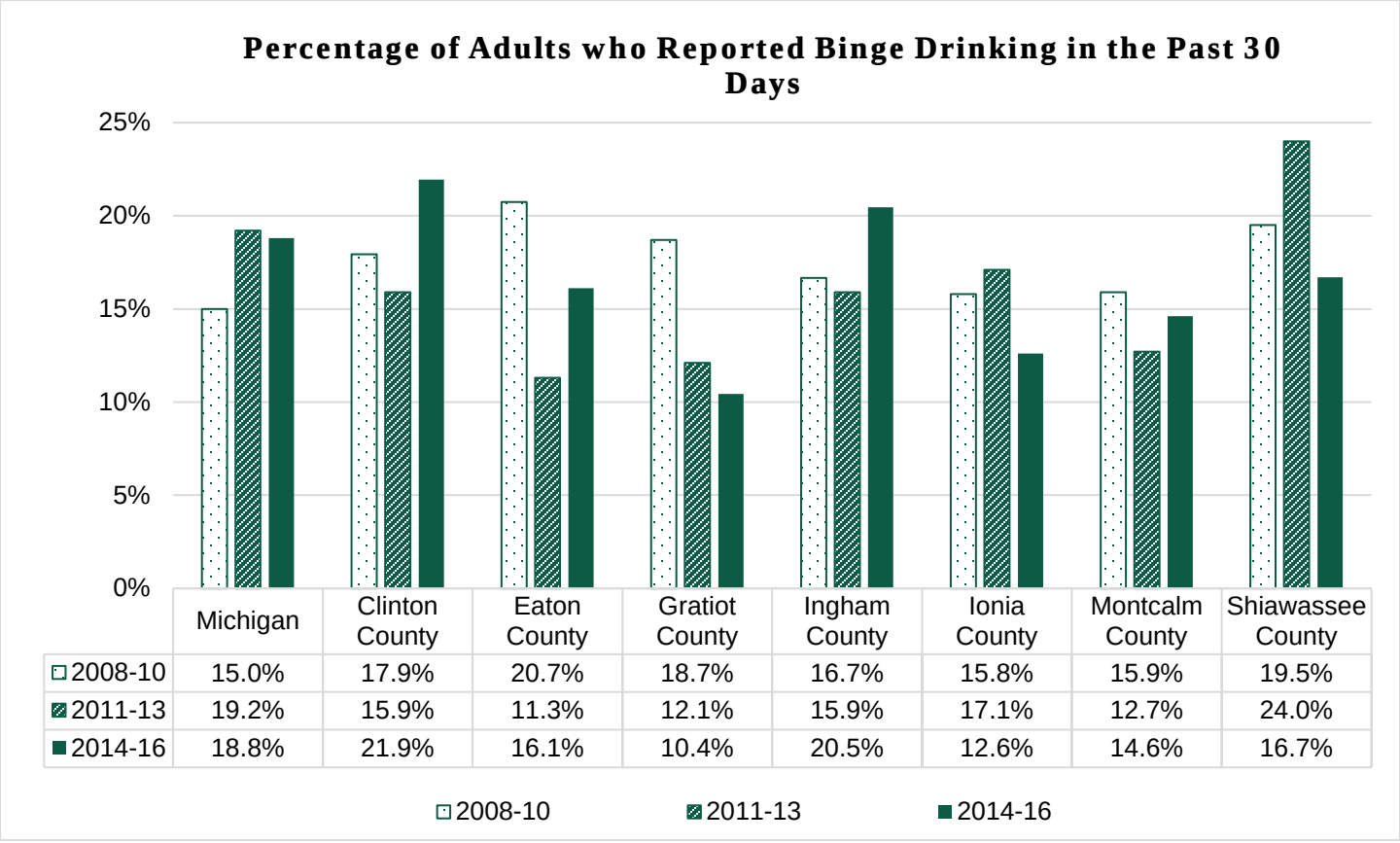
Reason for Measure: Each year approximately 443,000 premature deaths occur in the United States primarily due to smoking. Cigarette smoking is identified as a cause of multiple diseases, including various cancers, cardiovascular disease, respiratory conditions, low birth weight, and other adverse health 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 effectiveness of existing programs.[CHR]

Alcohol Use (Adults)

Measure: Binge drinking is defined as consuming more than 4 (for women) or 5 (for 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 & Social Capital Survey

Years: 2008-2010, 2011-2013, and 2014-2016



	Michigan	Clinton County	Eaton County	Gratiot County	Ingham County	Ionia County	Montcalm County	Shiawassee County
2008-10	15.0%	17.9%	20.7%	18.7%	16.7%	15.8%	15.9%	19.5%
2011-13	19.2%	15.9%	11.3%	12.1%	15.9%	17.1%	12.7%	24.0%
2014-16	18.8%	21.9%	16.1%	10.4%	20.5%	12.6%	14.6%	16.7%

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

Alcohol Use (Adolescents)

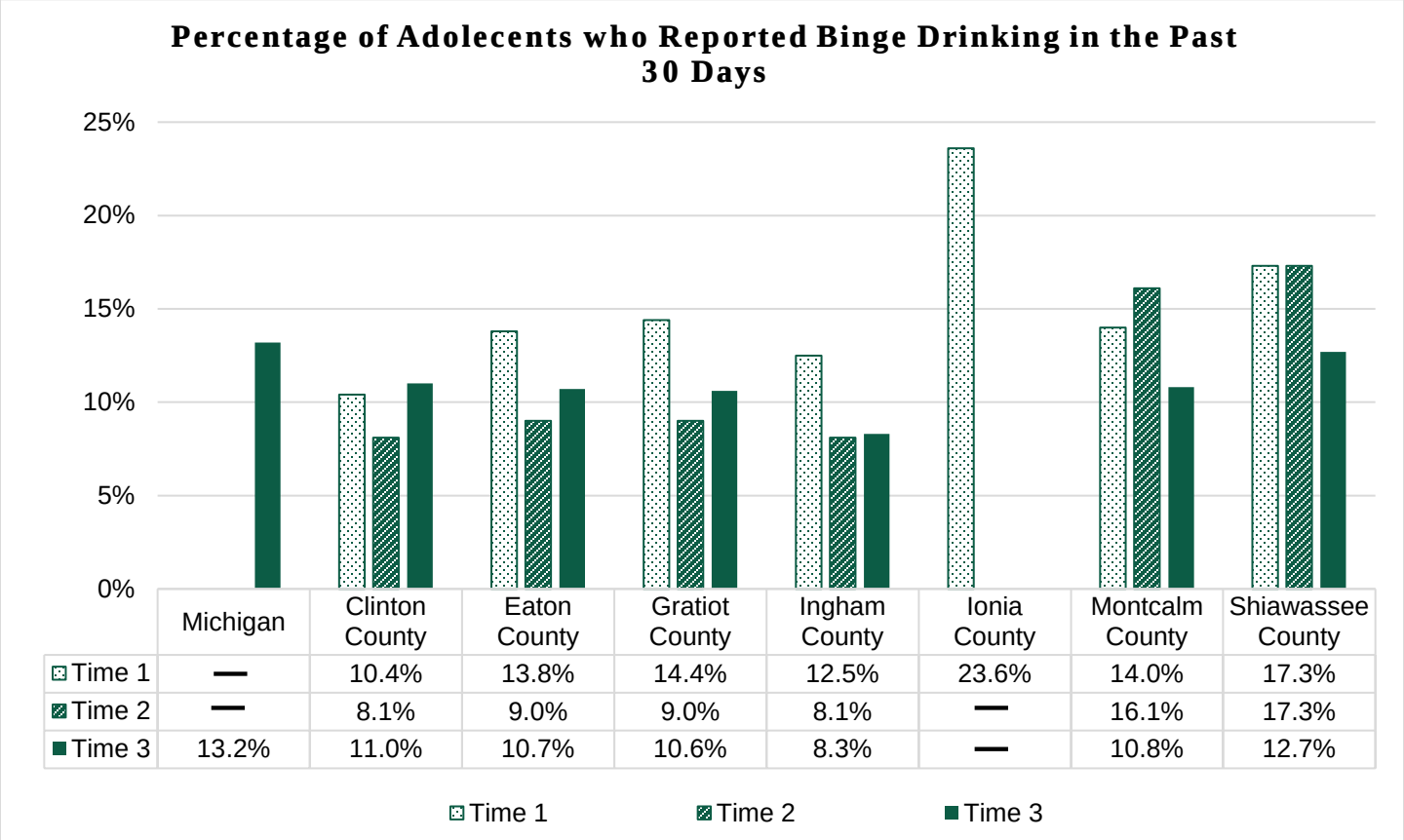
Measure: Adolescent binge drinking prevalence represents the percentage of students who had five or more drinks of alcohol in a row, that is, within a couple of hours, during the past 30 days.

Data Source:

Michigan Profile for Healthy Youth (MiPHY): the percentage for students in the 9th and 11th grades
Michigan Youth Risk Behavior Survey (MI YRBS): the percentage for students in the 9th through 12th grades

Years:

MiPHY: 2013-2014 (Time 1), 2015-2016 (Time 2), and 2017-2018 (Time 3) academic years
MI YRBS: 2016-2017 (Time 3) academic year; data for prior years is not available
**The MI YRBS and the MiPHY are administered in alternate academic years.*



	Michigan	Clinton County	Eaton County	Gratiot County	Ingham County	Ionia County	Montcalm County	Shiawassee County
Time 1	—	10.4%	13.8%	14.4%	12.5%	23.6%	14.0%	17.3%
Time 2	—	8.1%	9.0%	9.0%	8.1%	—	16.1%	17.3%
Time 3	13.2%	11.0%	10.7%	10.6%	8.3%	—	10.8%	12.7%

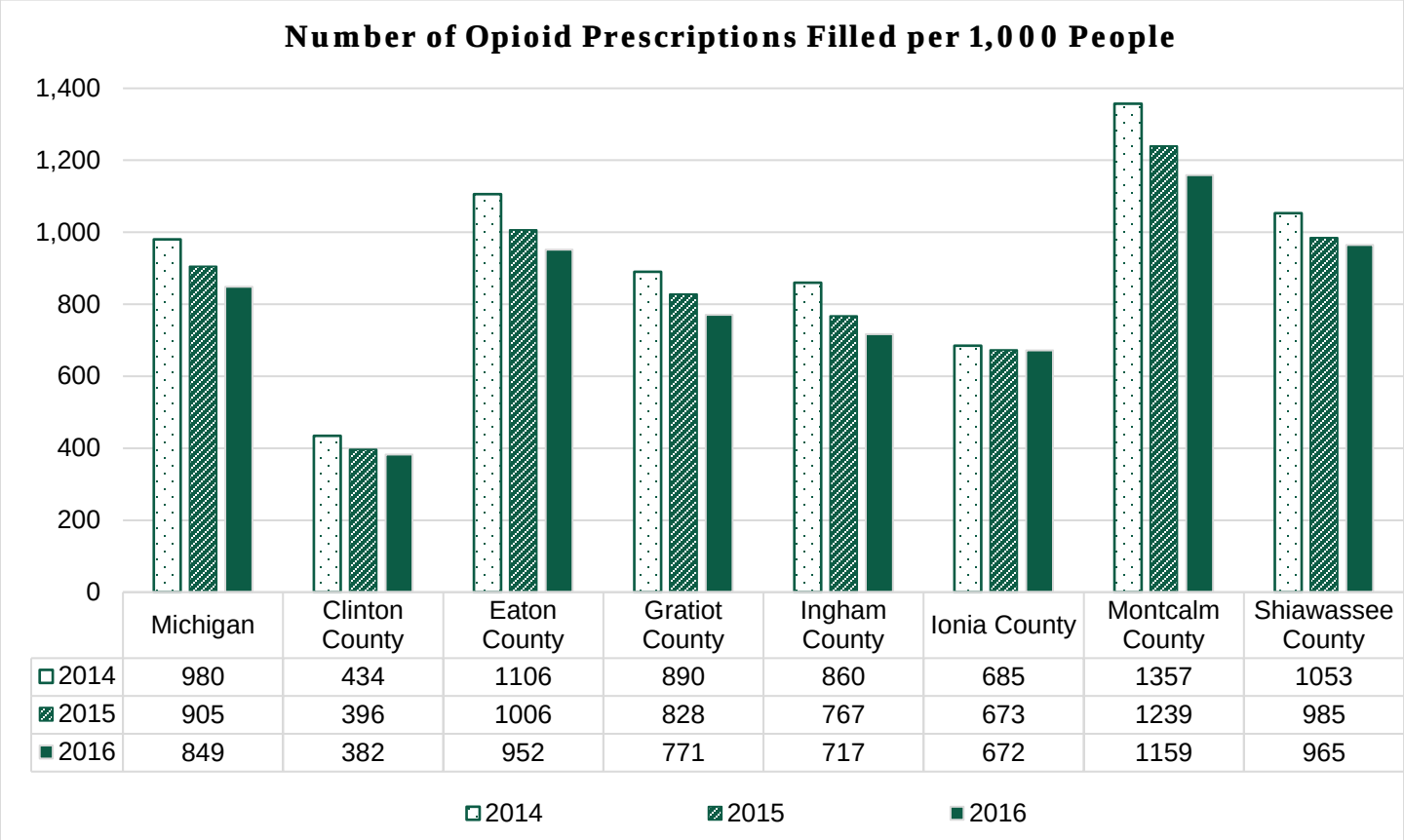
Reason for Measure: Binge drinking is a risk factor for a number of adverse health outcomes such as alcohol poisoning, hypertension, acute myocardial infarction, sexually transmitted infections, unintended pregnancy, fetal alcohol syndrome, sudden infant death syndrome, suicide, interpersonal violence,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

Substance Use (Adults)

Measure: The number of opioid prescriptions filled per 1,000 people.

Data Source: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Unintentional Injury Prevention

Years: 2014, 2015, and 2016



	Michigan	Clinton County	Eaton County	Gratiot County	Ingham County	Ionia County	Montcalm County	Shiawassee County
2014	980	434	1106	890	860	685	1357	1053
2015	905	396	1006	828	767	673	1239	985
2016	849	382	952	771	717	672	1159	965

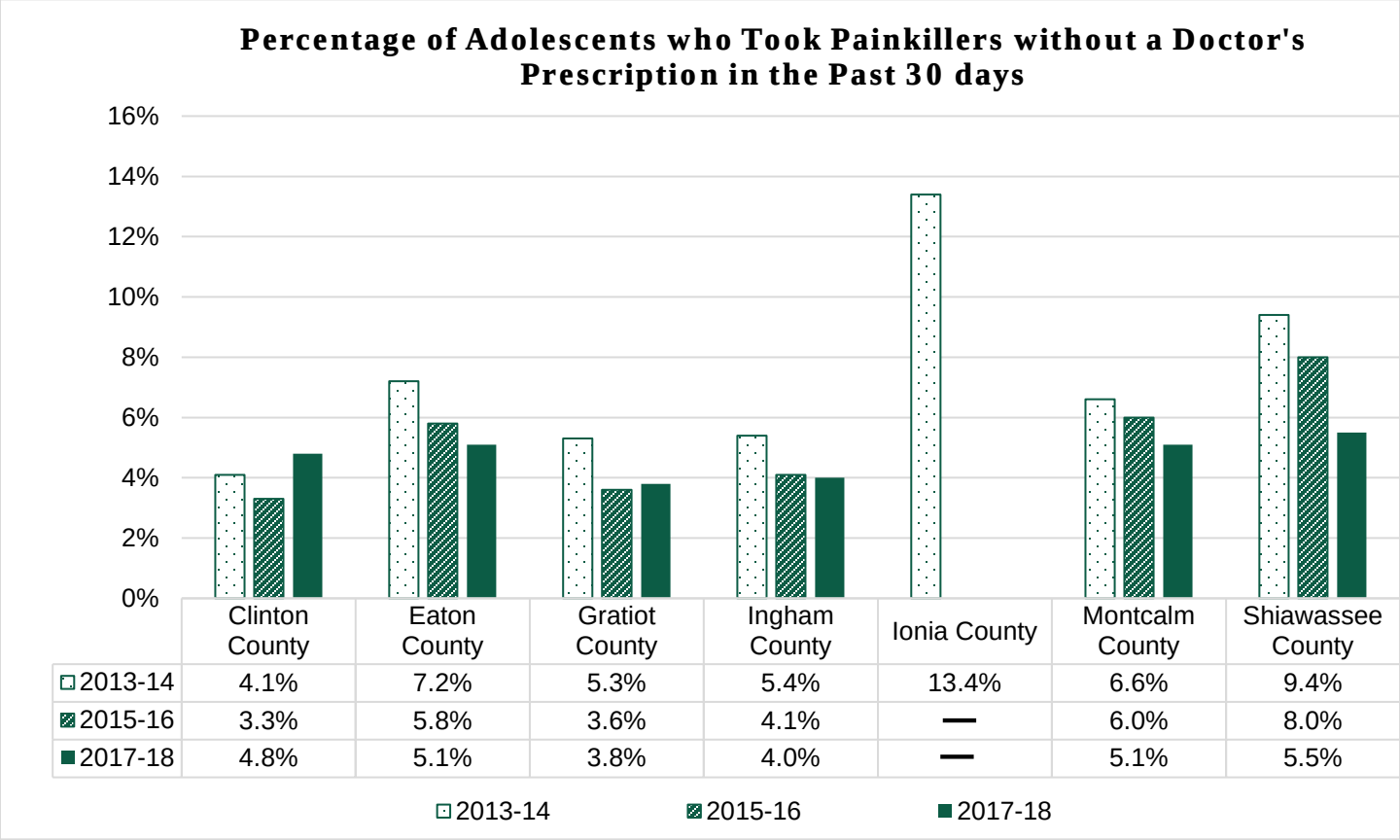
Reason for Measure: Prescription opioids have legitimate and beneficial uses for the treatment of chronic and acute pain. Most people who take them do not usually become dependent, but, for some, regular use of opioids can lead to dependence, which can then lead to abuse. For many opioid users, addiction starts with prescription opioids (their own or someone else's). A high rate of filled opioid prescriptions (i.e. those prescriptions that were physically dispensed) can be a sign of abuse. A study by the Centers for Disease Control and Prevention found that areas with high rates of filled opioid prescriptions tended to have more White residents and higher rates of poverty and unemployment.

Substance Use (Adolescents)

Measure: The percentage of adolescents (9th and 11th grade students) who reported taking painkillers, such as OxyContin, Codeine, Vicodin, or Percocet, without a doctor's prescription during the past 30 days.

Data Source: Michigan Profile for Healthy Youth (MiPHY)

Years: 2013-2014, 2015-2016, and 2017-2018 academic years



	Clinton County	Eaton County	Gratiot County	Ingham County	Ionia County	Montcalm County	Shiawassee County
2013-14	4.1%	7.2%	5.3%	5.4%	13.4%	6.6%	9.4%
2015-16	3.3%	5.8%	3.6%	4.1%	—	6.0%	8.0%
2017-18	4.8%	5.1%	3.8%	4.0%	—	5.1%	5.5%

Reason for Measure: In light of the ongoing opioid epidemic, it is important to remember how addiction can start in individual people. For many people, opioid addiction starts with either a prescribed medication they receive and then become dependent on, or by experimenting with pills prescribed to others that are found in the home. This particular indicator is measuring such experimentation; this information can be used to inform policies and interventions to alter prescribing practices or home storage practices of potentially habit-forming prescription drugs.

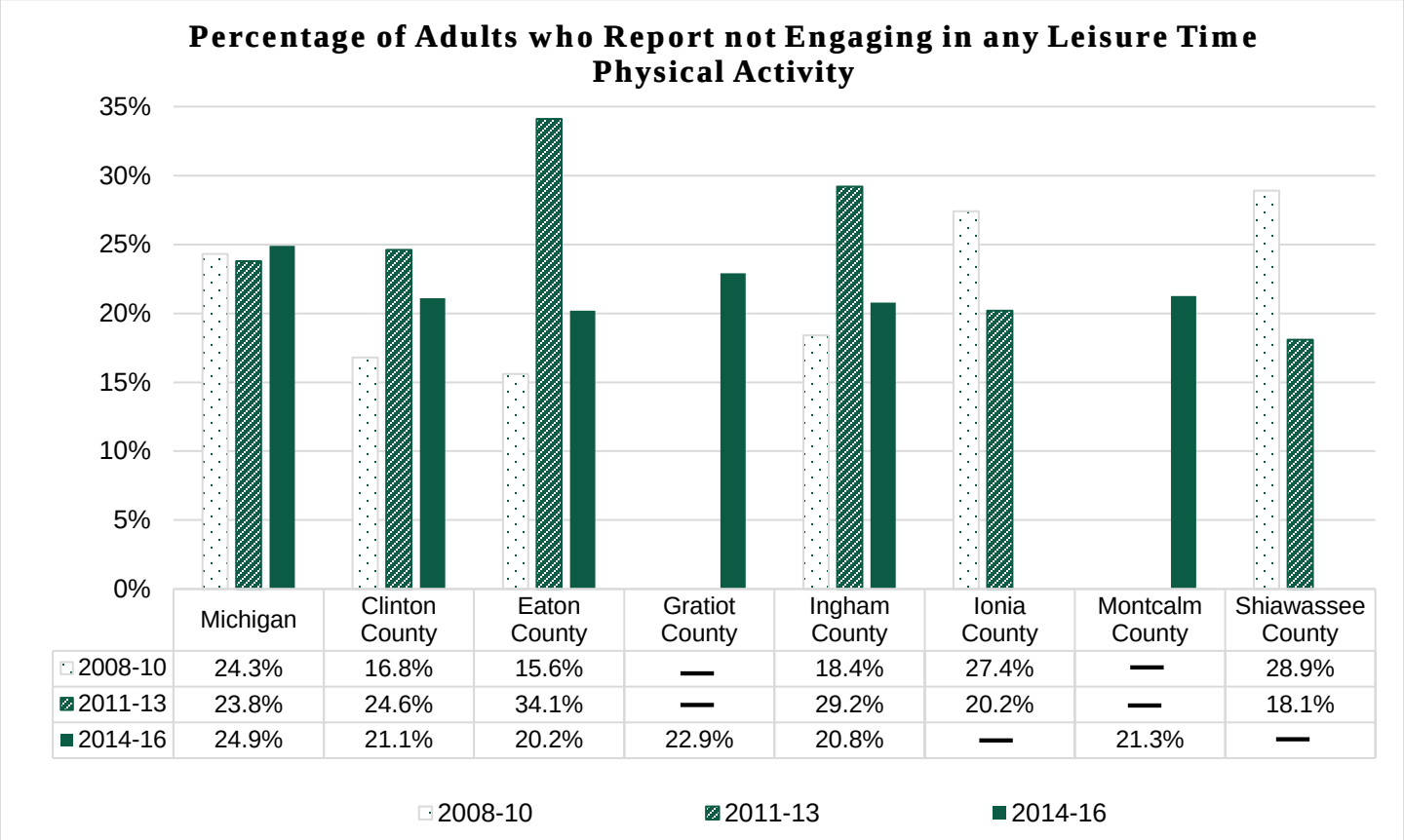
**Notes about this measure: State-wide data is not available for this measure as this question was not asked on the Michigan Youth Risk Behavior Survey.*

Physical Activity (Adults)

Measure: The percentage of adults who report not engaging in any leisure time physical activity.

Data Source:
Michigan Behavioral Risk Factor Surveillance System
Capital Area Behavioral Risk Factor & Social Capital Survey

Year: 2008-2010, 2011-2013, and 2014-2016



	Michigan	Clinton County	Eaton County	Gratiot County	Ingham County	Ionia County	Montcalm County	Shiawassee County
2008-10	24.3%	16.8%	15.6%	—	18.4%	27.4%	—	28.9%
2011-13	23.8%	24.6%	34.1%	—	29.2%	20.2%	—	18.1%
2014-16	24.9%	21.1%	20.2%	22.9%	20.8%	—	21.3%	—

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, and dementia.

**Notes about this measure: 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.*

Physical Activity (Adolescents)

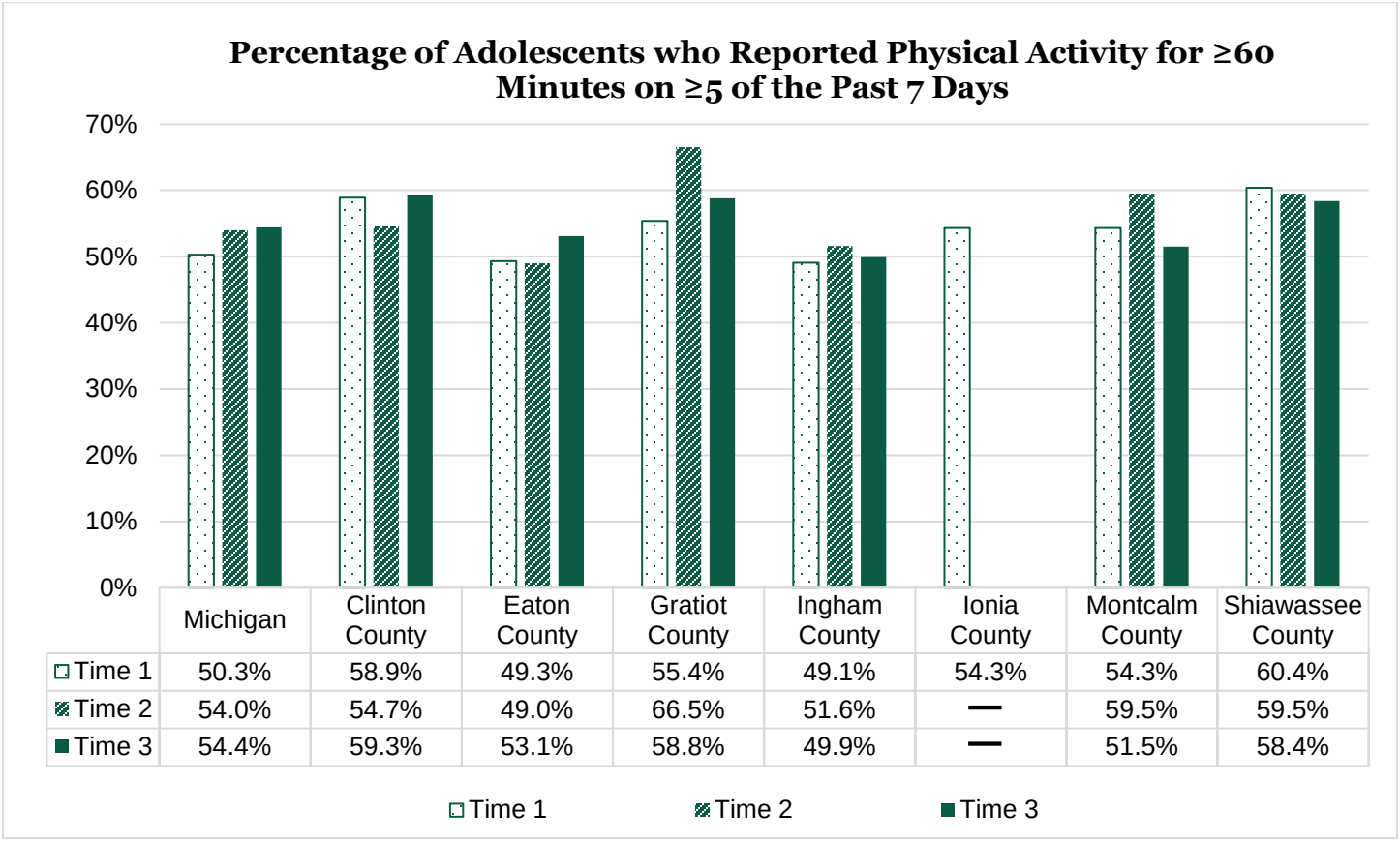
Measure: The percentage of adolescents engaging in the recommended level of physical activity, which means being physically active for a total of at least 60 minutes per day on five or more of the past seven days.

Data Source:

Michigan Profile for Healthy Youth (MiPHY): the percentage for students in the 9th and 11th grades
Michigan Youth Risk Behavior Survey (MI YRBS): the percentage for students in the 9th through 12th grades

Years:

MiPHY: 2013-2014 (Time 1), 2015-2016 (Time 2), and 2017-2018 (Time 3) academic years
MI YRBS: 2012-2013 (Time 1), 2014-2015 (Time 2), and 2016-2017 (Time 3) academic years
**The MI YRBS and the MiPHY are administered in alternate academic years.*



	Michigan	Clinton County	Eaton County	Gratiot County	Ingham County	Ionia County	Montcalm County	Shiawassee County
Time 1	50.3%	58.9%	49.3%	55.4%	49.1%	54.3%	54.3%	60.4%
Time 2	54.0%	54.7%	49.0%	66.5%	51.6%	—	59.5%	59.5%
Time 3	54.4%	59.3%	53.1%	58.8%	49.9%	—	51.5%	58.4%

Reason for Measure: As important as physical activity is for adults, it is even more important for children and adolescents because they are still developing. Appropriate levels of physical activity assist young people to:

- develop healthy musculoskeletal tissues (i.e. bones, muscles, and joints);
- develop a healthy cardiovascular system (i.e. heart and lungs);
- develop neuromuscular awareness (i.e. coordination and movement control); and
- maintain a healthy body weight.

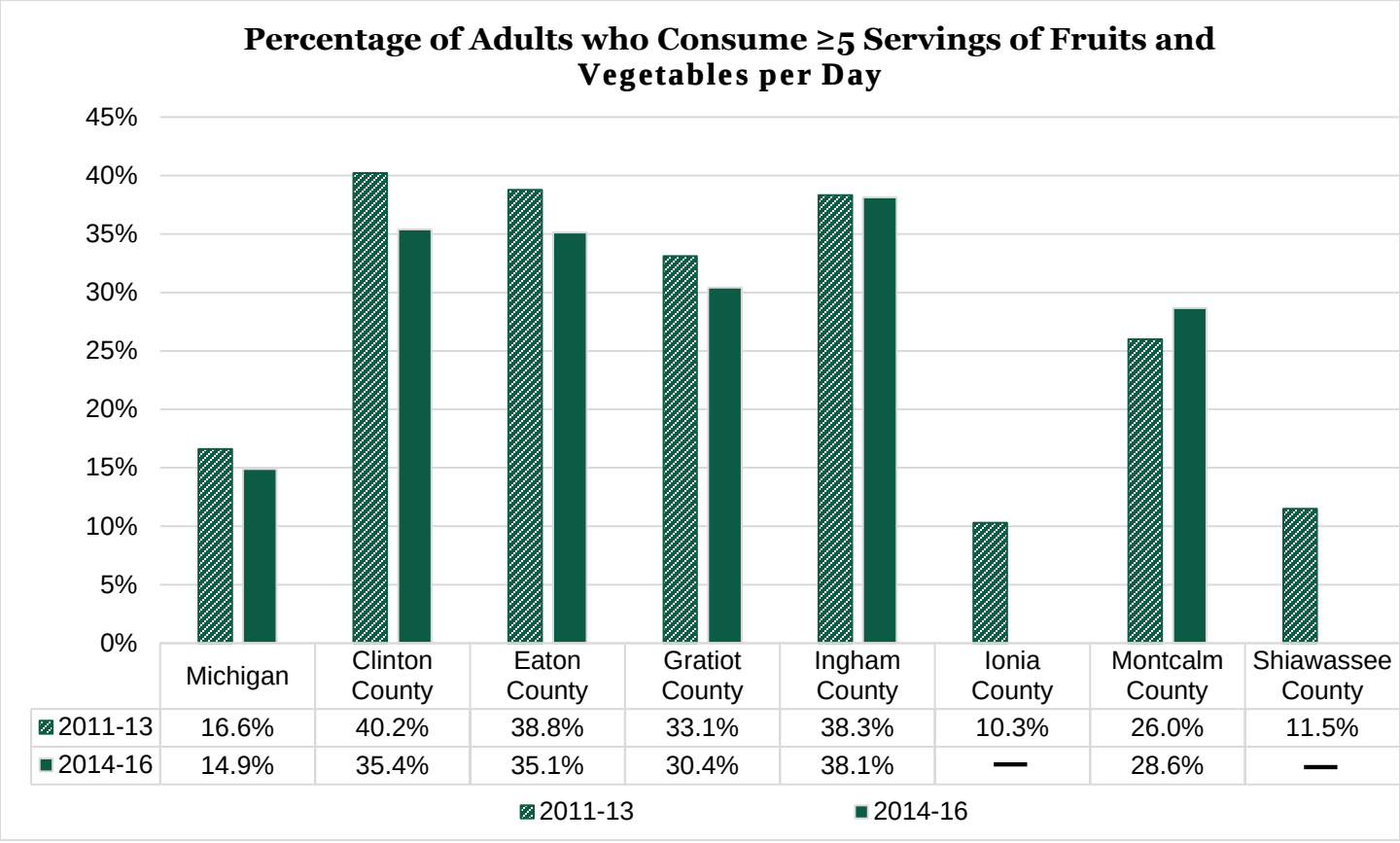
Physical activity has also been associated with psychological benefits in young people, including improved control over symptoms of anxiety and depression. Similarly, participation in physical activity can assist in the social development of young people by providing opportunities for self-expression, building self-confidence, and increasing social interaction and integration. It has also been suggested that physically active young people more readily adopt other healthy behaviors (e.g., avoidance of tobacco, alcohol, and drug use) and demonstrate higher academic performance at school.

Nutrition (Adults)

Measure: The percentage of adults who consume greater than or equal to 5 servings (or times) of fruits and vegetables per day.

Data Source:
Michigan Behavioral Risk Factor Surveillance System
Capital Area Behavioral Risk Factor & Social Capital Survey

Years: 2011-2013 and 2014-2016



	Michigan	Clinton County	Eaton County	Gratiot County	Ingham County	Ionia County	Montcalm County	Shiawassee County
2011-13	16.6%	40.2%	38.8%	33.1%	38.3%	10.3%	26.0%	11.5%
2014-16	14.9%	35.4%	35.1%	30.4%	38.1%	—	28.6%	—

Reason for Measure: Most adults consume a diet heavy in carbohydrates and fats, but have limited (both in amount and type of) 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 optimal health.

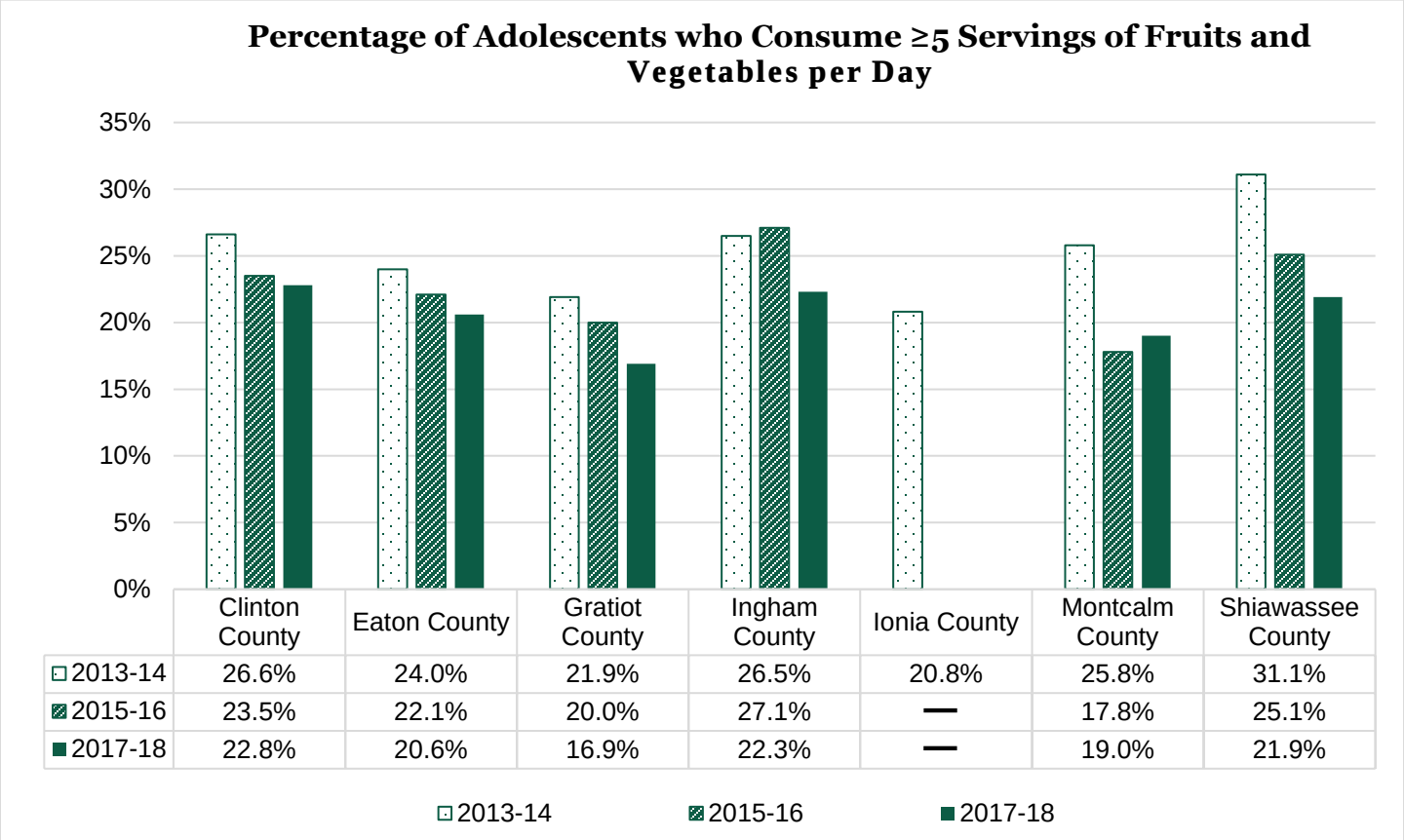
**Notes about this measure: Nutrition statistics from the MI BRFS may not be comparable to nutrition statistics from the Capital Area BRFS because the questions were worded slightly differently in the two survey instruments. The Capital Area BRFS asked about the number of servings of fruits and vegetable consumed, while the MI BRFS asked about the number of times fruits and vegetables were consumed. In 2010, the questions about nutrition in the Capital Area BRFS changed. Consequently, nutrition statistics from 2008-2010 differ from those from 2011-2013 and 2014-2016. 2008-2010 data is not presented in this report, and it is not recommended that they be used for trends. In 2011, the methodology for 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.*

Nutrition (Adolescents)

Measure: The percentage of adolescents (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 (MiPHY)

Years: 2013-2014, 2015-2016, and 2017-2018 academic years



	Clinton County	Eaton County	Gratiot County	Ingham County	Ionia County	Montcalm County	Shiawassee County
2013-14	26.6%	24.0%	21.9%	26.5%	20.8%	25.8%	31.1%
2015-16	23.5%	22.1%	20.0%	27.1%	—	17.8%	25.1%
2017-18	22.8%	20.6%	16.9%	22.3%	—	19.0%	21.9%

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

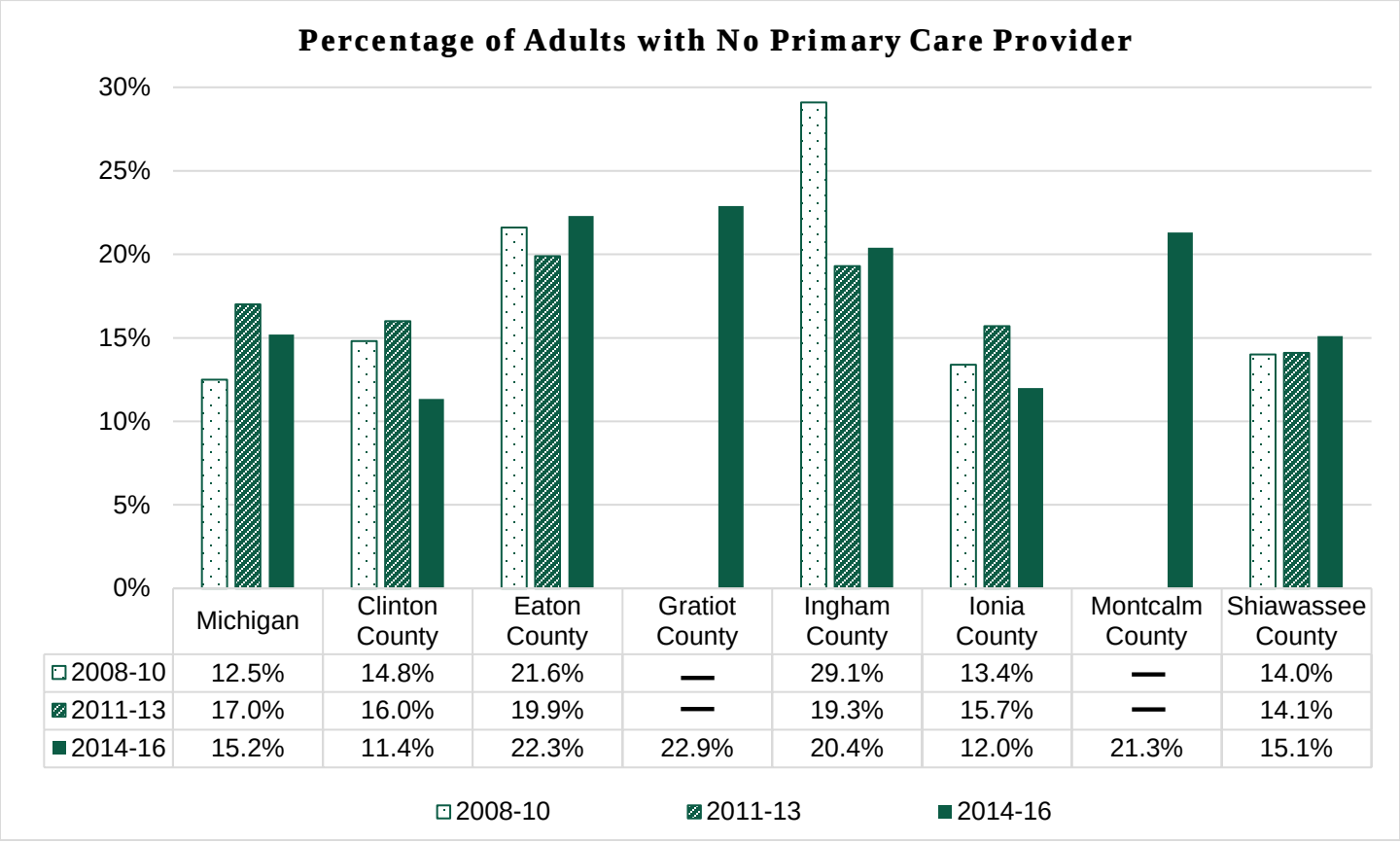
**Notes about this measure: State-level and county-level statistics on adolescents' fruit and vegetable consumption cannot be compared as different questions were asked on the MiPHY survey (for individual counties) and the Michigan Youth Risk Behavior Survey (statewide).*

Access to Primary Care

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

Data Source:
Michigan Behavioral Risk Factor Surveillance System
Capital Area Behavioral Risk Factor & Social Capital Survey

Years: 2008-2010, 2011-2013, and 2014-2016



	Michigan	Clinton County	Eaton County	Gratiot County	Ingham County	Ionia County	Montcalm County	Shiawassee County
2008-10	12.5%	14.8%	21.6%	—	29.1%	13.4%	—	14.0%
2011-13	17.0%	16.0%	19.9%	—	19.3%	15.7%	—	14.1%
2014-16	15.2%	11.4%	22.3%	22.9%	20.4%	12.0%	21.3%	15.1%

Reason for Measure: Having access to care requires not only having financial coverage but also access to providers. While high rates of specialist physicians have 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 to ensuring people can get preventive and primary care, and, when needed, referrals to appropriate specialty care.[CHR]

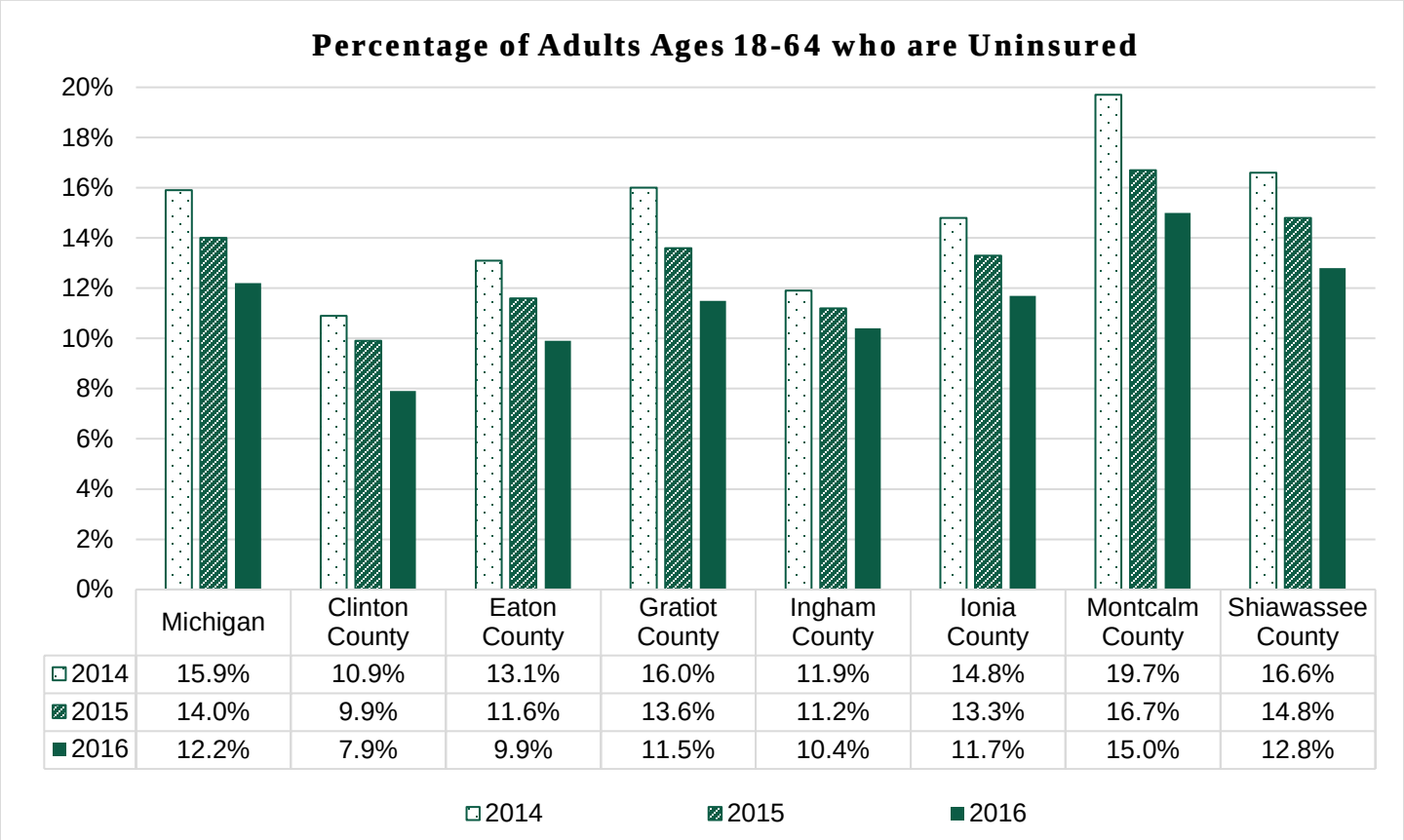
Notes about this measure: In 2010, the methodology of the Capital Area BRFS was changed to incorporate cell phones as well as landline telephones. Extreme caution should be used when using the statistics for trends.

Access to Insurance

Measure: The percentage of adults 18-64 years old without health insurance.

Data Source: U.S. Census Bureau, American Community Survey

Years: 2010-2014, 2011-2015, and 2012-2016 American Community Survey 5-Year Estimates



	Michigan	Clinton County	Eaton County	Gratiot County	Ingham County	Ionia County	Montcalm County	Shiawassee County
2014	15.9%	10.9%	13.1%	16.0%	11.9%	14.8%	19.7%	16.6%
2015	14.0%	9.9%	11.6%	13.6%	11.2%	13.3%	16.7%	14.8%
2016	12.2%	7.9%	9.9%	11.5%	10.4%	11.7%	15.0%	12.8%

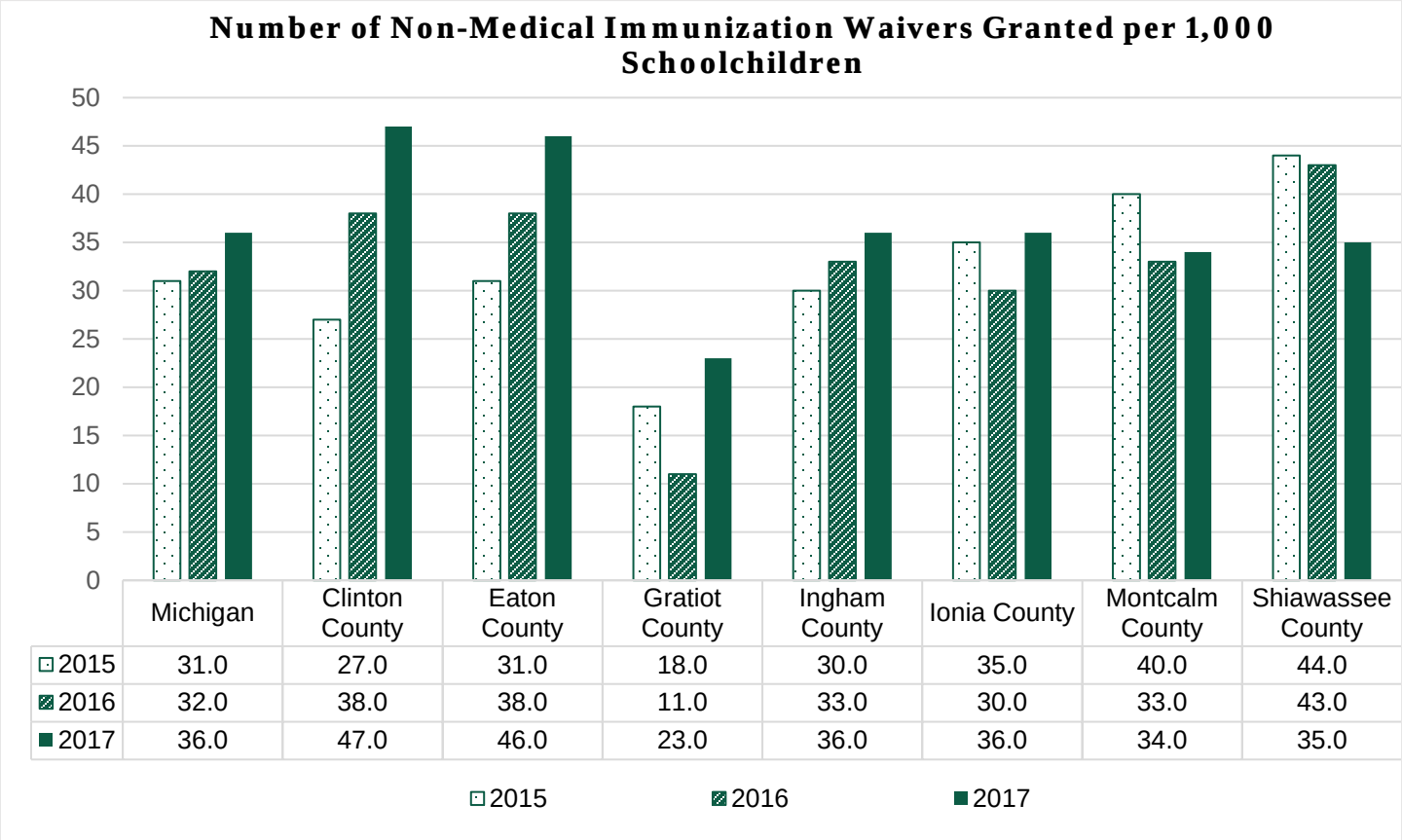
Reason for Measure: Health insurance coverage helps patients gain entry into the health care system. Lack of adequate coverage makes it difficult for people to get the health care they need and, when they do get care, burdens them with large medical bills. Uninsured people are more likely to have poor 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 individuals and to improve the organization and delivery of health care.

Communicable Disease Prevention

Measure: The rate of non-medical immunization waivers granted per 1,000 schoolchildren. Information about immunization status is collected for students in kindergarten and 7th grade, and for any student newly enrolled into the school district.

Data Source: Michigan Care Improvement Registry

Years: 2015 (running percent from June 2014-June 2015), 2016 (running percent from June 2015-June 2016), and 2017 (running percent from June 2016-June 2017)



	Michigan	Clinton County	Eaton County	Gratiot County	Ingham County	Ionia County	Montcalm County	Shiawassee County
2015	31.0	27.0	31.0	18.0	30.0	35.0	40.0	44.0
2016	32.0	38.0	38.0	11.0	33.0	30.0	33.0	43.0
2017	36.0	47.0	46.0	23.0	36.0	36.0	34.0	35.0

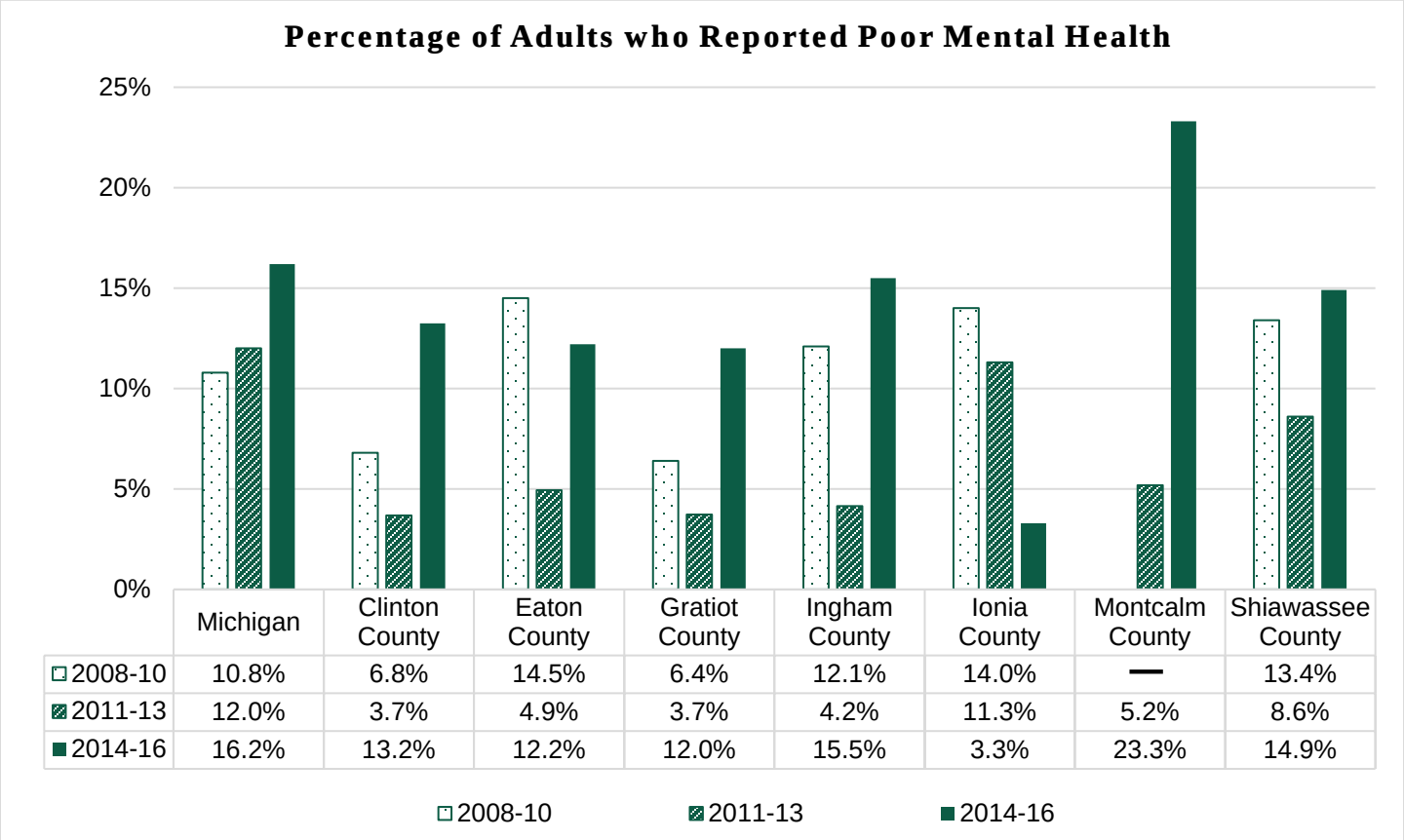
Reason for Measure: Many infectious diseases thought to be eliminated from this country, including pertussis, mumps, and measles, have reemerged in recent years. Outbreaks related to these and other vaccine-preventable diseases threaten the lives and well-being of the most vulnerable populations: children 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.

Mental Health (Adults)

Measure: The percentage of adults with poor mental health. Poor mental health is defined as reporting 14 or more days, out of the previous 30, in which a person's mental health was not good, which includes stress, depression, and problems with emotions.

Data Source:
Michigan Behavioral Risk Factor Surveillance System
Capital Area Behavioral Risk Factor & Social Capital Survey

Years: 2008-2010, 2011-2013, and 2014-2016



	Michigan	Clinton County	Eaton County	Gratiot County	Ingham County	Ionia County	Montcalm County	Shiawassee County
2008-10	10.8%	6.8%	14.5%	6.4%	12.1%	14.0%	—	13.4%
2011-13	12.0%	3.7%	4.9%	3.7%	4.2%	11.3%	5.2%	8.6%
2014-16	16.2%	13.2%	12.2%	12.0%	15.5%	3.3%	23.3%	14.9%

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 this measure: Mental health statistics from the MI BRFS may not be comparable to mental health statistics from the Capital Area BRFS because the questions about mental health were asked differently in the two surveys. 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 "During the past 30 days, for about how many days did a mental health condition or emotional problem keep you from doing your work or other usual activities?" 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.*

Mental Health (Adolescents)

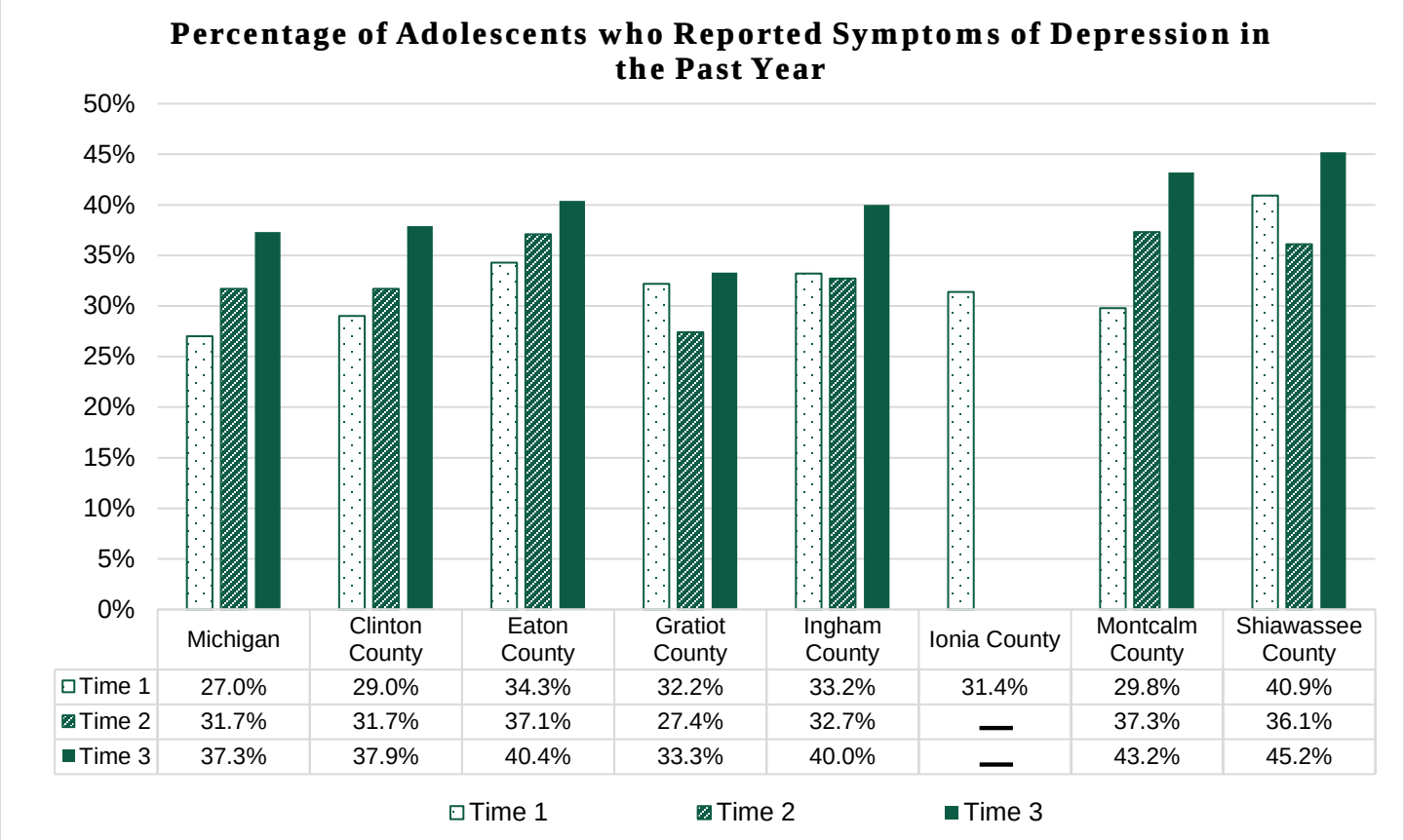
Measure: This indicator represents the percentage of students who felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months. The term mental health in this context includes, but is not limited to, stress, depression,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

Data Source:

Michigan Profile for Healthy Youth (MiPHY): the percentage for students in the 9th and 11th grades
Michigan Youth Risk Behavior Survey (MI YRBS): the percentage for students in the 9th through 12th grades

Years:

MiPHY: 2013-2014 (Time 1), 2015-2016 (Time 2), and 2017-2018 (Time 3) academic years
MI YRBS: 2012-2013 (Time 1), 2014-2015 (Time 2), and 2016-2017 (Time 3) academic years
**The MI YRBS and the MiPHY are administered in alternate academic years.*



	Michigan	Clinton County	Eaton County	Gratiot County	Ingham County	Ionia County	Montcalm County	Shiawassee County
Time 1	27.0%	29.0%	34.3%	32.2%	33.2%	31.4%	29.8%	40.9%
Time 2	31.7%	31.7%	37.1%	27.4%	32.7%	—	37.3%	36.1%
Time 3	37.3%	37.9%	40.4%	33.3%	40.0%	—	43.2%	45.2%

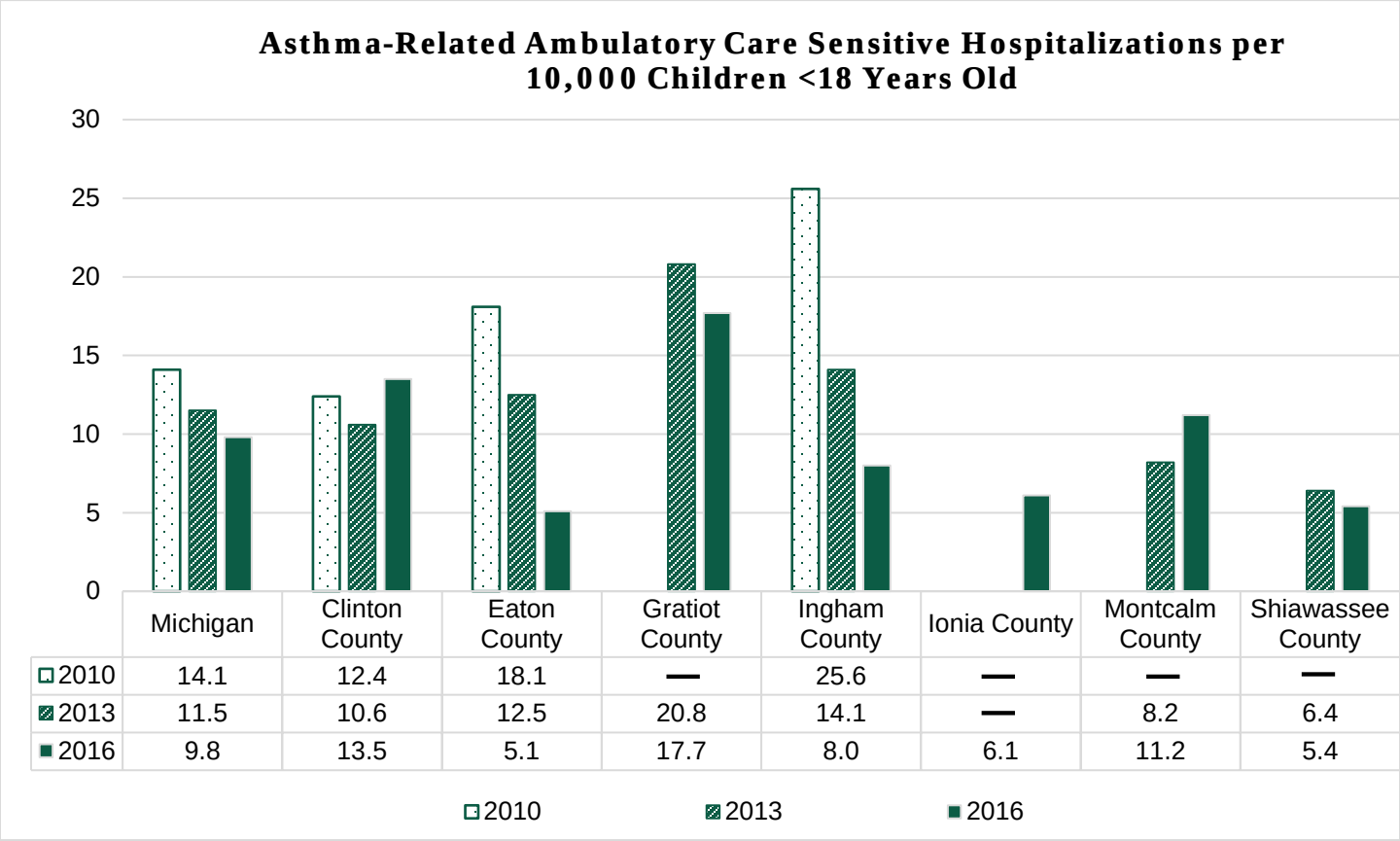
Reason for Measure: Overall health depends on both physical and mental well-being. Measuring the number of days when people report feeling depressed represents an important facet of health-related quality of life.[CHR]

Child Health

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

Data Source: Michigan Resident Inpatient Files created by the Michigan Department of Health and Human Services Division for Vital Records and Health Statistics using data from the Michigan Inpatient Database obtained with permission from the Michigan Health & Hospital Association Service Corporation

Years: 2010, 2013, and 2016



	Michigan	Clinton County	Eaton County	Gratiot County	Ingham County	Ionia County	Montcalm County	Shiawassee County
2010	14.1	12.4	18.1	—	25.6	—	—	—
2013	11.5	10.6	12.5	20.8	14.1	—	8.2	6.4
2016	9.8	13.5	5.1	17.7	8.0	6.1	11.2	5.4

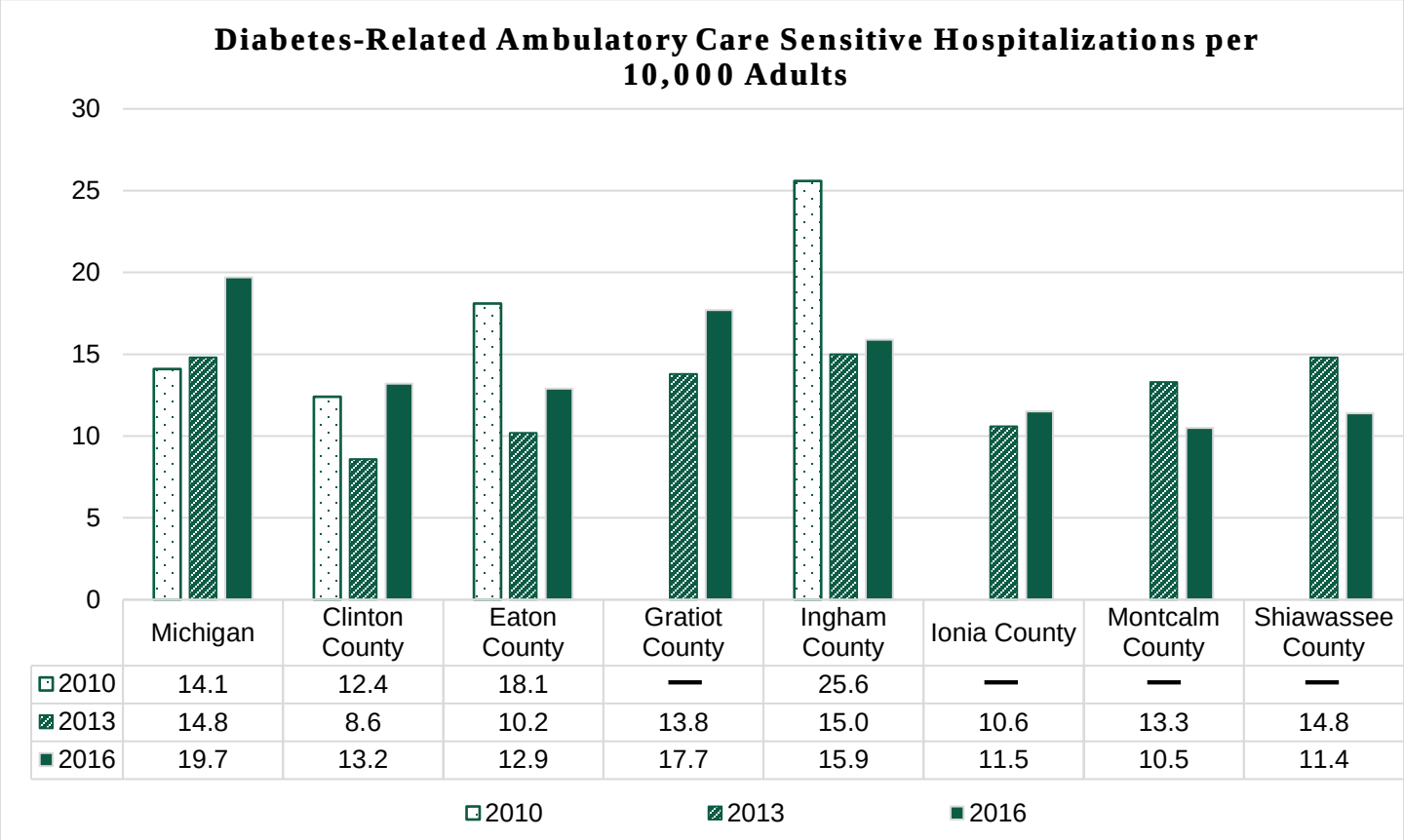
Reason for Measure: Asthma is an inflammation of the airways. The inflammation of asthma is chronic, which means it is always present and never goes away. Many factors can influence the prevalence of asthma and lead to asthma attacks. A majority of these factors are due to the environment such as dust,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

Chronic Disease – Diabetes

Measure: The rate of age-specific preventable hospitalizations related to diabetes per 10,000 adults.

Data Source: Michigan Resident Inpatient Files created by the Michigan Department of Health and Human Services Division for Vital Records and Health Statistics using data from the Michigan Inpatient Database obtained with permission from the Michigan Health & Hospital Association Service Corporation

Years: 2010, 2013, and 2016



	Michigan	Clinton County	Eaton County	Gratiot County	Ingham County	Ionia County	Montcalm County	Shiawassee County
2010	14.1	12.4	18.1	—	25.6	—	—	—
2013	14.8	8.6	10.2	13.8	15.0	10.6	13.3	14.8
2016	19.7	13.2	12.9	17.7	15.9	11.5	10.5	11.4

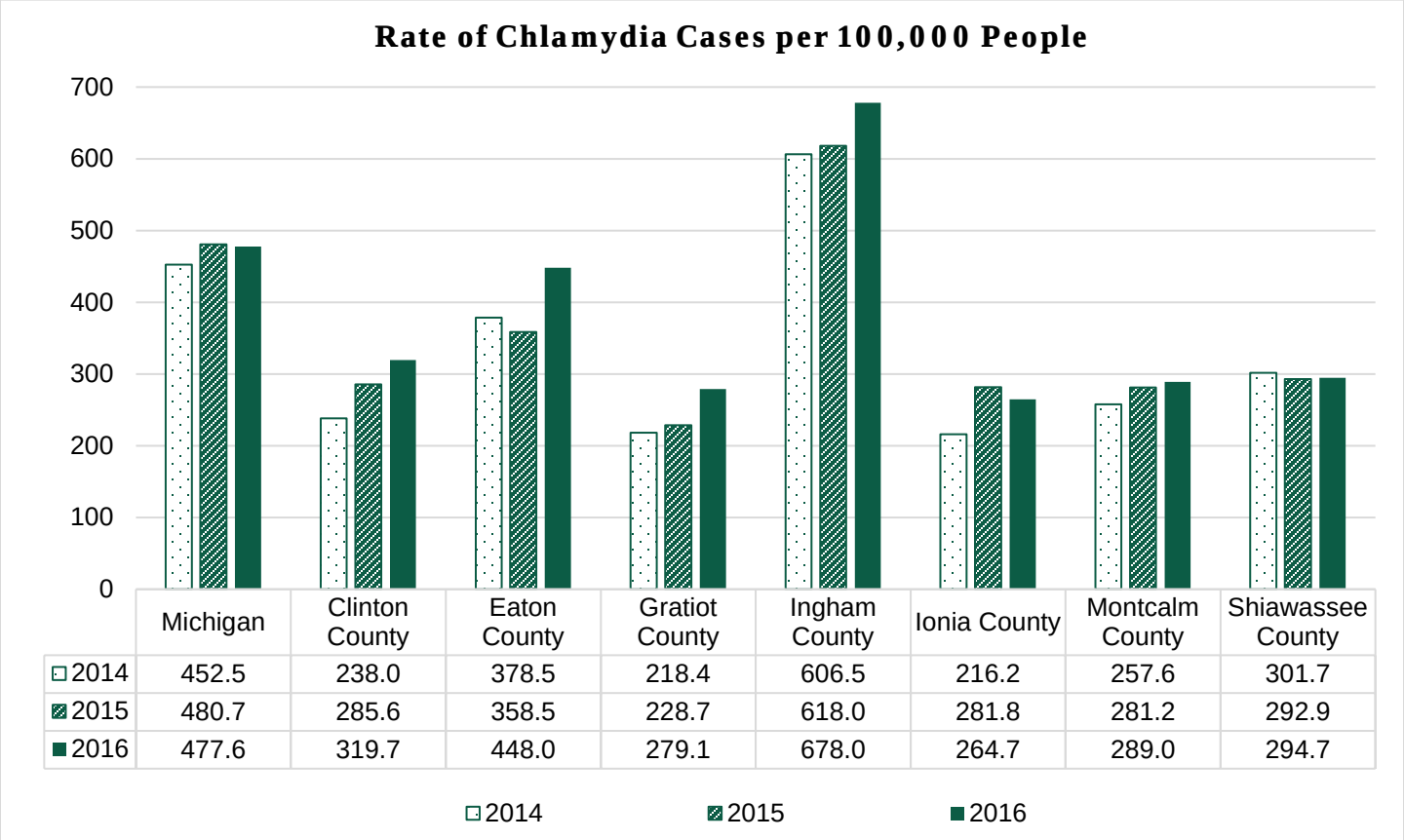
Reason for Measure: As rates of overweight and obese individuals increase, diabetes also continues to become more prevalent in the U.S. Diabetes presents as one of three types: Type 1, Type 2, or gestational diabetes. Diabetes is a chronic disease and is a significant cause of morbidity and mortality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

Communicable Disease

Measure: The rate of chlamydia cases per 100,000 people.

Data Source: Michigan Sexually Transmitted Diseases Database, STD & HIV Prevention Section, Bureau of Epidemiology, Michigan Department of Health and Human Services

Year: 2014, 2015, and 2016



	Michigan	Clinton County	Eaton County	Gratiot County	Ingham County	Ionia County	Montcalm County	Shiawassee County
2014	452.5	238.0	378.5	218.4	606.5	216.2	257.6	301.7
2015	480.7	285.6	358.5	228.7	618.0	281.8	281.2	292.9
2016	477.6	319.7	448.0	279.1	678.0	264.7	289.0	294.7

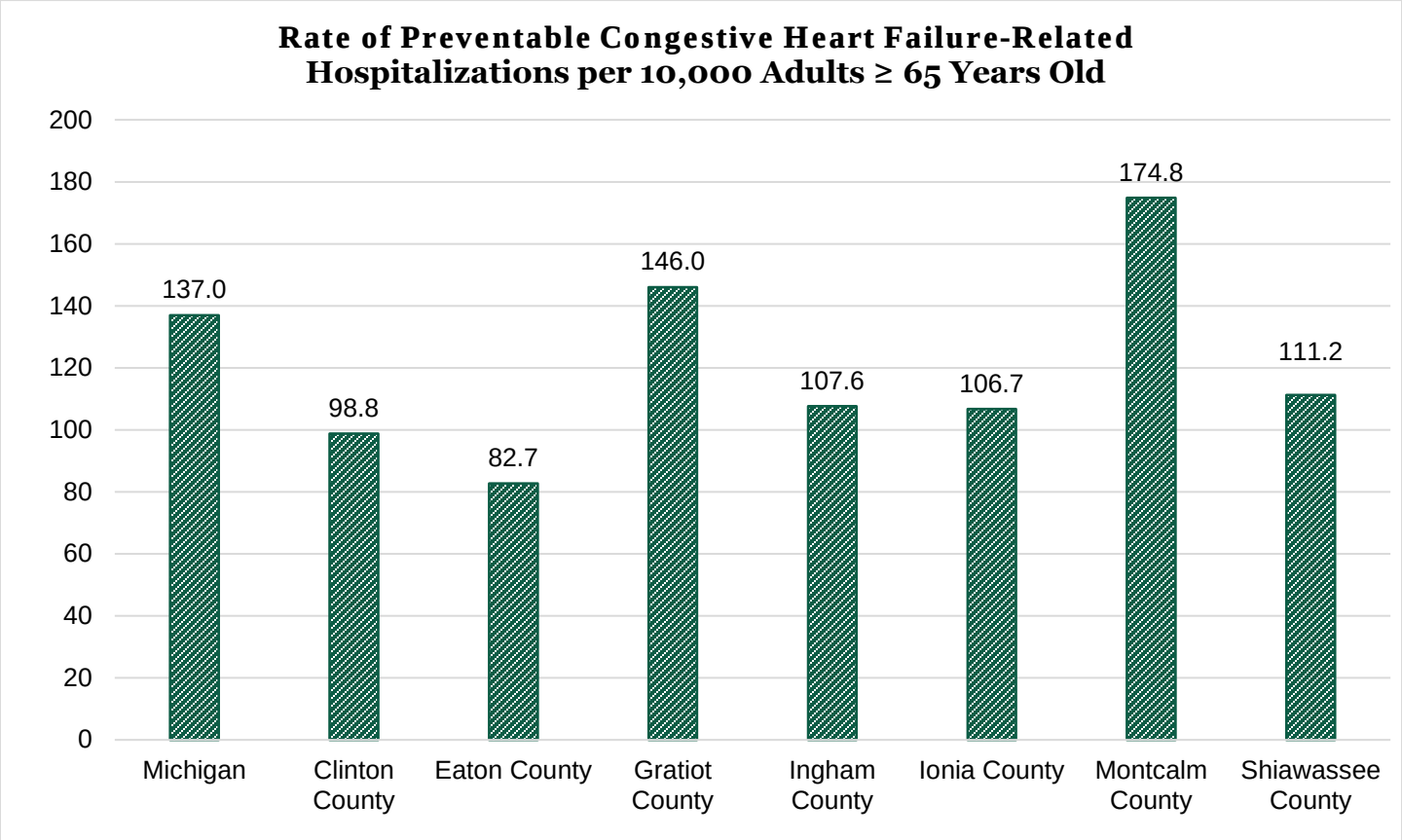
Reason for Measure: Chlamydia is a common sexually transmitted infection caused by the bacterium Chlamydia trachomatis. Chlamydia is of public health significance because of the impact of untreated disease on reproductive outcomes, transmission of other sexually acquired infections, and the costs to 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 Chlamydia 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.

Adult Health

Measure: The rate of age-specific preventable hospitalizations related to congestive heart failure per 10,000 adults 65 years of age and older.

Data Source: Michigan Resident Inpatient Files created by the Michigan Department of Health and Human Services Division for Vital Records and Health Statistics using data from the Michigan Inpatient Database obtained with permission from the Michigan Health & Hospital Association Service Corporation

Years: 2016



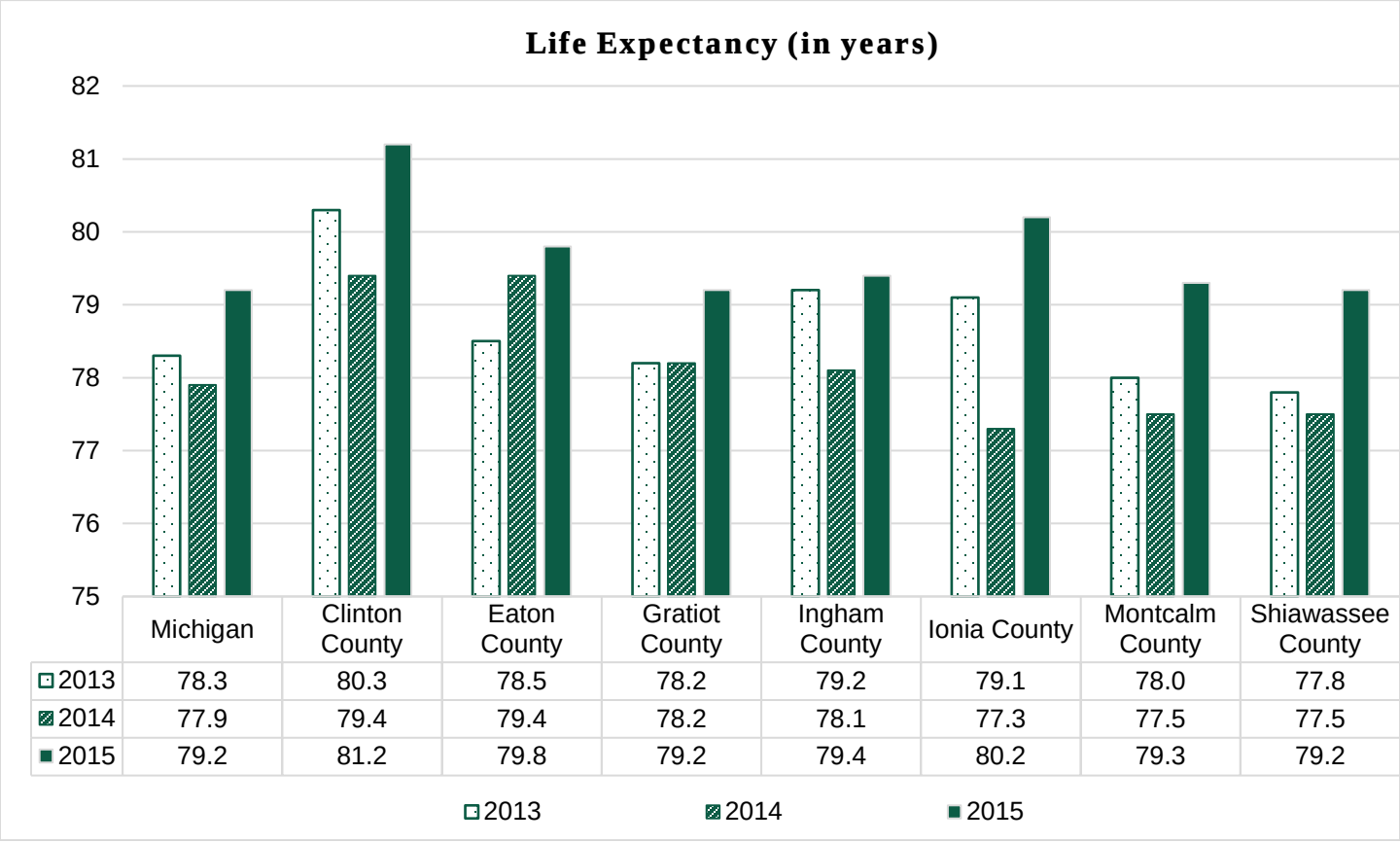
Reason for Measure: Congestive heart failure (CHF) is a chronic long-term condition in which the heart becomes increasingly incapable of pumping efficiently and, as a result, distributes an insufficient amount of blood throughout the body. It is primarily associated with high blood pressure (hypertension) 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.

Overall Mortality

Measure: Life Expectancy (in years)

Data Source:
Death Certificate Registry, Michigan Department of Health and Human Services
Census Annual Estimates of the Resident Population
U.S. Census Bureau, American Community Survey

Years: 2013, 2014, and 2015



	Michigan	Clinton County	Eaton County	Gratiot County	Ingham County	Ionia County	Montcalm County	Shiawassee County
2013	78.3	80.3	78.5	78.2	79.2	79.1	78.0	77.8
2014	77.9	79.4	79.4	78.2	78.1	77.3	77.5	77.5
2015	79.2	81.2	79.8	79.2	79.4	80.2	79.3	79.2

Reason for Measure: Life expectancy refers to the number of years a person is expected to live based on the statistical average. The life expectancy for a particular person or population group depends on several variables such as their lifestyle, access to healthcare, diet, economic status, and relevant mortality and morbidity data.

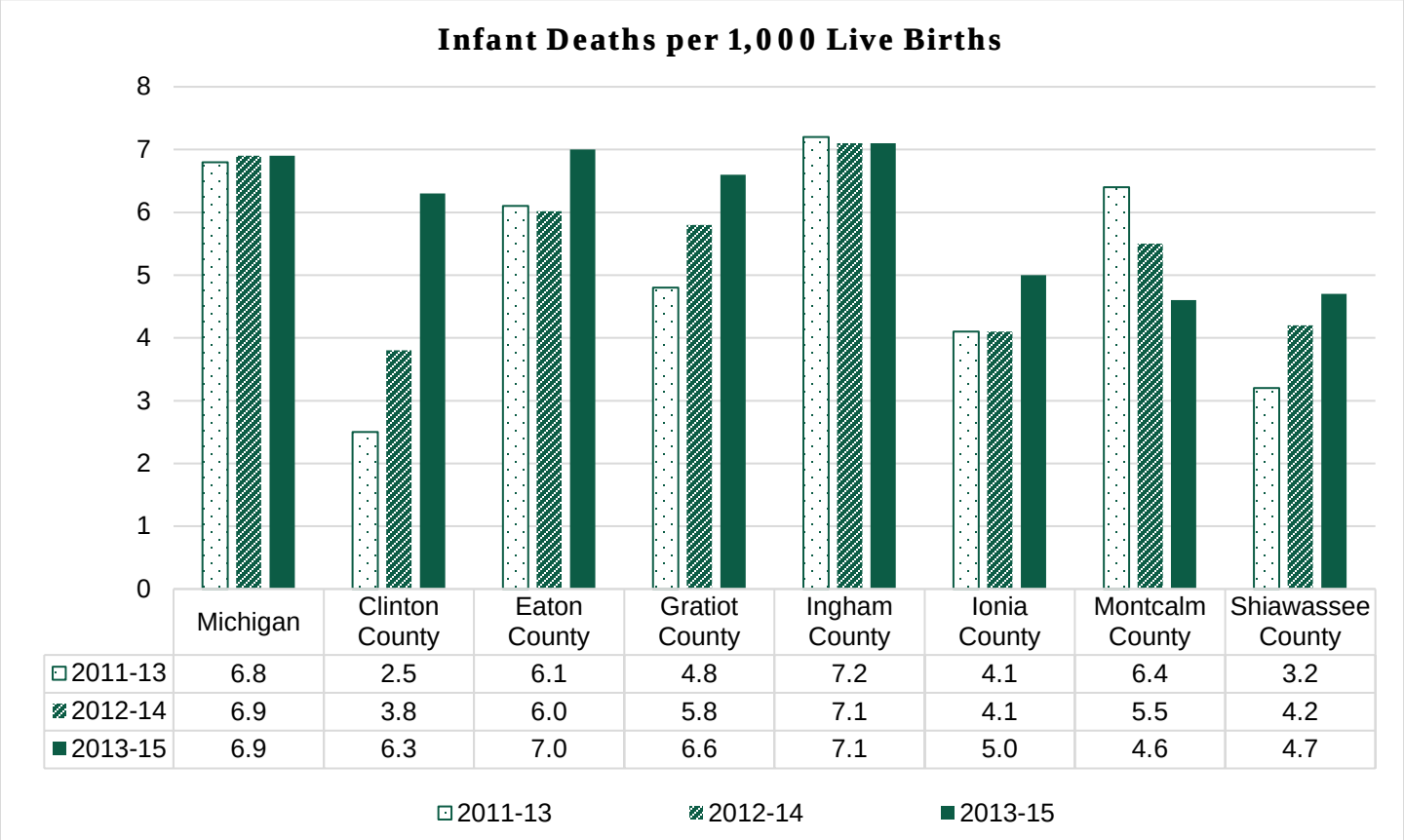
**Notes about this measure: Since life expectancy is calculated based on averages, an individual person may live for many years more or less than expected. Also, life expectancy cannot speak to the quality of the years lived. The estimates reported for life expectancy for the State of Michigan are close, but not identical, to what is calculated by MDHHS because different methodologies were used. The State of Michigan traditionally uses Greville's method. Chiang's method, which is more appropriate for smaller geographic areas, was used for this report.*

Maternal & Child Health

Measure: The number of infants who die before their first birthday per 1,000 live births.

Data Source:
Michigan Department of Health and Human Services Resident Birth File
Michigan Department of Health and Human Services Resident Linked Birth and Death File

Years: 2011-2013, 2012-2014, and 2013-2015 (three year averages)



	Michigan	Clinton County	Eaton County	Gratiot County	Ingham County	Ionia County	Montcalm County	Shiawassee County
2011-13	6.8	2.5	6.1	4.8	7.2	4.1	6.4	3.2
2012-14	6.9	3.8	6.0	5.8	7.1	4.1	5.5	4.2
2013-15	6.9	6.3	7.0	6.6	7.1	5.0	4.6	4.7

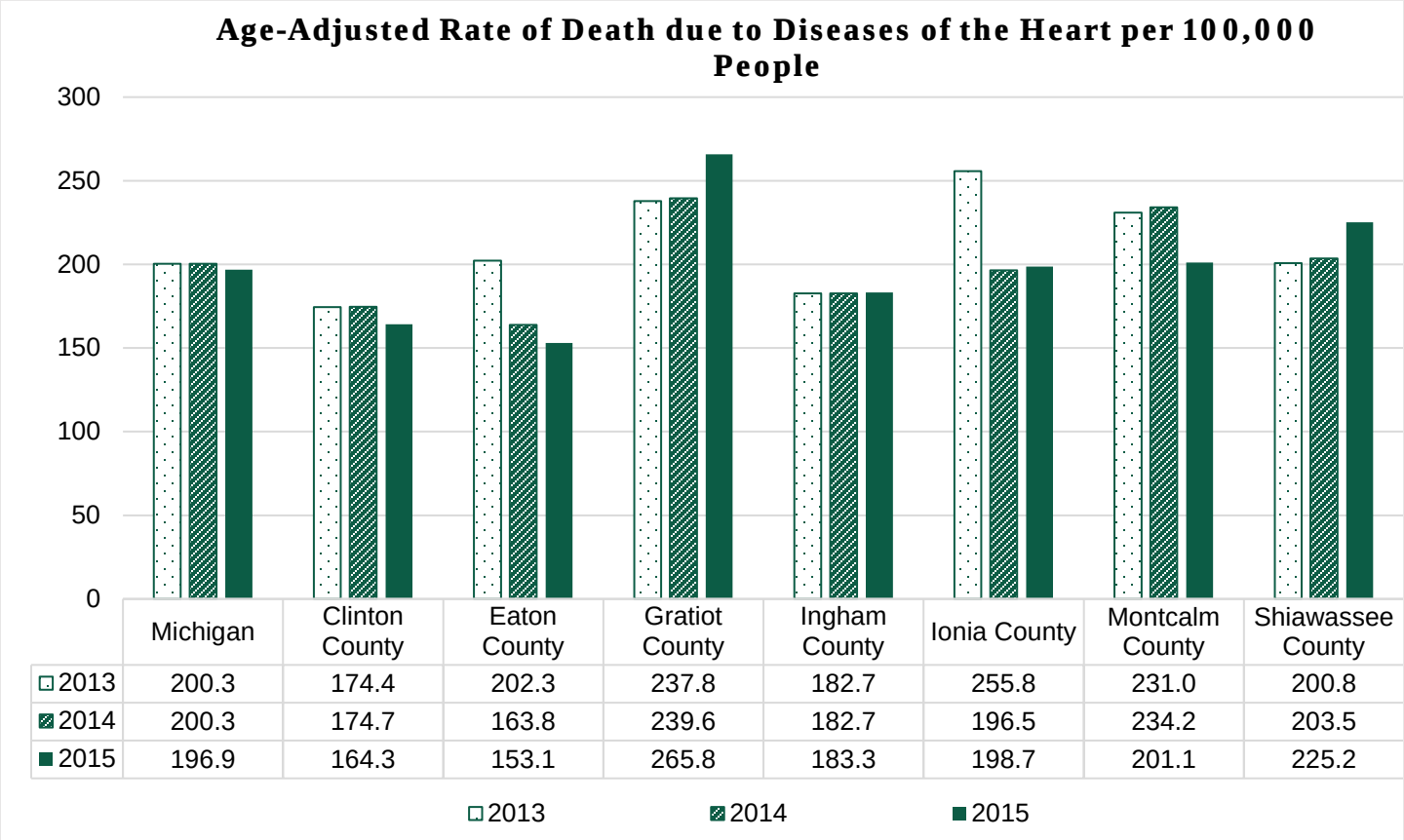
Reason for Measure: Infant mortality rates are an important indicator of the health of a community because they are associated with maternal health, quality of and access to medical care, socioeconomic conditions, public health practices, and power and wealth inequities. Black infants consistently fare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

Chronic Disease (Cardiovascular) – Mortality

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

Data Source: Michigan Department of Health and Human Services Resident Death File

Years: 2013, 2014, and 2015



	Michigan	Clinton County	Eaton County	Gratiot County	Ingham County	Ionia County	Montcalm County	Shiawassee County
2013	200.3	174.4	202.3	237.8	182.7	255.8	231.0	200.8
2014	200.3	174.7	163.8	239.6	182.7	196.5	234.2	203.5
2015	196.9	164.3	153.1	265.8	183.3	198.7	201.1	225.2

Reason for Measure: Cardiovascular disease is the largest cause of death in Michigan. Cardiovascular disease includes diseases of the heart and blood vessels in the body. Examples of such diseases are: coronary heart disease, heart failure, sudden cardiac death, and hypertensive heart disease. Cardiovascular disease is an important indicator to track due to the risk of chronic morbidity and mortality that accompany it. Cardiovascular disease is often linked to other factors that can influence health. Low education, low income, and low socioeconomic status have all been associated with increased cardiovascular disease and cardiac arrests.[MDHHS]

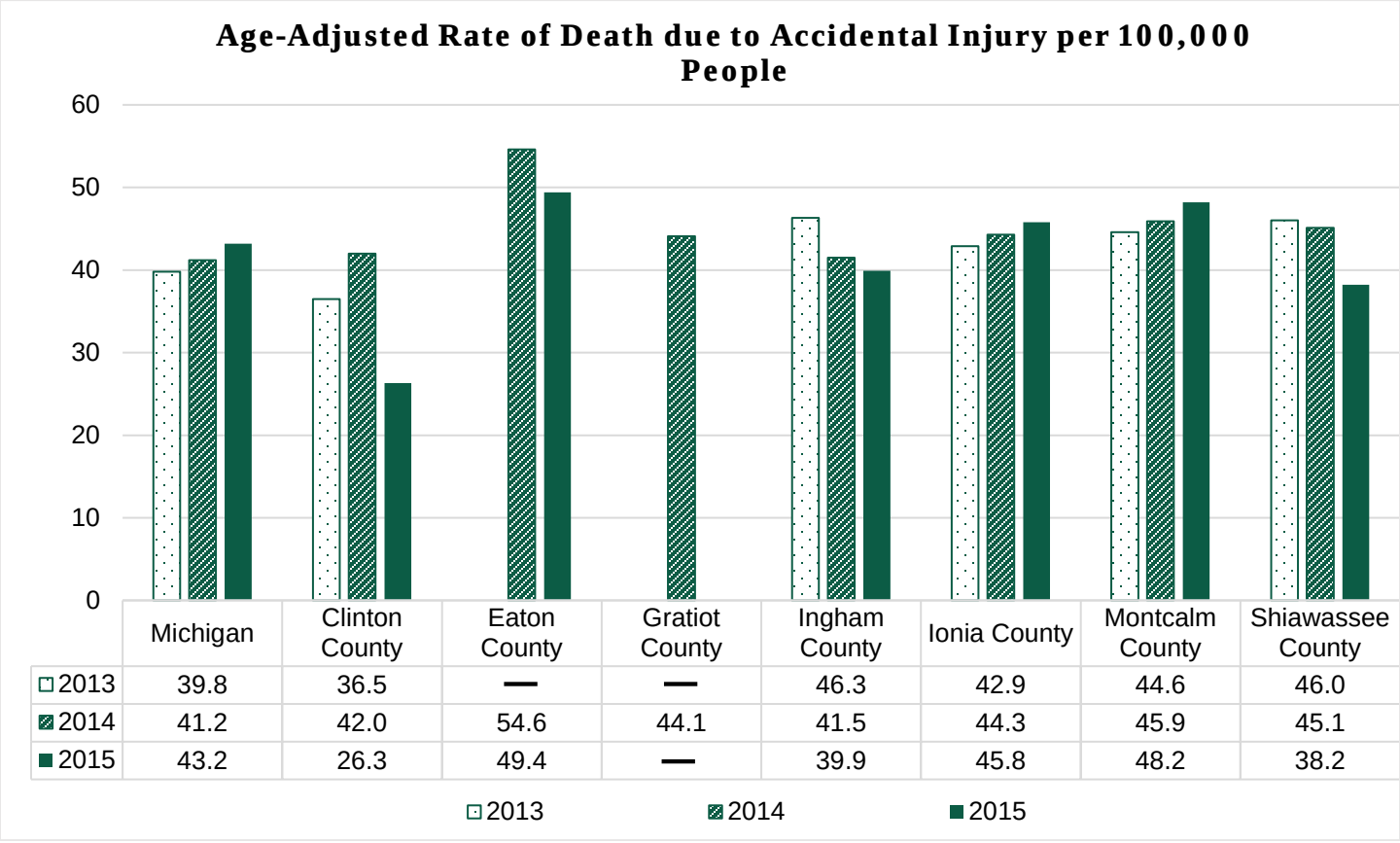
Notes about this measure: Cases are identified for inclusion using the underlying cause of death which is the condition giving rise to the chain of events leading to death. Causes of death are classified in accordance with the Tenth Revision of the International Classifications of Diseases (ICD-10), a coding structure developed by the World Health Organization.

Safety Policies & Practices – Unintentional Injury

Measure: The age-adjusted rate of death 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 and Human Services Resident Death File

Years: 2013, 2014, and 2015



	Michigan	Clinton County	Eaton County	Gratiot County	Ingham County	Ionia County	Montcalm County	Shiawassee County
2013	39.8	36.5	—	—	46.3	42.9	44.6	46.0
2014	41.2	42.0	54.6	44.1	41.5	44.3	45.9	45.1
2015	43.2	26.3	49.4	—	39.9	45.8	48.2	38.2

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.

Notes about this measure: Cases are identified for inclusion using the underlying cause of death which is the condition giving rise to the chain of events leading to death. Causes of death are classified in accordance with the Tenth Revision of the International Classifications of Diseases (ICD-10), a coding structure developed by the World Health Organization.

Qualitative Data

This section contains the qualitative data gathered by Healthy! Capital Counties and by Sparrow Health System to supplement and expand upon the quantitative data presented above. First, the results from the Healthy! Capital Counties focus groups are provided along with participant quotes that delve deeper into each theme. Next, the focus groups and key informant interviews conducted on behalf of Sparrow Health System by the Michigan Public Health Institute are summarized. Quotes from these focus groups and key informant interviews are also provided to explain the perspectives of those living and working in Sparrow Health System's service areas in the words of those people.

"In Our Own Words…": Results from the Healthy! Capital Counties Focus Groups

When presented alongside quantitative (numerical) data, qualitative data enriches information by revealing the thoughts and beliefs of community members 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.

In order to gather information from individuals who represent groups of people that tend to experience greater health disparities, have greater health needs, or are traditionally hard-to-survey, Healthy! Capital Counties conducted six focus groups between March and May of 2018. Focus groups ranged in size from 5 to 12 participants, and a total of 56 people took part. 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 with a $25 gift card for Meijer or Walmart and were entered into a raffle for one $75 Visa gift card per group.

Groups of people that were actively solicited for input included:

- People with disabilities;
- People recovered/recovering from substance addiction;
- People who do not have health insurance;
- People who have low incomes or are unemployed;
- People who identify as Spanish-speaking Hispanic or Latino/a; and
- People who identify as persons of color.

Focus groups were held in various locations throughout the three-county focus area (Clinton, Eaton, and Ingham Counties), including:

- Union Street Center in Eaton Rapids;
- Clinton County District Courthouse in St. Johns; and
- Peckham, Cristo Rey Church, Allen Neighborhood Center, and the Greater Lansing Housing Coalition in Lansing.

Focus groups were recorded and the data was analyzed by one individual. For analysis at the individual group level, participants' responses to each question were summarized; topics that popped up throughout each group's discussion were also noted and summarized. The analyst noted themes of deeper meaning as applicable. For analysis among the groups, the analyst compared data for each question and topic. The main similarities and differences among the groups were noted. Throughout this process, relevant quotations were pulled out to support themes.

Note about the 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.

Healthy! Capital Counties wishes to thank the many organizations and individuals who assisted in coordinating and recruiting for these focus groups.

Participant Demographics

Race/Ethnicity (self-identified)	**Number of Participants**
White or Caucasian (non-Hispanic/Latino)	24
Black or African American (non-Hispanic/Latino)	13
Hispanic/Latino (any race)	15
Native American	1
More than one race	2
No response/Other	3

Age	**Number of Participants**
18-24	6
25-34	11
35-44	8
45-54	8
55-64	14
65-74	4
75+	4
No Response	1

Housing Status	**Number of Participants**
Currently have permanent housing	41
Do not currently have permanent housing	2
Currently living in temporary housing (shelter, transitional housing)	4
Living with a friend or relative	8
Have been homeless in the past	14
Past use of housing services (local housing services, vouchers, shelters, etc.)	13
Other	1
No Response	

Employment Status	**Number of Participants**
Not working, looking for work	10
Not working, not looking/On disability	10
Working part-time	14
Working full-time	10
Stay at Home Parent/Homemaker	3
Retired	9
No Response	3

Health Care Coverage	Number of Participants
Private Insurance	14
County/Health Department Plan	5
Healthy Michigan	5
Military Health Plan	2
Medicaid	23
Medicare	10
Other	1
Uninsured	2
No Response	1

Disability Status	Number of Participants
Mental Health Condition	16
Physical Disability	20
Sensory Impairment	4
Developmental Disability	5
Other	16
Caretaker for a Person with a Disability	10
In Recovery from Substance Addiction	2
No Response	7

Social Services Received	Number of Participants
Used or Currently Uses WIC	24
Used or Currently Uses SNAP or Food Bank/Pantry	40

Summary of Focus Group Discussions

1. 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, or Medicaid at the time make a difference?

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

Not Enough Local Providers Practicing a Specialty

"There are certain, I guess, specialties, where the number of physicians that are practicing in this area, it's hard to find them. Then those that are practicing don't accept Medicaid at all. So, you end up being very limited."

Lack of Quality Care or a Lack of Providers Who are Able to Diagnose What's Wrong

"One of the things that I have had an awakening about is the quality of healthcare that's available in the Lansing area. I had an issue a couple of years ago, where my body, because of my medication, went into liver failure. I went from being perfectly fine to being on the liver transplant list, but doctors in Lansing could not diagnose that. They ended up sending me to Ann Arbor for evaluation. … That was really disappointing to know that the quality of healthcare that I needed to have taken care of was not available here."

Legislation That Affects Care (Mentioned by One Participant)

"[Governor Snyder] just approved this step law, which means people that are going on biological therapy no longer have to go through the blasted step program where you have to fail a medication to be put on a different medication. I had to fail so many different medications before I could be put on another medication."
"It bugs me when legislators think they know what they're doing and they want to block people from using biologics. It's like okay, then why should people be able to do their own insulin shots at home if you're going to block us from taking our biologics at home?"

Insurance Companies (including Medicaid) or the Government Affecting Care

"It's really hard to get specialized services, because you have to have a referral, because you have Medicaid. Your doctor has to try everything he can before he sends you to the specialist."

"Health care is a business model controlled by the insurance company, and it pisses me off that a doctor can say I need something, and, yet, an insurance company can say, 'We're not covering that.' Then I've got to be stuck with even less than the generics sometimes."

Participants acknowledged that being low income and/or having Medicaid affects one's ability to get care and the quality of care. However, just having insurance doesn't guarantee affordability of care.

Healthcare with Medicaid

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 harder to find types of care. Participants talked about how, once they find a provider that accepts Medicaid, the wait is typically very long before they can get in 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). Medicaid coverage can also be inconsistent, and losing that coverage can affect health.

"I have a hard time finding dental care that takes Medicaid. And then if they do it's in Lansing, and I don't drive."

"It's just really stressful, when I see him in pain, and I know his blood sugar is 300, but we can't get in with his doctor for almost six months, because they're full, and there are no doctors in the area that will take his Medicaid that are accepting new patients."

"But, if I try and change my doctor now, first, I'm locked into that doctor for the next year. Then, on top of that, if I do change my doctor, I still have to try and find a doctor that accepts my care, through Medicaid, that no one wants to take. I've had people tell me, 'No, we don't take that. Thank god.'

"The problem that I have with Medicaid—it's a blessing to have some insurance; any insurance is better than none. But when you make a doctor appointment, it's like they put you on the back burner. But if you have a ton of money, they're like, 'Oh yes, yes sir, come in the next day.' If you got Medicaid, you might be waiting a whole month or two months to get some medical assistance."

"I don't know about you guys, but I feel like being low income sometimes affects—or they look at your insurance, I don't know if that's just me…"

"No, they do."

"They do."

"[I was on Medicaid, and] they get me on a good medication. … I felt like I was 20 again. ... I went out and got a job. They took away my insurance right away, I couldn't afford [the medication], I lost [the medication], and I end

up back sick again, end up back in the system again, got my Medicaid back. I went back on [the medication], and my body rejected it. It didn't work on me this time. So, then that means they had to go up the next tier."

Healthcare with non-Medicaid Insurance

One participant said that with Medicare, they have no issues finding providers; another said they have no problems finding providers with their private insurance. One individual with insurance said they had trouble finding a doctor who accepts it. Participants had good experiences with Veterans Affairs healthcare. Participants with insurance mentioned issues with getting care because insurance coverage or quality varied, insurance didn't cover it, and/or because their deductible or co-insurance was too high to afford. One participant mentioned the large-hospital takeovers of independent offices and how that caused them to have to pay more to see the same doctor.

"And [Ingham Health Plan] only covers what they refer… I don't have everything I need."

"It used to be really good insurance, and they just don't cover near as much as they used to. So, sometimes [my mom] does real well after a medical encounter with the bill, and other times she gets stuck with a ridiculous amount of money. Of course, she's on a very fixed income. But, right now, her biggest issue is hearing aid—she has to wear a hearing aid in both ears—and her insurance will pay zero on that."

"It's always been a great experience [with Veterans Affairs health care]. You know, I've heard some horror stories about some of the things that have been going on in veterans hospitals elsewhere, but not here. I've always gotten very good treatment here, whether it be Battle Creek or Ann Arbor or Detroit or wherever."

"My insurance is different from my friend's. My friend, she goes for that insurance, maybe she's paying more for her insurance, and then she goes to the good doctors."

Insurance-Independent Issues Affecting Care

Participants indicated that regardless of whether one has Medicaid or private insurance, the medical system can be burdensome for persons with limited income. This includes costs of medication, office visits, and incidental expenses and having to see a doctor in order to get medication refills. However, participants did mention providers who are willing to help patients reduce costs. Regardless of income level, navigating insurance is generally difficult, and getting care isn't always easy.

"We have a huge deduction on our Medicaid. I can't even take him to the doctor. … And so last week when my son was sick, the lot of okay, we're going to do this Nyquil thing, or we're going to do this. And hopefully it's not an infection, and if it is, where are we going to get the money? ... And he's under 19 years old; he's only 9. He should get insurance. It's not by my fault that he doesn't."

"It's [the elderly] pay for their medication or they pay for their meals. It shouldn't be like that in this county. I also see it, because I work with adjudicated youth, I see it there, the lack of healthcare that they've had throughout Michigan, not just in our counties. I've seen it in the schools because I've been a substitute teacher. And how kids can't – and you'll be like, 'Why aren't you at home going to the doctor?' 'Can't afford it.' Kids know this. Something not right."

"With my medications, my doctor requires that I show up every month for an appointment to get my medications. I can't afford that, so finally, I was able to talk her into filling them over the phone."

"For me, it's even small things. I have to pay for parking. To go to my doctor. I understand, your hospital's growing, you have this great new center for cancer, and you're a great heart hospital. I have $10 to last me two weeks, and you want me to give you two of my $10 to go see my doctor? I'll ride the bus."

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

Medicaid

Particularly in the Eaton rural group, participants discussed that it can be hard to find preventative care providers (e.g., dentists, ophthalmologists) that accept Medicaid, are taking new patients, and are nearby. However, one participant expressed that Medicaid enabled her to get preventative care services and keep up on doctor's visits. Another participant on Medicaid was very satisfied with her family doctor and eye doctor.

"Because I am on Medicaid, I do get preventative services pretty well and can keep up on all of my needed doctor visits. But I know … that once I find a better job and make more, then I'm going to be cut from services, and I'm going to have to figure out a way of health care, probably for me and my children."

Non-Medicaid

Some participants with insurance other than Medicaid mentioned issues with getting care they needed because insurance coverage varied, insurance didn't cover it, they couldn't find a provider who takes their insurance, and/or because their deductible or co-insurance was too high to afford—including for preventive services, like mammograms. Dental care was an area that was mentioned by a few individuals with non-Medicaid insurance as being not covered.

"I'm being told I have high blood sugar, and the medications they want to give me are not covered [by Ingham Health Plan]. And also, especially, the mammogram they want to do on me isn't covered."

"I had to be on my husband's insurance for a while because of the co-pays and everything, and even my prescription that I've been on for five years I had to pay for. And the doctor said, 'You can't just get cut off of it; you can't just stop taking it.' Well, what am I supposed to do? If I can't afford it, I can't take it. So, it's more of like a health risk, like you're going to a doctor to get help for your health, but then they're causing you to not be able to get that."

"I pay to go to the dentist because I don't have insurance that pays for it." *[insurance was private, from employer]*

Another participant said that in the home where they live, the program pays for the majority of health services, including medical, dental, and mental health—they "have everything that [they] need."

b. 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, it's hard to find providers that accept Medicaid, there are language barriers, there aren't any nearby, or because people don't know how to access them or don't have the resources to do so. Community Mental Health (CMH) was criticized, especially over their perceived tendency to only see people who are very low functioning or who express a desire to self-harm or harm someone else; their perceived use of medication that causes side effects or makes you sick or crazier was also mentioned.

"In this area, this is a mental health desert. Despite the fact that we have two medical schools right up the road at Michigan State, no one stays at Lansing. People come, get their education, and then leave. So, when you need a mental health provider, it's very hard to find one. First of all, there are not large numbers of providers in this area. Then, when you start looking at providers who are accepting new patients, the number gets even smaller and then of those that are accepting new patients, those that accept Medicare or accept Medicaid, it reduces the number even further."

“I even went to MSU psychiatry, but the co-pay is $40. So, it’s like, I need my mental health [to be] good for not just me but my daughter, and yet I didn’t get that because of the money, the co-pay.”

“[CMH] said because I’m high functioning, I’m too high functioning for them.”

“[Psychiatrists are] all booked, and without Community Mental Health, I can’t find one, because everybody’s booked. My primary care doctor right now, thank god, is doing my psychiatric meds for me even though he says I don’t like doing them. … He has 15 patients he told me that are trying to get in to a psychiatrist who can’t, because Community Mental Health is turning them all down because they said they’re too high functioning.”

“I have Community Mental Health, or maybe a private practice or two, that offers therapy and will accept my insurance, and then Community Mental Health gives you, ‘Do you hear voices?’ ‘No.’ ‘Do you see things?’ ‘No.’ ‘Are you suicidal?’ ‘No.’ ‘Are you homicidal?’ ‘Do I need to be, to see the doctor? Because I can be.’ I hate saying that to people, but it’s the truth, you know what I mean, and I will do whatever I need to do to get help.”

Culture Can Also Be a Barrier to Care

“I’ve found that we Mexicans don’t want to ask for help because, why, if we’re not crazy? I [had therapy and] was not crazy, but I needed to learn in order to help my son.”

Inadequacy of Care

Quantity and quality of care [though not necessarily from mental health specialists] were also criticized by some participants.

“Medicaid limits you in terms of the number of visits that you have per year. When you’re dealing with issues of mental health, that usually is not something that can be resolved in 20 visits. Which, if you happen to have medication to manage your condition, those visits are split between seeing a psychiatrist and seeing a therapist. … The alternative is to use Community Mental Health if you have Medicaid. If you don’t have Medicaid, then you’re pretty much on your own. But with Community Mental Health, again, you’re allotted only a certain amount of time and then you’re on your own again.”

“I’m trying to do everything I can for [my daughter]. You know, she’s on Medicaid. What I didn’t like, that Bridges Crisis thing, they let the people walk out. Then all they do is call the cops. I’m like, wait a minute. I’m limited to what I can do. [They say,] “Just let her go, let her go. We’ll get the cops to get her.” What if you don’t find her? Then the person’s dead! 50-50 chance of getting someone back into mental health. They’re already not thinking correctly, and Community Mental Health makes situation worse.”

“I went to the doctor here, in Clinton County… I’ve been to about three or four different ones because they just either can’t figure out what’s wrong with me or they don’t want to prescribe me anything that they don’t feel comfortable with.”

“All three of those doctors, they told me I was too young to be on any sort of anti-anxiety medication. Yeah, I see young people abusing things, but when I’ve been on a prescription for five years, I’m not going to be abusing it, but I guess they just think that I am because I’m so young. But if I need that mental help and I know that something’s going to work because I’ve been on it, why won’t they?”

“I’ve had someone say, ‘Get the [expletive] out. Go see a shrink.’”

“I kind of felt like [the provider wasn’t] really listening to what I was saying, and so I kind of sought it out on my own for a different counselor, therapist, psychologist, whatever you want to call it. And then I found someone that I feel that listens to me better.”

Another participant spoke very positively about the State of Michigan and CMH and how they helped her and her son navigate and get mental health treatment.

“Any person can go [to CMH] to ask for help, and they give you information, and then, you integrate it to the appointments, or the psychiatrist doctor, or if it’s just a therapist.”

Two participants discussed their attempts to access care when pregnant or postpartum. One individual has Medicaid coverage when she is pregnant, and she is able to see a counselor with no co-pay. Another participant has postpartum depression, and her insurance didn’t cover inpatient treatment, and her copay for outpatient was too expensive, so she wasn’t able to access care.

“They’ve always taken really good care of me pregnant-wise. My deductible is $1,500 a month when I’m not pregnant, so it’s like, don’t really go to the doctor unless you absolutely have to. But as far as during being pregnant, I’ve been able to see a counselor. And I haven’t had to have a co-pay or anything like that. … So, I just try to, I guess, invest as much as I can while I have access to it, and then when the baby’s born, I’m not sure how much that’s going to change or what, but I guess I’ll find out.”

“I think that they need to have some type of program or some kind of something for [moms who aren’t pregnant or have postpartum depression].”

2. 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 the 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 have had both good and bad providers and good and bad relationships with their providers. One participant mentioned that having rapport is important, especially when you have a lot of health issues going on (which can be an issue with changing residents, etc.). Good providers were associated with going above and beyond (e.g., willing to do “pep talk” appointments, telling them to call if needed), 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.

“[Veterans Affairs providers] are trained to establish immediate dialogue in a relationship with patients. … They seem to cue in on my anxieties, my pains, and things to that effect. So, kudos to the VA certainly. They’re doing a great job.”

“When I went I told the doctor about my [hand circulation problem] but then I told him about my mother, she had poor circulation and they amputated her left leg. My brother had quadruple heart bypass. And so, I’ll tell you what, he got me right in to a heart specialist to see if everything’s pumping right and why this is happening. ... But he just listened and he got me right in to a specialist.”

“I think it’s somewhat confidence in which you feel the person from your country has more sympathy with you, so they listen to you. … In my country ... I’ve always had the same doctor, and he’s the one who knows my story, and has known me for many years. So, it’s like a friend, an acquaintance, something like that.”

“I kind of had to shop around for a good doctor because the first two we tried, it just felt like we were a number and they were shuffling us in and out. … I found one that really listened, and she was good at explaining stuff to me in common language and not all the fancy doctor words. Once I found her, for my kids, I found out she was a family doctor. So, then I just moved to her too and now we just all see her because she’s so great. But for a while it was hard to find someone that you could feel like they were listening to you and you could understand them, and you didn’t feel rushed and just hurry up let’s do your appointment and get you out. But it was worth it.”

Bad providers were associated with prescribing medication inappropriately or offering expensive treatment or treatment that causes side effects, dismissing concerns that patients think are serious (which can lead to serious problems), talking to patients paternalistically (e.g., you need to do this or that), not listening, judging patients in ways that affect treatment, 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).

"She didn't even know me from Adam to be calling me a drug addict. For the first time she'd ever seen me, I don't think she even read my chart or anything."

"And I'm like, 'Look, I have this, this, this, this and this going on.' 'Well, you're overwhelming me, and let's deal with this the next appointment.' I'm not waiting another four weeks!"

"The physical therapist [was] like, 'You know what? I think this might have actually been a misdiagnosis … I think part of your muscular problem is that you have this damage to this area, that's never been treated, or looked at.' And, she looked through all of my medical records— nobody even bothered to look there. Even though that's where I'm saying the pain was. All it took was somebody pressing their thumb in the right spot to help me. And no one would listen."

"Sometimes when you go to complain about something, [doctors] say, "No, no, this is not related to this.' How can it be not related to this? …. So they don't listen to you anymore … about the complaint. They say, 'Don't interrupt me.' I talk about what happened to me so they know how to diagnose me, then [the doctor] doesn't give you enough time to listen to you. In addition to that, sometimes [the doctor] does something not related to your complaint. For example, you complain about pain in your hand, and [the doctor] sends you for something about the urine."

In terms of relationships with providers and getting care, participants spoke 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. Culture was also mentioned as having the potential to effect relationships. Two participants felt that nurses/NPs/PAs are "better" than doctors—specifically that they listen, care, and are more engaged. One possible reason given regarding nurses is that they see fewer patients than doctors.

"Then, on the other hand, I've screwed up too with my doctor, where I had bouts of the pancreatitis that were not acute that I went to urgent care [for] ... But I never let my doctor know that, so all this time that [problem was getting worse]. If I'd let him know I was having these smaller attacks of it, he might've caught on then what was going on."

"I have a good rapport with [doctors] because they respect me because they know I know medical knowledge. I go in there, I treat them with respect though, I'm always on time for my appointments … I discuss my stuff with them, I come prepared with questions, I don't take up a lot of their time. I understand they're busy but I come with intelligent questions for them and I try to make their time as valuable as my time."

"I have a good relationship with the providers that I see, but I think a lot of that falls up on me to be insistent about getting the answers that I need from the doctor. … I do think that a lot of it falls on the individual to make sure that he or she gets what they themselves need from their doctor."

"I've got to be my own advocate, and if I don't, then my health is going to go downhill."

"[My doctor's] from India, and, culturally, he's just really different than what I was raised. He's just very to the point, and when he's driving home a point … 'You need to this!' And, I'm like, okay."

Several spoke of "firing" their bad providers or "letting them go," including for not listening. Having bad providers can affect how patients approach new providers or care.

“I had to have hand surgery a couple of months ago, and I went in to the doctor telling him, ‘I’m going to watch every move you make, I don’t trust doctors anymore. I’m going to be very vigilant, and be careful what you do, because I’m watching every move you make, because I’ve been hurt by too many doctors.’”

“I just, I feel like I’m kind of lost now since I’ve been to three different [providers] here in St. Johns. And I’ve looked up some, but I kind of feel like I shouldn’t even go because I’ve been let down these three times from these doctors. It’s just like I’m kind of at a loss right now.”

“I went through some really excruciating pain and bad times with one doctor. … I fired a doctor, a cancer doctor, and hired another cancer doctor at a different hospital, different corporation, because my quality for life was very poor. She was using me for money; I did not need my medication she had me on.”

Communication between providers also doesn’t always happen.

“I’ve had a bad experience with [providers] exchanging information like they’re supposed to, even when you request it. I said, ‘I would like a copy of this sent to me and to my doctor.’ I’ll be lucky if I even get mine, my doctor seldom gets his. Like when you go to labs, like external labs and the blood test and all that. And then I’ll see my doctor a few months later, he’s the one who ordered them but he never got them.”

Some participants mentioned that because they are overweight, their concerns are often put in the category of “it’s because you’re fat,” even with problems that don’t seem related to weight. They remarked that it’s “like discrimination” or “size-ist,” though they did acknowledge that obesity can cause health problems. One example is that, when speaking about workplace accommodations for pain (e.g., standing desks), a participant said that doctors might not write a prescription if someone is overweight.

“You have to go to your doctor that takes four months to go see, that ‘Hey, I’m getting a lot of lower back pain from my chair at work.’ … And, that’s all they’ll say: ‘No, I’m not going to give you a prescription for that, because you’re fat.’”

“I feel like because I am obese, because I am a large person, I am automatically in the category of, ‘It’s because you’re fat.’ … I don’t have high cholesterol, I don’t have high blood pressure, I have no pre-diabetic symptoms, I am perfectly healthy. My heart is good. … But, every time the doctor sees me, ‘You’re obese. You need to lose weight.’ Came here for an ear infection, which doesn’t have anything to do with the rest of me ‘that’s fat.’ I feel ashamed when I go to the doctor, and they pretty much just lay on me, ‘Well, if you didn’t weigh this much, if you did this, if you did that.’”

“[Cheap, unhealthy food], or not eat, which one’s healthier? That’s kind of how my doctor makes me feel.”

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.

“I think that here [in America], because it’s the government, there’s a specific amount of time, let’s say, five minutes, ten minutes, in which you’d be heard [at a healthcare visit, at] the most.”

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

Changes/reductions in normal activities (and having to take medications) were the most talked-about changes that people had or chose to make in their lives due to having a chronic disease. Finances and relationships were also mentioned as being impacted. Participants’ normal activities can also be impacted by chronic disease.

“The only thing that [my husband and I] can do is try to work as much as possible, even though me and my husband, we’ve already missed so much time. In fact, because of FMLA, he missed 495 hours last year.”

“I used to be very involved in my church and I’m … lucky if I go to church maybe what twice a month or even monthly? And I used to teach Sunday school, I can’t do that anymore. … I used to go to festivals…”

“The disease itself is life-altering because all of my life I was a working professional. I earned pretty well in everything. To go from 100 to zero in a matter of several months, it’s a life changing experience.”

“I’m taking a medication in which they forbid Vitamin K. And that’s the green vegetables, onions, garlic, and many more. So, if I wished to lead a healthy life, I wouldn’t be able to do it. It’s very hard for me because I can’t.”

Chronic disease and feeling unhealthy can also affect finances and relationships (including having custody of children or children wanting to live with parents).

“My biggest obstacle right now is trying to maintain a job. I have a child support case in court tomorrow. … With the disability of hoarding, and things, and I have ADD. So, it just, it makes it very difficult. I can’t say that I’ve ever worked a 40-hour-a-week job, and I’m being court-ordered to pay this child support.”

“It affects relationships, and ability to do just social things, and right now, my ability to drive is affected. I can still drive, I just can’t drive long distances, right now.”

“[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.”

Medications were listed as very important to controlling many participants’ conditions. A common problem with medication was that it can cause side effects or complications, especially if it’s not being managed well. Not all conditions can be managed to the level the individual wants. Medication can sometimes be hard to get, especially with society’s current drug problems. For conditions that relate to stress, such as high blood pressure, and to cope with emotions/moods, participants also spoke of the power of pets.

“I take medicine for [my chronic condition]. I don’t have a problem with it most of the time.”

“Recently I was diagnosed with acute pancreatitis, and they say it was caused by my [medication]. … When I got out of the hospital, I developed some type of breathing problem. But, I guess it was from too much fluids, where I was just lying there for three and a half days and they had me on IV and all that. And then being cut off from [medication] at the same time, which gets rid of excess fluid.”

“Another doctor was the one that [saw that my medications conflicted] because when I went in, I didn’t see my regular doctor. [He] took me off that medicine, and I was good. But you know I could have died over a doctor not checking my medicine.”

“And the heart doctor came in and prescribed me [medication] to discharge me. But, they didn’t give me instructions [and then I had a serious complication from an interaction].”

“It’s to the point where nobody will touch me, there’s nothing they can do for me but just give me pain pills. I’ve already accepted that if I can get my pain down to a five, I never go below a five, if I can get myself down to a five on a scale of 1 to 10, I’m happy. And most people look at me and go, ‘what?’”

“Why do [doctors] have to hear [it from specialists that they can’t do anything for the condition] over and over again [before pain pills are prescribed]? They have to send me to certain places to get the same information back. It doesn’t, it’s just wasting tax payer’s money.”

“All three of those doctors, they told me I was too young to be on any sort of anti-anxiety medication also. Yeah, I see young people abusing things but when I’ve been on a prescription for five years. I don’t think that I’m—I’m not going to be abusing it but I guess they just think that I am because I’m so young.”

“Having animals is more healthy than people realize because it takes some of the stress away and you relax…You figure animals love you no matter what you do. They just love you period.”

Sometimes conditions can be treated through only lifestyle changes.

“Before I was not having to take anything to control my sugar, and now I cannot get off the insulin because of this one drug I took.”

“My sugar was controlled by diet”.

“I take a lot of medication four times a day, or three times a day. But, what I noticed, too, is that I didn’t need those medications anymore, or vitamins, either, when I changed my eating habits.”

“I’m not on medications now, I’ve been trying to manage it with exercise and food choices.”

Participants discussed trouble explaining or having people understand disabilities, especially “hidden” ones.

“A lot of people don’t understand [condition], because it’s not that common and it affects everybody in a different way. So, it’s hard to tell doctors, because I look normal, but then I wouldn’t move, and it’s like a whole different thing. ... So, it’s kind of hard for me to explain to people so that they understand what’s going on. So that’s been a challenge.”

“And, I heard [other participant] say earlier that he has hidden disabilities, as do I, also. So, you don’t know what that means—so people look at you, and they don’t think anything about that. But, they don’t know the day to day struggles, just to get through each day.”

“Every day is a matter of trying to take care of myself, but also trying to help other people understand what it is I’m going through because when people look at me, they think that I look fine – I mean, I am fine, it is what it is, I have what I have, I’m not my illness, but still trying to get people to understand the things I experience as a person with [chronic disease]. It’s difficult. It’s very, very difficult.”

a. 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?

Stress, 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. One participant said they would have tried a natural preventive treatment if they’d known.

“My dad has diabetes. … I think that, for prevention, he should have had a better diet. And my father doesn’t like vegetables, for example. He wants meat on everything. If the food is only vegetables, rice and vegetables, he says that isn’t food because it has to have meat. So, to my dad, the main problem is his diet.”

“…I think a lot of [my military experience] contributed to my stress and my high blood pressure. But I think surviving the mean streets of [city] as a kid, or it could perhaps be even genetic, I don’t know. So, with me it’s just a multitude of different caveats or bullet point concerns that has contributed.”

“I think that diet would have been different if [I’d been] able to do it for myself, because during the recession, my husband lost his job. ... So, we had to be on food stamps. Well, you’ve got to make so many food stamps try to last you as long as you can. Or if you’ve got to go to the food pantry, it’s all carbs.”

"I have a thyroid disease. Both my parents had hypertension. So, I purposefully growing up watched my salt intake. I didn't get [hypertension]."

"I want to say everyday life – when you wake up, you know you've got to be able to pay a bill. It's coming. If it's not there, it's coming. And you try not to get stressed out. Every chance I get, I budget. I try to keep it under control because you aren't going to ever be stress free."

"I think lifestyle definitely has a huge impact, especially with me. … [I]n your busy world and you're dealing with kids, work, whatever, things happen, you don't eat healthy as you could, not exercising … All of those things build up and it's hard on your – I mean not just what you can physically see, but inside, clogging the arteries. Yeah, it definitely takes a toll."

"Hypertension and diabetes runs in my family on both sides. So, I had a genetic predisposition, which doesn't mean I had to have it, but I didn't become diabetic until I was almost 50. … I do think maybe if I had continued to be more active at that time, I could have prolonged it or it may not have happened because at the time I was studying, I was fairly sedentary. … I was eating whatever on the go, no concern about was this healthy. I think that contributed to it and maybe brought on the onset because I had a predisposition."

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."

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

Overall, being healthy might take a lot of personal effort—e.g., to find free/low-cost opportunities, to learn how to eat/buy healthy food, to get to stores, to take the time to cook with fresh produce, etc. 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.

a. 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

Some participants discussed a lack of safe spaces for physical activity (due to unsafe sidewalks and limited access to nearby parks, nearby low-cost exercise options, and indoor options during the colder months). Many discussed the food desert effect, where places to buy healthy, less expensive foods are harder to access due to distance and transportation barriers or are fewer in number whereas places that don't have healthy food options and/or that are more expensive are closer or greater in number. Lastly, one group discussed the proliferation of vacant buildings in Lansing, which often have icy sidewalks.

"Our sidewalks are a mess. They're not safe to walk. If you have any ambulatory problems, they're not safe to walk them."

"I wish there were more parks available. I can compare, for instance, before I moved back to Lansing, I lived in Ann Arbor. In Ann Arbor, on every other street corner there's a park. They make a different use of their greenspace than we do. It's very hard to find a park without having to physically get in the car or get on the bus and go a ways to get to a park. It's really, really hard."

“It’s like where you don’t live close to a supermarket where you can get a variety of foods and at a good price, and some of them might go on sales off and on, versus the convenience stores, where they’re going to eat you alive. You cannot shop in a convenience store and live like that for a whole month, from month to month.”

“So many of our neighborhoods are really food deserts, because the big chain stores are on the outskirts. ... If you’re anywhere in between and you don’t have a vehicle, transportation access, you’re left with Quality Dairy and some of the mom-and-pop stores on the corners that don’t necessarily have healthy food.”

“Something that makes it difficult to be healthy is the two-hour walk to Family Fare for me. So, I could just go to Family Dollar and grab stuff to eat. And everything there is in a box or in a can.”

“[There are] six pizza places in this… little town, yeah.”

“I think [vacant houses are] a lot of the problems with the East Side. There are a lot of vacant houses, houses that have been torn down. You can only do so many gardens. Some of the space, when she was talking about the parks, they should be using some of those spaces as a small park.”

“A lot of our vacant buildings and homes and stuff are actually owned by the county because the land bank, but the land bank doesn’t do anything with them. You end up with the sidewalks that don’t get taken care of because it’s not an individual who the city can ticket. It’s the county itself that owns the properties. There’s a lot of work to be done.”

Programs and Resources

Participants mentioned a general lack of affordable exercise programs as well as limited advertising and knowledge of those that do exist. Even with assistance programs, some people still can’t afford the relatively higher prices of healthier food, and some food assistance programs (e.g., Project FRESH) are limited to certain demographics and/or times of year and may not provide many healthy food options. Farmers’ markets can also be expensive and are often only open for part of the year. A need for nutrition education (including instruction on how to cook healthy meals, how to identify healthy items available in stores, and how to make healthy choices with available resources) was also mentioned.

“I think there’s a real need for education. … I think if more people … were educated about how to [read labels] and the importance of doing it, then perhaps more people would do it. But it’s very difficult to find the education you need in order to make the better choices. Having, I don’t know, like an education class of, here are five stores that are local to you and here’s a good 40-item list of things that don’t have a ton of additives and they are affordable. ... Or even just teaching people how to make things themselves.”

“It’s like well [AL!VE is] not even comparable to the YMCA. That is way more expensive than YMCA, because YMCA helps with the low-income slide. They’ll put you on the sliding scale for your income and stuff. So, I was really hoping for the Y [in Eaton Rapids], and I don’t want to drive all the way out to the one on Waverly here.”

“Sometimes I don’t eat real healthy. Sometimes, you don’t have the money to be able to eat real healthy. So, I use the produce programs and stuff that they have. Every little bit helps out.”

“I feel like that’s another problem: the cheap food is the not-healthy food, and the more expensive it gets is the healthier.”

“[It’s cheaper to eat unhealthy foods], especially when you can get ramen noodles, four for $1. And buy a bag of chips and a can of chili, and if you spread this night out of this, the next night this. It is what it is. Too much money for state assistance, which is fine, whatever, I don’t really want your assistance; I’d rather do it on my own. But, it is hard for someone who has state insurance, whose income is above the poverty line. So, you don’t get assistance, and when your doctor lays into you about being large, and different things like this. Well, what do you want me to do? I just won’t eat, I just won’t eat. I go through this phase of, I’m just not eating today. You know, chips or not eat, which one’s healthier?” That’s kind of how my doctor makes me feel.”

“If you’ve got to go to the food pantry, it’s all carbs. It’s not good for the development of your children.”

Safety

In the non-Clinton County and non-Eaton County rural groups, a lack of safety was identified. Participants said that nearby parks and neighborhoods were unsafe due to various factors including drugs, liquor store/“drunks,” prostitution, fast traffic, and loose dogs.

“Well, we have parks where I live—I live on the east side—but I guess I live in the ghetto side. We have a lot of drugs and prostituting and stuff where I live. So, the park is nowhere to go and hang out because the cars will go by and beep at you thinking you’re prostituting in the park.”

“The whole neighborhood called Animal Control. They tried to get the [dog] … Animal Control told us, ‘Find out who the neighbor is.’ Are we supposed to be investigators or something? I don’t care who owns the dog as long as the dog don’t bite my head off or foot off. We’ve got to be safe. We’ve got little kids running around the neighborhood. We don’t need nobody getting bit.”

“We deal with the drunks all the time; they’re walking down the street. We deal with the drug houses; we deal with the guns.”

Housing

Participants noted difficulty in finding good, affordable housing. Section 8 is seen as hard to get and a very lengthy process. There is a lack of affordable housing options being built; there is a lack of houses for people that need them. Houses can be very close together, which was seen as a potential safety issue due fire, construction mishaps, and other concerns. Resources to help fix up the interior of houses or to make them handicap-accessible are needed. One participant mentioned that it’s hard to find smoke-free, barrier-free subsided housing. Participants noted that people can’t always choose where they want to live—rather, their income or other situation dictates it—and that there are health disparities between the inner city and suburbs.

“They need to build more houses, and where all they’re tearing these houses down, they need to build houses, because there’s a lot of people out there that need places to live. And they’re making them into gardens, and it’s crazy … We need people there, not gardens.”

“There’s a lot of disparity when it comes to the neighborhoods. I think most people want to live in a vibrant neighborhood that’s safe, that has activity, that has good neighbors, those kinds of things. I think everyone wants that. But there’s very much a difference between the inner city and the suburbs. If you can afford to move to the suburbs, it’s a wonderful thing. If you’re in the city, you’re stuck. There’s not a lot you can do. So, that disparity, it shows not just in the neighborhood itself, but in the health of the people in the neighborhood. If you look around you and your neighbors are unhealthy, chances are you’re unhealthy too because everyone around you is like you.”

“[You] shouldn’t have to be homeless to be able to get [Section 8]. As long as the place that you’re at accepts it, that should be good enough, you shouldn’t have to be put on the [long waiting] list. And no wonder, because it’s expensive. If you’re on Social Security disability and you have to pay rent, $600-something a month, that doesn’t leave you much to live on.”

Substances

In general, substances weren’t a large focus of any of the groups. However, some issues related to how substances can impact health were noted.

“I don’t think there is any [addiction treatment] in Eaton Rapids, but for the hospital if you OD or something. A lot of it’s just swept underneath the rug, which leads back to the mental illness issues and everything else.”

“And what makes [gardening] difficult is that some people go out to smoke. And we’re in the garden, in a place that is clean and for relaxing; you’re smelling the smoke.”

“I know alcoholism’s a big thing in this community. We have more liquor stores and more bars and more places to buy liquor than we have anything else. And many, many people utilize it to the point of sickness.”

Miscellaneous

One group discussed a lack of awareness, community, health care (for those with certain insurances, like Medicaid), and people and service providers who care. Another theme that emerged in one group in particular was that of community responsibility. Some issues (poor housing, gun violence) were seen as things that are the community’s fault; some believed gun violence lately is kids’ fault, although others remarked that the issue is complex (there was agreement in the group that adults need to safely secure their guns). Finally, one participant mentioned that speed at which conditions are diagnosed can affect health.

“Part of the problem is awareness. Change starts in your own community, and it doesn’t matter what kind of change. Drug use, mental illness, spousal abuse, being poor, illiterate, whatever it is, it all starts within your own community. … There’s just not enough awareness, I think.”

“I think that’s part of the problem, is you have a lack of community. And I don’t just mean your neighborhood, I mean Sparrow working with McLaren doctors, to work with Community Mental Health, to work with DHS, to on down the line. And, I think that’s a lot of the problem, and a lot of the stigma, because I have state insurance, because I have this, because I have this; you get put in these categories, you know, you’re in a category. ... It shouldn’t be like that, it should be, we’re all the same. It doesn’t matter if you have McLaren, Medicaid, or Blue Cross/Blue Shield, or you’re government insurance, because you’re a government employee, or all those things shouldn’t matter. We should all receive the same respect and treatment, no matter what.”

“My grandfather passed away. … I missed a [dentist] appointment. The man who raised me, who is basically my father, passed away, and because I forgot I had a dentist appointment, because I had this major life event ... I couldn’t get dental services anymore. ‘Oh, you missed an appointment; shame on you.’”

“I understand there are few professionals who go into medicine or dental care to not make money, there are those who genuinely want to help people. But, there’s not very many, and there are not a lot of opportunities, and there’s a greater need than there are providers.”

“There are service providers that do care: they are stretched beyond thin, and then the people that are the ones that allow them to either provide a service, or provide additional services are like, ‘No, don’t worry about that; that’s not important. [Person with tooth problems,] you don’t need teeth! Don’t worry, you’ll be fine!’”

“[People] don’t take care of their house; they’re always in the streets, and they condemn the houses. That’s why the other houses are getting knocked down—because the people that rent them don’t take care of them, so they have to knock them down because they’re not up to code, the landlord doesn’t want to put all that money back in there.”

“[Gun violence is the fault of] the kids and the adults, because the adults by law, if you have a gun you’re supposed to keep it locked up.”

“I know sometimes the hospitals, they have a hard time reading different symptoms or diagnosing your blood. You don’t get immediate help. Sometimes you have to wait. That will cause problems.”

5. Thinking about the future… Do you feel your children are likely to be healthier than you, less healthy than you, or the same?

Responses to this question seemed pretty split. Many participants said that this is dependent on changes that may or may not be made, but that there is the potential for children to be healthier.

a. Less Healthy

Participants mentioned a variety of factors when discussing the likelihood that their children would be less healthy than they are, including food, technology, today's culture, and the motivation of youth today.

Food

Issues surrounding the negative impact of food on health included the addition of additives and chemicals to, and environmental (growing) concerns around, food; the higher cost of healthy (e.g., organic) food; the presence of food deserts; food and drink options available in schools; the modern desire for convenience (e.g., fast food), instant gratification, and unhealthy food; and youth not knowing how to cook.

"In today's world and generation, they didn't practice what the older generations did, and that was, everything was homemade, fresher ingredients. Whereas today you have far more additives and preservatives and this and that that really you can't even spell out anymore."

"I'm surprised at all of these young folks that don't know how to cook. What scares me is, if they don't know how to cook, even if they have access to healthy stuff, how are they going to prepare it?"

"When I went to elementary school, we had a regular cafeteria with good food in it. They didn't have the junk food like pizza and stuff like that, which I like. But, still, it didn't have all the junk food. We had real good, healthy food."

"But [pizza is] considered healthy because it has whole wheat crust. That's why they consider it healthy."

"I think pizza's on the menu once a week here at school."

"So many of our neighborhoods are really food deserts because the big chain stores are on the outskirts. … If you're anywhere in between [the outskirts] and you don't have a vehicle, transportation access, you're left with Quality Dairy and some of the mom-and-pop stores on the corners that don't necessarily have healthy food."

Technology

In the Spanish-speaking group, technology was attributed as the cause of distracted driving and a decrease in exercise and engagement in sports. A lack of communication outside of technology (i.e. face-to-face interaction) was also seen as affecting youth's heath.

"I'd say that [children's health] will be a little worse. Before, we weren't allowed to be watching television so much. What they'd have us do is play sports. Right now, no child wants to do anything that was done before. Before, when I was a child, there were ropes to jump with, there were different things, play ball, there were many healthy games. Now, I sometimes, I even tell my children that we should play something like that. 'Mommy, that's not interesting.' How is it not interesting? It's interesting because it's a sport."

Culture/Motivation

Today's culture of convenience and instant gratification, time demands, and youth's lack of motivation to work or do something with their life were given as additional factors contributing to poorer health.

"There are many young people … not interested in doing anything normal for their lives. They don't care much. They do drugs, too. They smoke. The girls now, they get pregnant. Who takes care of the children?"

"The grandparents. And I blame welfare, too … I'd say that well, they get pregnant the first time, okay, let's help with this baby. If you get pregnant again, we're not going to help you again. Maybe a little bit, but you have to work. And yes, they have to work, but they only work the hours they want to. Why? Because they get tired."

"We live in the time where everything is instant gratification. We microwave everything."

Wage Stagnation

"The cost of everything is rising but yet people's wages and income is not rising to make up for the increased cost. So, just based on that factor alone, I don't think that the kids today are going to have healthier lives."

b. More Healthy

When considering that children will likely be healthier, participants mainly discussed food/nutrition.

Food

Food-related factors that lead to a promising outlook on whether youth will have better health are the already-existing good eating habits and enjoyment of fruits and vegetables that parents/grandparents see in their kids and increased knowledge of the harm of some additives, trans fats, etc.

"They're making a big deal out of what they take out of food, whereas when I was little, they were like, 'This is cheaper; let's put it in the food.' Well, now we've seen it doesn't benefit us and they're starting to advertise, 'Well, we don't have this in there.'"

"[My kids] love their vegetables. They eat very well, their kids eat very well, and now my greatgrandchildren … they eat avocados, they eat bananas. These kids are teaching their children to eat good foods, not garbage. So, I think my great-grandkids are going to eat better than anybody."

Other

Education (even in kids' TV shows) for today's youth and parents as well as WIC were also seen as factors that could contribute to healthier futures for children.

"I think the younger generations now, they have a lot more education and they're a lot more active, when they get off their video games and their computers."
"Something else I do with my five-year-old, he likes watching Daniel Tiger's Neighborhood, and they always do a little song in every episode. One is, you have to try new foods that might taste good. He's always telling his sisters that. … So, it's cute, and it sticks in his mind, and I love that it sticks in his mind."

"WIC has been a huge asset for me … WIC is like, there are all the healthy foods that we can provide for you. And that helps. But they also do their counseling, and they'll teach me things, [like], even if you put a healthy meal in front of your kid, you know how to make them finish the whole thing."

c. Neutral

Some participants considered the following factors as having the potential to make today's youth healthier than they are.

Technology

Technology could positively impact the health of youth by giving them access to information, healthy apps, etc.—but only if they use it to their advantage.

"All of us in here probably are computer literate some, and you can get on the computer and look for a recipe. Knowledge is no good if you don't use it to your benefit. You can have all the access you can, and if you don't make healthier choices, then you're still in the same boat."

Food

One participant said that if healthy food becomes cheaper and unhealthy food becomes more expensive that it would help the next generation be healthier.

"With the cheap stuff being not-so-great food … if that changes as [my daughter] grows up, I feel like she'll be definitely healthier than me."

Role Models and Family

Participants noted that role models and family can play a key role in ensuring children have positive health outcomes. This includes parents having a healthy relationship and having strong family foundations and healthy habits and teaching them to their kids as well as positive grandparent involvement in the family.

"I'm hopeful that once we, as adults, become aware of the choices we're making, then we realize that our children and grandchildren are modeling what it is that we bring to the table. Perhaps that will change the way we do things or we can change it to help them."

"Depending on the mom and dad, depending on the relationship between the two, is what the child's health depends on. If both parents have a balance with their food and everything, a moment for their phone, and have a schedule ready for everyone. So, it depends on that is how their child's health will be."

"The majority of older people are the ones who have to get a little more involved, like [grandparents] have to be a part of the family … help their children to instill things in their grandchildren. Like, healthy food and having a schedule for everything, because technology has advanced a lot."

One participant mentioned that "We're trying to at least have something, good health, to learn. There are programs. We're trying to learn good things. Health or also, in school, there are classes on medicine, on how you should take care of yourself, and on all of those things."

6. We are interested in making our community a healthier place for older adults to live. What things do you think are important for that to happen?

Increasing community center–type experiences and programs as well as improving care in nursing homes and rehabilitation centers were the two most-discussed ways to improve the health of seniors.

Transportation

The improvement of public transit services came up in the Eaton rural and Clinton County groups. It was mentioned that Eatran isn't easy to get ahold of, and that it would be good if Clinton Transit had expanded service hours. One participant mentioned that getting to community centers isn't always easy.

"There are a lot of community centers and places to go exercise at, but if you're going to take an hour or more to get to a place and then go back home… That's what I've seen in the community a lot. A lot of people want to participate, but there's no way to reach these places."

"[Clinton Transit] is the only bus company in Clinton County, and a lot of low income, elderly, handicapped, mentally disabled people depend on it, especially for doctor and medical appointments. And they're great at doing that, but if they could go later in the evening, past 5:30 p.m. or 6:00 p.m., whatever it is. And then they're shut down completely on the weekends."

"Even if they stayed open till like 2:00 p.m. on a Saturday and then were available for people who go to church—church or a Saturday, maybe something recreational."

Community and Support

It was recognized that seniors need a community to support them, including advocates and good neighbors. Increasing community programs, the importance of (and perceived lack of current) common neighborliness, and improvements for safety and health were mentioned.

“I think one of the main things is just to be more neighborly. When I was growing up, we used to check on our neighbors, and if there were seniors around and if their family wasn’t there, we’d check on them, ‘How are you doing?’, if they need anything. … But that, I think, is one of the big issues, especially for seniors, because we need to care about them more, check in on them. … That’s what I don’t see and I don’t know how to encourage that or make that happen, because people are just set in their ways.”

“I think they need [a strong] advocacy group, people that will advocate for them. Because when they don’t ask for help, then they need to have someone to help them ask for help because they don’t know where to go.”

“A lot of the things that help the elderly are those community center-type experiences, because if you’re over 63, and you’re retired, your kids have moved out, and your family’s gone cross country, or out of the country, you’re alone. And, if your spouse dies, God forbid, because then you’re truly alone.”

Safety and Physical Health

Suggestions for improvements related to safety included financial support for making homes accessible and making the neighborhood environment safer. Suggestions to help ensure physical health included improving care in nursing homes and rehabilitation centers as well as ensuring there is a quick response when seniors need assistance (e.g., food assistance).

“[To make our community safer for older adults, it’s important to] have resources to help build ramps, have resources to help modify houses.”

“Let me walk through the neighborhood without getting chewed at by a dog.”

“It’s not safe for older people some places. I don’t feel too unsafe in Lansing … But walking in the neighborhood nowadays is so hard, and that’s one of my biggest concerns … too many people who don’t care about their dogs.”

“You know, [a nursing facility] only bathe[s] them twice a week. Like, mandatory, by law?”

Miscellaneous

One participant pointed out that within the “senior”/“older adult” demographic, there are different groups (e.g., younger, often more affluent, two-person-family seniors; older, widowed seniors who live alone and might have trouble making ends meet) with varying needs. In particular, an effort should be made to reach the latter group. Participants noted that education can be a helpful tool for improving seniors’ health. It was also recognized that seniors may not want to ask for help because they have pride or want to remain independent.

“A lot of [one group of seniors] are individuals who get food stamps. They may have Section 8. They kind of are a forgotten part of the senior demographic who have a hard time making ends meet every month, who run out of food. … How do you reach that group of seniors? Again, when you’re dealing with that group, you run into some of the same problems that you do with people who have children. … Nutrition-wise, what choices do you need to make in order to maximize your nutrition while maximizing the limited income that you have? How do you prepare foods? Those are all things you’re faced with when you have children and you’re on a limited income but you’re also faced with when you’re a senior on a limited income because perhaps now you have health issues or mobility issues you don’t have when you were 20, 30, 40, 50. There has to be the recognition that within that term ‘senior,’ there’s a spectrum of what senior means. … It has to be a recognition and then a concerted effort to do an outreach to those people, I think.”

“I have a mother who’s 84 and she’s proud. … She doesn’t have a car, but she gets SpecTran, and she will not ask me to pick her up. She will not ask me to take her places. It’s that generation. Her generation – you can’t do anything for her. I try, but she just will not accept. … But as she gets older, I can see she’s getting more frail and more fragile. … How do you get them to see you need some help now?”

7. Some people have more opportunities than others. In an ideal world, what would need to change in order for everyone to have the opportunity to be healthy?

Participants across several groups suggested that health care, including mental health care, and access to health care need to be improved. Changes to community, programs, and resources and infrastructure were also mentioned.

Access to Health Care

Participants spoke about wanting more affordable and/or more equal insurance coverage (including universal health care) for everyone.

"I think right now we're kind of in an all or nothing situation. There are people who have absolutely no help whatsoever, and then there are people who have full [health] coverage. So, when you talk more about an equity situation, maybe person B, who had nothing, is brought up a level, that's still better than where they were. It's a step in the right direction. It's not in the direction of communism or socialism, and they may not have everything that they need and they may still have to say no to some things or even supplement what they're getting."

"I just feel that health care should be a right, a basic right, and not a privilege to those who can afford it. It's kind of an insult to human dignity to look at it in other ways, I think."

"I know if we had access to that, where all of our citizens had [universal health care], we would be better off. But I doubt if this country is willing to move in that direction."

"I think a lot of the inequities in the system and the way medication is given, the way that medical care is provided, there are disparities in the system, and, unfortunately, it always comes down to the battles between the haves and the have-nots. … Everyone can see what needs to be done, but in order for that to happen, someone has to be willing to give up something so everyone else can have. Unfortunately, in the world in which we live, no one wants to do that. … The sad part of it is, as a society, everyone comes out better when there is equality all the way around."

Improvements to and Non-Discrimination in Health Care

In many groups, participants mentioned that the care people receive or the accessibility of that care, whether due to treatment constraints or discrimination, is affected by type of insurance, with people who receive Medicaid being most negatively impacted. Participants hoped for a broader acceptance of different types of insurance. Two participants offered suggestions to improve care for persons with Medicaid, including requiring that a certain percentage of a provider's patients have Medicaid, requiring community service hours, or offering incentives (tax breaks, etc.) to providers. Another suggested changes to the healthcare system, including expanded appointment hours. Participants also discussed needed improvements to mental health care, including increased affordability, improved service availability, and providers being more understanding. One participant felt that doctors need to change how they interact with patients, such as admitting when they don't know something.

"I almost feel like, why aren't we making this a state law that every doctor must offer at least 15 hours of community service a month, to practice in the State of Michigan?"

"Or, a certain percentage [of their practice] for Medicaid."

"I think with the Medicaid, because it's so limited to certain care, I think they should find a way to expand that. I think it's very limited, what you can go to and what you can get."

"And the discrimination is crazy, like she said, on what kind of insurance you have, because I notice the difference. I'm on Medicare and Medicaid now. And since I've been put on the Medicare as my primary, the

difference in the treatment level that I got when I was in [the hospital] this time was a heck of a lot better than when I was just on the Medicaid prior."

"I think they should improve Community Mental Health. They need more, stretch out more help, more resources to help."

"I just think [mental health care] should be a lot cheaper, and that would make everybody in an ideal world – if everybody had their mental health in check, then everything would be okay."

"Everybody to have access to pretty much every kind of [health benefits: experimental drugs, medicines, testing, etc.]; not just the big athletes, not just the big stars on TV."

"Obviously, mental health care is something that's critical. Just turning people out into the streets is not solving the problems. People don't get better being turned out into the street, in the same way that people don't get better with their health if they don't have proper nutrition or have access to proper nutrition."

"I'm tired of doctors taking a guess. If you don't know something, just tell me, 'I don't know something.' Don't tell me, 'Try this, so I can kill you.' I want you to tell me the truth. This is my life. My life is in jeopardy. … If he doesn't get this medication right … then [my daughter's] back in the hospital."

Community, Programs, and Resources

Enhancing a sense of community, increasing availability and knowledge of resources available, and improving community awareness and decreasing stigma were discussed, especially in the Spanish-speaking and special needs groups. Ideas offered included forming community-based programs where resources and efforts are pooled so that everyone benefits and creating more helping programs. The importance of extending a hand and reaching out to neighbors and other community members was emphasized. In the chronic disease group, improvements in access to healthy foods and nutrition also emerged as a desired change. These improvements could include increased affordability, having healthier food offered at schools and through Meals on Wheels (including the ability to cater to dietary restrictions/needs), and increased nutrition education.

"The country I'm from, the majority of the people cultivate everything healthfully … Sometimes, they have community programs in which the community comes together to plant vegetables. And when the harvest comes, each person takes a little bit to their house from the work they've done."

"It would be beautiful to … have housing where … single moms can live there, seniors can live there, and things like that, so that, I think of some of these great senior citizen men in the community, that are still able to be functioning people, could help a single mom with electrical, plumbing, handyman repairs, so that you're feeding into each other. Because a lot of these older people, their kids have moved away, their grandkids are gone. But, they would be a great mentor for single moms' kids, who need a break, and the kids could go hang out with this adopted grandma. Something where [housing is] affordable."

"[There needs to be a] resource book. I know [Capital Area Community Services] does a book, but that's way out towards Vermontville. No one knows about it unless you've done services through CACS and gotten their commodities. They need to have a program where there's commodities out [near Eaton Rapids], more so CACS compared to just going to a food bank. And make it accessible for our seniors and for anybody who needs it that is on that line. And a resource book—pick up that book and be able to say, 'You know I can't pay my rent today. I've got denied from DHS. What's the next step?'"

"With my friends, there was a woman that, I don't know if she doesn't have a house, or what. So, we thought that forming a little group and asking her … if she needed medicine, or if she needed help, so that we could help her, since she doesn't communicate much with people. We can ask, we can talk to her and see if she needs help, or if she is sick. So, to me, that's like having a team to be able to help people like that."

"Something like [the YMCA] in the community would be great for the teens because YMCA has a lot of the teen programs."

"[In an ideal world we could have food that would help everyone to be healthy,] healthy food would be less expensive, and the junkier food would be more expensive."

"If I had been taught that earlier, eating healthy, I would have done better than eating what I did before, but I wasn't taught that. That's something they need to teach everybody."

Infrastructure

Adding physical infrastructure and related programming could also improve health.

"I think, if nothing else, like we said, the biggest struggle is exercise. I guess maybe having … some kind of community center, or some kind of physical – yeah, there's [Gym], which is $10 a month, but like these people are saying, if you're struggling to just pay your bills, that extra $10 is either a meal or gas. … And, just some kind of community center where there's swimming pools … a sauna …"

"We have all these empty schools all over Lansing. Use them! There's a beautiful architecture that we could save, if we just opened them up to the public. Whether it's housing for the poor, or it's food kitchens, or it's community centers."

Miscellaneous

The need for and the loss of "old-school discipline" was discussed by a few participants in one group as something that has eroded and is needed to address some of the youth-related issues today (like drug use). One participant stated the need for parents to be trauma-informed and have their own supports. Another lamented that the drug issue has gotten so "out of control" that there's no easy answer to what we can do about it.

"I think there also needs to be a source of ... what can cause trauma. I don't think some parents are very knowledgeable on that in a kid's mind. And I also think that there should be more resources on when parents need a break. And reliable resources … actual support groups to say, 'Hey, maybe you're struggling a little bit; let me help you.' And with no judgment because I think a lot of parents feel judged nowadays."

"In answer to [what the community can do to address the drug issue], because today's society with laws and nuances, there's pot stores now for medical marijuana cards, things in community awareness campaigns perhaps, law enforcement. There's no answer to that question. What can we do to impede or abate this issue? Really, it's gotten so much out of control. But there's access, like I said, to pot stores. What's next, I don't know. So, it's the world has changed."

8. 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.

Schools

The most frequent reason for bringing up schools was to discuss the food available for students. Participants recognize that some students rely on school meals and don't necessarily have another option (like bringing cold lunch or getting better meals at home), and that schools should be serving healthy meals. Many participants were very critical of the lack of nutritional quality in food served at schools.

"A lot of kids, the only square good meal they get a day is that school lunch."

“That school lunch, yep, or breakfast.”

“I know some of those kids, the only meals they got were the breakfast they got at school, and the lunch they got at school.”

“I think they need to take pop machines out of the schools as well, especially the high school. My son said there are kids that come into class every day with a 20-ounce of pop. And I don’t think that’s very healthy.”

“The [chocolate milk at schools] is full of crazy crap … it’s got all the sugar in it. But that’s supposed to be part of your healthy lunch because it meets federal criteria, which is questionable.”

“[China and Japan have healthier] school lunches, it’s pretty crazy. Even Europe has better food choices.”

Some participants said that kids aren’t being taught about nutrition or cooking today in general. Schools were mentioned as a good place to educate kids on health topics.

“Part of the problem is awareness. Change starts in your own community, and it doesn’t matter what kind of change. Drug use, mental illness, spousal abuse, being poor, illiterate, whatever it is, it all starts within your own community.”

“I’m saying, that’s where school comes in.”

One group agreed that the school system doesn’t facilitate well-being for children because they have to get up early, do standardized testing (which was not seen as an ideal way to evaluate kids), and are overworked; there’s no hands-on learning.

“They go to school way too early. All [school] is is testing. … There’s a Dr. Seuss saying, ‘If you judge a fish by whether it can climb a tree, you’re going to think it’s stupid its whole life.’ If you think my kid is stupid because of his test score, or this, that, or the other, no.”

Issues of school safety were also briefly touched on, including the problems with drugs, lack of security, and school shootings.

“How can our kids be healthy in schools when there’s so much danger? The school shootings and that really bother me.”

Law, Government, and Politics

The potential for law, government, and politics—on local, state, and federal levels— to impact health and health determinants was mentioned across groups. The federal government was said to affect health and conditions impacting health through, for example, agencies like the FDA, federal school nutrition criteria, and requiring better nutrition labeling on foods. State laws, like Michigan’s step law, can help determine what medication people can or cannot get. Locally, the enforcement of ordinances can affect health conditions. Laws dictating care given in nursing homes were mentioned, as was the fact that judges can determine if people can receive disability. One participant said his care-seeking behavior will potentially change due to politics and legal deliberations.

“A lot of that, when people go out of the country [for health care] it’s because they’re getting treatment that’s not FDA-approved. So, universally, it might be working in Europe or Mexico or Canada, but in the United States, the FDA hasn’t approved that medication. So, the doctors can’t use it here, so you have to go where you can get it. You see that happening a lot.”

“When it snows and ices, the sidewalks, you can’t go through them. The neighbors, the homeowners, they don’t shovel, and the city doesn’t enforce the ordinance. ... I think that’s one of the issues, is the sidewalks and the ice

and making sure the neighbors have got a path. There are people that have got to bring their kids in strollers in the winter."

"Legally, you only have to feed your kids one square meal a day, because some people don't have it like that. But, think about it, our kids are up 14 hours out of the day. They're active; they're moving around. They need more nourishment."

"But I'm debating, maybe I should push to have this operation because of the political situation we have. That could go away overnight. And then I'll have no insurance, and I'll probably get stuck with $100,000."

Gun Violence

Most of the groups mentioned gun violence, ranging from saying it's a barrier to health for today's youth, being worried about someone being violent in one's neighborhood, and in terms of who should be blamed for gun violence, especially in youth.

"I think a lot of seniors become antisocial because there is a lot of crime that's getting worse and worse in the city. So, people try to separate themselves from crime … They're scared to open the door. You don't know if somebody's going to have a .22 facing you if you open the door nowadays."

"What gets me [is] … try to take a gun into the airport. It's not going to happen; you're not gonna get near. But yet, if they can do that for airports, why can't they do that for schools? How about thicker glass and heavy-duty doors … metal detectors you have to go through. If that's what it takes, let's do it."

Finances and Assistance Programs

Finances were seen as a determinant of health in terms of being able to afford health care or resources that can help people be healthy, like exercise, nutritious foods, home modifications, and living environment. It can be a limiting factor in seeking care and in making healthy choices. In one group, participants discussed the concepts of spending money on health care, but not having anything left to live on and also determining whether or not it's worth it to pay to go to the doctor for preventative services if you can't afford to deal with any problems that are found.

"And then the question is, what if they find something [at a preventative care visit], and then it's just more tests and more tests? And then you're like, what are you supposed to do with that?"

"What's the point of spending all of your money on maintaining your health if you don't have much money left to live life? What's the quality of life there?"

"Trade-offs" for people with limited resources were mentioned in a few groups: going to the doctor vs. paying for rent, food, and/or utilities; using gas to get to work vs. using gas to go buy milk; buying medications vs. buying meals; and getting a job to earn money vs. needing benefits from the state which might be lost as income increases. One participant expressed a desire for a better transition or weaning off period between having services and not having any.

"There's times you try to budget out your money, and you might fall short where you don't really have the gas. [You've] got gas to go to work. But you need to get that one gallon of milk. So, [do] you waste the gas to go get the milk, or do you just improvise … because you live so far out somewhere?"

"Once I find a better job and make more, then I'm going be cut from services, and I'm going to have to figure out a way of healthcare and probably for me and my children. So, that's concerning to me. And that kind of puts people in a predicament where, do you better yourself and get cut [from] your services? … I don't want to be on services my whole life. But I wish there was a way, if you're trying to better yourself, that they wean you off services not just completely cut you off services."

“I went out and got a job. They took away my insurance right away, and I couldn’t afford [my medication]. I lost [my medication], and I end up back sick again, end up back in the system again, got my Medicaid back…”

Discrimination

Several groups spoke about feeling discriminated against or treated differently because they were on Medicaid or because they were obese. One participant with Medicaid discussed feeling like she wasn’t treated as well, which she realized when she got Medicare coverage. Others felt like people on Medicaid are not prioritized when they try to make an appointment to see a provider. Participants who were overweight often felt like they were treated differently, that their problems were all blamed on their weight.

“But if you have a ton of money, they’re like, ‘Oh yes, yes sir, come in the next day.’ If you have Medicaid, you might be waiting a whole month or two months to get some medical assistance.”

“When I went in front of the judge for disability, he told me I was obese, overweight.”

“Yeah, it’s funny how that judge was a doctor, wasn’t it?”

“I feel like because I am obese, because I am a large person, I am automatically in the category of, ‘[You’re having whatever medical problem] because you’re fat.”

“Yes.”

“It’s like discrimination. Because I’m a big person, because I was born and weighed almost 10 pounds, and my whole life, I’ve been a big person, I’m unhealthy because I’m large, and that’s all my problem.”

“And the discrimination is crazy, like she said, on what kind of insurance you have, because I notice the difference. I’m on Medicare and Medicaid now. And since I’ve been put on the Medicare as my primary, the difference in the treatment level that I got when I was in [hospital] this time was a heck of a lot better than when I was just on the Medicaid prior.”

“It makes a difference.”

SPARROW HEALTH SYSTEM FOCUS GROUPS AND KEY INFORMANT INTERVIEWS

On behalf of Sparrow Health System, the Michigan Public Health Institute conducted a total of four additional focus groups and thirteen key informant interviews. The goal of the focus groups and interviews was to gather information about the health of the community and to collect thoughts and feedback about local health needs from people living or working in the regions served by the five hospitals. Each hospital took part in identifying participants for the focus groups and interviews and assisted MPHI with recruitment when necessary.

Focus groups were conducted in June and July of 2018, and topics covered included rural health and access to care. Each focus group lasted approximately 90 minutes and participants were provided with an incentive (e.g., refreshments and/or gift card) to thank them for their participation. Key informant interviews were conducted by telephone in August and September of 2018. Interviews lasted approximately 30-45 minutes.

Sparrow Carson Hospital invited community members to participate in their focus group. Three community members participated and represented the perspective of those who utilize resources in the community. A total of four key informant interviews were conducted on behalf of Sparrow Carson. Interview participants included healthcare providers and mental health professionals.

Sparrow Clinton Hospital chose to hold a focus group that addressed the topics of access to care and hospital readmission due to chronic conditions. A total of three people took part in the focus group. The participants included community members and health care providers. Sparrow Clinton Hospital identified four participants for the key informant interviews. Those that participated represented education, emergency services, programs serving children and families, and local health experts.

Sparrow Ionia Hospital hosted a focus group which explored health in a rural setting. A total of fifteen people representing health care and community-based services, including educational and religious organizations, participated. In addition, five key informant interviews were conducted with educators, local health experts, and mental health services providers.

Sparrow Specialty Hospital's focus group was designed to gather information about integrated care services. Seven people representing the hospital, skilled nursing and rehabilitation facilities, and organizations serving older adults participated. Three key informant interviews were conducted on behalf of Sparrow Specialty Hospital. Participants included hospital representatives, case managers, and health care providers.

Focus group discussion guides and key informant interview questions were designed to highlight three areas: 1) the participant's vision for a healthy community, 2) where the community is now in terms of its health needs, and 3) what the community needs to be healthy. Each hospital was given the opportunity to review the focus group discussion guides and key informant interview questions to ensure they would capture the desired level of information on the topics of interest. Please see Appendix B for the focus group discussion guides and Appendix C for the key informant interview questions.

MPHI recorded and transcribed each focus group and key informant interview. Transcriptions were imported into NVivo 10 to be coded for themes. The following discussion of the findings summarizes those themes. Quotes are used throughout the discussion to ensure that the information presented is described in the participants' own words. In order to protect participant privacy, names and organizational affiliations will not be identified in this report.

Rural Communities

Throughout the focus groups and key informant interviews, participants noted the strong sense of community found in rural areas and often personally knew a variety of individuals who were working to improve the health status of those who live and work in the area.

"What I like best is that everyone knows everyone. It's very much a family environment. And I think the people are very kind and they are very much willing to listen, and to learn, and to respond to what you're doing. They're very kind-hearted people and they're very enjoyable, and it's nice to walk outside, and you see 'em on the street and you can wave and talk to 'em. So that's the nice thing about this. This truly is a community and it makes you really enjoy your work."

However, some participants observed that enthusiasm was waning as positive results were slow to materialize and members of the younger generations were moving away in favor of the opportunities available in more populous areas of Michigan. Commonly cited reasons for relocating included wanting access to better schools for children as well as employment or educational opportunities for adults.

"I think there is just there is a lot of caring people in this town, but it's just I think they're frustrated. They've been—it's just a few have been fighting for so long and have been trying for so long and it's just after a while you're just burned out. People are just burned out. And I'm not really sure why. You don't get those new people like you said coming to our community that can—to help."

"It seems like this is just a stop on a going-somewhere-else-better [for the younger generation]. You just kind of stop by here and then move on with your life. This isn't a, 'This is where we're going to be and grow our families and grow our life' for the most part."

"People move out of the community because of the school and no jobs. But I think that you have to start right from the ground and work up to have a healthy community. And to have a healthy community, you need to have jobs, there need to be more businesses downtown, and you need to have a better school."

"The hard part with the schools is that funding is on like how many students you have and that kind of stuff and if you don't have—it's a catch-22 because you can't have one without the other and so it's hard to get the schools to be better if you can't get more people so you can get more funding. And without the funding, you can't make the schools any better. So it's just like this vicious cycle."

In particular, the status of key community institutions, such as major places of employment in the region, can have a significant impact on residents' morale and willingness to remain living in the area. Residents hoped to be included in the conversation when decisions were made related to workforce reduction, and wanted to feel as if their thoughts were heard and taken into consideration. Engaging local community members was of particular importance to people living in rural areas where some residents believe that "outsiders" are not familiar with the way business is conducted and how people customarily interact with one another outside of large, urban regions.

"People that we know and people that worked here lost their jobs. And so that's and for whatever reason, whether it was the downsizing or whatever. So you feel for—small communities are tight knit and are pretty tight knit. So they're concerned about their family and friends. … It gives people a bad attitude. … When they work there forever and then all of a sudden, 20-50 people lost their jobs. But when you think about that, now them 20-30 people, all their family around here, all their friends are around here. Don't you think they're all going to get an attitude? You bet ya. … The loyalty, and big cities don't really understand it either. … But they can't come into a small town and just do away with everybody and treat everybody like they're nothing and that's basically how everyone has felt here."

In the short-term, residents felt that the loss of jobs had impacted their ability to access quality healthcare services. In the long-term, residents were fearful that downsizing, and the potential subsequent closure of, a major place of employment in the region would turn rural communities into "ghost towns."

"The downsizing and the way they did it was very uncalled for. So that was—that's rough on our families. So I try to pass things. But during all of that, it—a lot of—it felt like the quality of work that was coming in after all of these experienced people were being kicked out went down. So I know a lot of people that didn't want to come anymore because—and it—I mean some of it was just hurt feelings. But some of it was there no longer is experience. They're putting newer people in here [at the hospital] that don't know as much. And maybe not that they don't know what they're doing, but they don't have the experience. They don't have the time put in."

"I mean our families are surrounded by a lot of the money that comes out of this hospital. And if the hospital is no longer here, this community will cease to exist for a big chunk of it. Maybe not all of it, but we might as well not even be on the map. We're tiny enough as it is. So it's—when—if you think of it in a big city if something happens and 10%-20% of the people leave, it's not a big deal. You have hundreds and thousands more people. You lose 10%-20% of the people here and that's a huge chunk. So that'd be devastating for here. Every other business would practically shut down and it'd just turn into a ghost town or so it feels like. … and then there's the prison, too. And they're always talking about shutting down a prison. They want to shut down another one. It could be half of ours, it could be somewhere in the U.P. You just don't know."

Opportunities to Engage in and Knowledge of Healthy Lifestyles

Many participants stressed that there is a significant need for additional community-based health education sessions on a variety of topics, including nutrition, physical activity, and prescription medication management. While several participants remarked that people today are more interested in consuming healthy foods and participating in physical activity than past generations, they were generally unsure of how best to reach community members who were less motivated, or had fewer opportunities, to make healthy lifestyle changes as well as those individuals who were already experiencing the negative effects of a sedentary lifestyle and poor nutrition. Participants emphasized the need to ensure programming was engaging and motivational for all members of the community, regardless of age or fitness level.

"I think every community no matter where you live could probably use some lessons on health. So where do you start? It starts from within yourself. What kind of health do you want for yourself, for your family? You can sit and preach to everybody all you want. But once they walk away, they're going to do what they want to do."

"I don't think you can force anybody to do anything, but I think you can make sure people are educated enough to if they wanted to make that decision, make that decision."

"Where are they all being brought together for someone that they can have the whole wellness thing? It's pretty much all spread out and you've got to seek it out and you've got to have the drive and desire really to pull that all together. … I think in our community we have from time to time, people will put out these weight loss challenges and you put money in the pot and they all do it short-term for the financial benefit. But it's kind of sporadic on who sponsors those. But it's not really done with a healthy focus. I think we have opportunity, and I think there's people that are interested, but I think they need kind of an organized opportunity to get on the right track and to invest in that healthy lifestyle."

"I think you have got to have some incentive for the patients to come. … They need to be incentivized to do it and there has to be some reward system in place to help. I mean basically even the Weight Watchers has rewards kind of. It may be non-monetary, but it's a, you kind of get rewarded: you get praise, you get something out of it. And I don't think we have programs that do that. … There's got to be some other reason to go. You've got to make the person feel they want to be there."

"People are not eating right, they're gaining weight, then they are more likely to develop adult onset diabetes. And then the complications from that: high blood pressure, high cholesterol, heart disease, stroke, things like that all sort of follow from that poor nutrition."

"Mid-Michigan has fairly high obesity rates and because that has diabetes, and then that leads to other medical problems: heart disease, and high blood pressure, and stuff like that. When we work with our overweight diabetics, or pre-diabetics even, they really don't have a basic understanding of nutrition and stuff like that."

"I would like to see more community education as well. Maybe not just medical but maybe starting like with the younger kids in the schools and getting more programs in there that continue and maybe bringing the families with the kids. Just starting them young on healthy diets, healthy lifestyles because I see 'em at the other end where they've got a whole lifelong of bad choices and they're stuck and you can't go back. Preventing those COPDs [chronic obstructive pulmonary disease], and the CHFs [congestive heart failure], and the diabetes from the get-go."

"Any community you're going to have various generations and younger generations tend to be more physically fitness minded than our older generations. And I think a big thing is how are we going to engage that older generation and the value of maintaining physical activity to maintain your physical health? How are we going to engage them? I mean in the schools, we can address with children. And kids are typically much more active than our senior population, so I think that's the big thing is not only how do we engage them, how do we tailor the message to our senior population that there is a value with it."

"Something like that now where they're doing these walks and fundraisers, and all that, something to get the community together and organized and do some fundraising and support for the community planning some kind of event that's special to them. Those kind of things I think would be nice for everybody to kind of organize around."

<u>*Nutrition*</u>

Interest in consuming healthy foods was generally high among all participants; however, knowledge of current nutrition guidelines varied and some were uncertain which foods should be included in a well-balanced diet due to changing recommendations.

"[Adolescents today are] more health conscious. We have put out cookies, and chips, and stuff, and that stuff will last for weeks. We put out … ants on a log and they're gone in three minutes. … The celery with peanut butter and raisins on it. And in my day—wow, I'm not that old—but when I was a kid, those ants on a log would still be sitting there."

"I'm talking about when you get on the Internet. Like I don't even use my cookbook anymore. I get on there. 'I want a recipe for this. I want a recipe for that.' And then there would be about four or five different recipes: a healthier one, a healthier one, or a bad one."

"They're going to say, 'Well, this way of eating healthy is going to be what's going to keep you alive the longest and this is going to keep you the healthiest.' Well, now this one's completely different ... So they can't both be [correct]. 'Eat butter.' 'Don't eat butter.' 'Eat eggs.' 'Don't eat eggs.'"

In particular, community members with chronic or complex conditions experienced difficulty following nutrition recommendations for a variety of reasons, including limited knowledge of the impact of food and beverage choices on health outcomes. In some cases, these choices led to frequent, and often avoidable, hospital admissions.

"The problem is what we see is you can educate them like the CHFers and the COPDers over and over again and they still do the same thing. They still drink the fluid and [eat] the bad food. And I don't know how you get them to not do it. … [They] come back to the emergency room for you to fix it. And I don't think they do it just to be mean. I just think they can't get past it or they start off trying to do good and then they just fall back into that routine because they don't feel good and this [unhealthy foods and beverages] is something that makes them feel good."

"They're diabetic—and you open their fridge and they've got six two-liters of Mountain Dew and they've got three packages of cookies and that's all they have in their house. And it's the education of why they can't do it to stop that re-admittance. So and sometimes we can educate them in the home, but I think also it's starting with the education process before discharge for a lot of these high flyers."

Even in rural, agricultural communities participants noted that there can be limited access to healthy food options. Barriers to accessing nutritious foods included distance or lack of transportation needed to travel to grocery stores, the relatively higher prices of healthier options, and the prevalence of fast food restaurants.

"You could walk to the store or something or walk to the dollar store. But for us, it was like you're screwed if it's a snowstorm, you can't go anywhere, you're stuck, you're done. [The grocery store in a neighboring city] closed. The closest one we had was in [a farther away city] and their stuff is almost double the price of here in town."

"Believe it or not, even in our rural community that has a lot of agriculture, we do have a food desert. And so that's an issue, too, is we're constantly looking for ways to try to increase people's access to healthy food."

"It's easier to eat that really good fat food and cheaper than it is to eat healthy. It's a lot cheaper. When you have a family and you make goulash, spaghetti with all the noodles, and stuff aren't good for ya, but we love 'em. And so it's how people have been programmed to eat and they can't afford to eat any other way because they can't."

"You can educate but people are still feeding their kids based on what they can afford. Pasta is way doggone cheaper than fruits and vegetables and that makes it hard."

"I think we do have like at our school, they have the third meal I think it's called. So they do the sack lunches so the kids they—and I think there is a qualifying thing that kids can take a sandwich home for supper because sadly at school that's the only meal that the kids get."

"If you look—drive down there, we have a tremendous amount of fast food restaurants all lined up right there."

Despite these challenges, participants mentioned several resources available in the local community, including farmers' markets and cooking classes, which increased access to and knowledge of healthy food choices.

"We have the farmer's market there, too, which has been a huge draw and it's growing and they just built a new building. So I think it's the resources you have and that gets people more excited if you have those."

"You hit that one person that doesn't understand and then all of a sudden they change everything in their family and there is four people in that family now that are now are now not at risk for diabetes, or heart disease, or anything like that."

"Maybe have a series of cooking classes or something like that to teach them. … They had it [previously] for a very specific target [population]. ... It was very targeted for like low-income

families on how to cook on a budget and cook healthy, which was all very valuable. … But it wasn't open like to the general population."

"The healthy cooking classes [are] great for people with diabetes or heart disease to help with healthy food options and prep."

While participants spoke favorably about a variety of cooking classes and nutrition education sessions, some individuals did note that classes can be canceled frequently, particularly in rural areas, due to low attendance. Factors negatively impacting attendance included the limited ability of the target population to take time off from work to attend as well as transportation barriers (i.e. distance, lack of public transportation, inability to drive due to health conditions). Some provided suggestions to increase attendance, including offering free "lunch and learn" sessions.

"So diabetic education does happen … but what invariably happens is they'll run a class up [in a rural city] but they don't get enough people to sign up for it at one time that they usually cancel it."

Physical Activity

In general, community members were aware of a number of local resources that promoted physical activity, including walking trails, bike paths, various exercise programs, and the Safe Routes to School movement.

"The libraries county-wide are trying to get this river walk going where families would go and walk the trails and then stop—I don't know how often—maybe every quarter mile or eighth of a mile and read a page of a book. And they read the book as they walk the trail. … And then they do an activity with it."

"We have just a tiny, tiny, little—I don't even know if you could call it a mall, but like a strip mall. And we do see people—I do see people in there doing laps. But it's very tiny. It's very tiny. And now with school security, they can't have the schools open like they used to. So I think we have to look at what are the options that people have. And I think that it's an ongoing challenge. It's nothing new. It's not unique to our community. But how are we connecting the dots to motivate people that the investment in time is worth it for their health? Those are some of my thoughts and concerns."

"We do have opportunities in town where we can go to the high school track and do laps there. We do have some walking trails that have been developed. They have really ramped up those trails, the Rails to Trails and improved those. And actually you see that they are being used. We have more fitness centers that have come to town, which provide that ongoing opportunity so that people can be there in the winter months that don't want to go out on the trails. So we have had some of those strengths that have come to town."

"We have a couple programs with things like Curves and, gosh, those kind of programs I think are really good for our patients. I really like those and those are really great. And it's keeping people outdoors, it's keeping people moving, and it's good."

Despite this level of awareness, barriers to engaging in physical activity unfortunately remained prevalent. A number of participants noted safety concerns that impacted the extent to which both children and adults could exercise outside, while others spoke about harsh winter weather that impeded opportunities during certain times of the year.

"I think if we had safe places for [children] to go, too, to get exercise, that would be helpful. Because I know it's harder and harder to just let—when we were young, we were outside playing all day long. And then you would check in for dinner with your parents. But it's not a safe enough world out there to do that anymore."

"If I'm at work, you don't go outside, you stay inside, the doors are locked. When I get home, you can go out and play. I mean…" "And most parents are working two or three jobs. The kids don't get outside at all. "…because you can't trust. I mean I never came home. I left in the morning and I wasn't home until and it'd start getting dark and she'd start worrying. But you can't do that anymore. You just can't send them to the park. Or you shouldn't." "And I know in the winter, too, when it was so cold. It's like, 'I can't go outside in this with my little 18 month old.' Like, 'That's not safe.' When it was super, super cold. And there's just really not a good place to—we would go to Meijer." "There's no mall with a playground."

"I worked on Mackinaw Island the last four years, so biking was my transportation. I worked on the halfway point, so it was a four-mile bike ride to and from work every day. That was really my mode of transportation. … And it was really rough to—when I started out, getting to do that, it was really hard. And my back hurt and everything else hurt. But the more you do it, the better it is, and by the end, I was surprised. I got off my heart meds, I got—I was feeling a lot better as a person. So but this winter was really rough because it was like, 'I have nowhere to go ride my bike and have nothing.'"

"We need more sidewalks so people can walk because … they have to walk on the road almost always. And that's—it doesn't work. Again, when winter comes around or at times with just the amount of traffic, it's impossible for people to walk from one area to another."

Several participants also noted that opportunities to engage in physical activity were not equally accessible to people of all ages. In particular, older adults may have greater difficulty finding opportunities to engage in physical activity and children may have limited access when facilities are not available in the local community and an adult must drive them to another community to access these resources. Traveling to another community to access resources poses its own set of challenges due to the cost of gas and limited options for public transportation. Some participants recommended that local gyms offer the opportunity for older adults to exercise at the facility free of charge.

"I mean certainly people can go walking in town and stuff like that or bike riding in town. So and the younger population certainly can do that. But the older population has more difficulty doing some of those type of things."

"Someone could come pick them up, take them to school, they could do the exercise program and maybe they have … a trainer … there to try to organize that for a while and sort of get people into that mode. And then in the summer time you could do it more outside of course."

"I was just thinking that over the years, in our community we've really had a decline in like things for the youth to do such as like the roller rink has gone, the bowling alley is kind of barely there. … We're losing these things in our community and they're shutting down. The one thing that I think about is what do we have for our youth to do in our own community? I mean our city park, they can play volleyball there. They can walk around in there, we have a wonderful kids' park. It's beautiful and there's a lot of things there. We have some tennis courts and some basketball courts. But what do we have really for like socially for youth to do in our community? That's just one thing that kids, they travel down and they'll go down to [a more urban area] to the indoor soccer arena and I hear a lot of the soccer teams they travel down there and do that. And it would be wonderful to have like an indoor soccer arena in our own community where kids can be physically active year round … even during the winter months."

"I think probably some—and I don't know if these are doable in this area, but if there was some sort of public transportation, that would help a lot of our patients also to be able to get to see us or even get out to do things like go to the parks and stuff like that. But there's really no public transportation right in our town."

Prescription Medication Management

While participants recognized the significant impact of engaging in physical activity and consuming nutritious foods on overall health, numerous community members and healthcare providers noted that limited knowledge of or ability to adequately manage prescription medications could have a significant adverse effect on both individual health outcomes and overall healthcare costs (e.g., due to unnecessary hospital admissions when medications are taken incorrectly). In particular, participants thought that medications should be explained to patients in such a way that patients feel comfortable asking for clarification and, ultimately, could understand what was being prescribed to them and for what frequency, dosage, and length of time the medication should be taken. When necessary, additional community-based supports should be provided to ensure medications are administered safely and effectively.

> *"You get those folks that aren't eligible for home health and but they're still not managing themselves quite as well as they could or need to. So whether it's reconciling meds to make sure the pillbox and the pills are set up correctly, monitoring blood pressures, or weights, or breath sounds, or blood sugars, or whatever the case is. … Sometimes we have some that we give meds every day, so we show up and, 'Here is your medications,' just to make sure that they are compliant in doing things like they should."*

> *"We see a lot where upon discharge either from the hospital or the facility, no matter how many times you go over their medicines, what they have to take, how they have to take it, why, they still don't understand because they're afraid to ask questions to think that they're stupid for not knowing their own health. And so some of 'em we see, they have two-three year old medicines that they still want to take. And they're just not educated on why you can't take that."*

> *"The med reconciliation that they do for a patient when they get discharged - it's Chinese. If you're not a physician, you don't know how to read that. So it's all about you dumbing it down for the patient, not writing "PRN" or "VID", or explaining what this med is for, when to take it, what time of the day. I think that's a huge piece. Because like you said, they don't want to ask because they don't want to look stupid, but it's not in English for a lot of these people."*

> *"It's the re-admittance, it's the high flyers, it's those that come in because they didn't understand the medicine and they didn't even take it when they're supposed to, or they took too much, or they took two of 'em that interact with each other. It's the education."*

Access to Services

Throughout the region served by Sparrow Health System, access to services proved to be a significant barrier faced by community members of all ages and socioeconomic statuses. However, participants acknowledged that structural inequities placed a number of vulnerable populations at a disproportionality higher risk of experiencing adverse health outcomes. Several commented that systems-level policies and practices should be implemented that address the root causes of such disparities.

> *"I think it's really clear that increasing inequality is a huge driver of health problems in this country. That we try to take actions on a local level like provide people with car seats or try to boost the immunization rate, and the social conditions within which people are living really aren't addressed. And so my vision really would be for a more just and equitable community that would lay the foundations for health."*

> *"I would look toward the social determinants of health, people's constraints, choices and options. And inequality drives trauma and right now [,in this county, the focus] is all about adverse childhood experiences and trauma, and how that influences health. So I do think we need to look at policies that would tend to sort of reverse the slide that's going on with inequality in our community. So we talk about sometimes we use language incorrectly and we talk about education, for example, as a social determinant of health. But really it's your race, gender, social*

class, LGBT status that drives who you are, that drives what your experiences are with education: do you go to a segregated school, are you bullied? Those kinds of things. And so I do feel … that it's the real social determinants that is where we need to focus."

Awareness

At the most basic level, participants noted that community members are unable to access services when they are not aware that such services exist. Some participants attributed lack of awareness to gaps in communication while others attributed it to limited community member motivation to learn about available resources. Regardless, participants hoped to see an increased presence of centralized referral and informational resources to facilitate the connection of community members in need with appropriate services.

"We know that there's a consistent segment of people in this community that are eligible for WIC and we just cannot seem to reach them no matter what we try. And it also seems like there's a communication gap between people in the community where just because somebody is using valuable health services, that doesn't mean that they're telling their friends or neighbors that those services are available. And so there are a lot of communication gaps, even though there are quite a few services available."

"You see a certain population in our community knows where to go, and what to do, or at least who to ask, and there is a large portion that does not because they just they don't care until they need to know. And by the time they need to know, it's too late and they don't really understand it, and it's trying to incorporate that earlier just health in general should be incorporated earlier into even I think educational programs to get them to the healthy mind already started."

"It'd be nice if we had one person who can say, 'Well, here is where you can go' and kind of self-help for yourself here if you look to these, these, and these things, this is where you can find cheaper medications, cheaper programs, or rides, those kind of things. If one person could be a liaison for all these people who have a hard time getting around, if there's one person at the hospital who says, 'This is where you go.' Like a kind of case manager for the underserved and they could call this hotline, that would be kind of neat."

A number of participants recommended various ways that healthcare and community-based organizations could raise awareness of available services and resources, including increasing the quality and frequency of appropriate referrals and notifying community members about these opportunities through social media, traditional news outlets, and face-to-face communication. Other suggestions included distributing flyers at the grocery store, playing informational videos at the Secretary of State, partnering with local houses of worship to reach members of the congregation, utilizing beginning of the school year communications/informational packets to reach families, and announcing when a new organization or facility is licensed and opens up.

"I think community knowledge is very difficult to get out there. Not everybody reads the newspapers, television is probably seen by most, but we don't—it's expensive to advertise on television, especially if you're a free clinic. So but TV probably gets to more people than newspapers do nowadays. It used to be the other way around, but nowadays it's TV, and what you can do, and of course there is very few people listen to local stations anymore. That's your other problem. Local news—local stations aren't as popular as all of the cable stations are. And you can advertise on local stations, but that's not getting all the community. So I think figuring out a way to get to the public, it's almost a door-to-door thing. Going and meeting with people. And that would take volunteers."

"I think that's something we're striving here as an agency to deal with our partners but just with community members is to make sure that we're communicating really well and in different formats. I mean we're trying really hard with like the social media platform and then the newspaper. We try really hard to have articles in there or to have different things going there. And then just the

communication with the actual partners like making sure that we're trying to have a unified front and offer what the community really needs."

"We need to do a better job communicating amongst each other what services we have available, and we need to do a better job referring clients to one another. And then we all need to do a better job reaching out to the public: press releases, and articles in the paper, and Facebook posts, and everything else. For whatever reason, it never seems like it's enough. And we have yet to hit on that magic bullet for how do we reach people really effectively."

While providers generally felt as if there had been an expanded effort to increase cross-agency communication to facilitate referrals, some noted that additional work needed to be done to ensure the right people were receiving the information and were knowledgeable about a wide variety of available resources and services.

"I mean we're all on speed dial with each other. So what it did is it took away the siloes. Everybody's got something they can do to help. And like I said, I can't fix this, but I know somebody that knows somebody. And it's working great. … I just like I guess I'll call it kind of our high touch approach to things. If we can't fix what it is, we probably know somebody that can make the connection again. … We get to know them better because we only have so many. And we can get, kind of bore down to some of the underlying issues and help address 'em. So I guess that's probably the strength is the fact of being small in this case and being able to take the time we need with—and get to know our patients as well as we can."

"Probably what we've been trying to do is increase our opportunity to have I guess reasons or occasions to get together where we can share our things, share what we do and then ask questions of those [people and organizations] when we've got a particular situation we need help with. But so probably the biggest, best thing we've got around here is the fact that we do have these situations or environments where we get together where like I said, you can—I'll give you an idea. These meetings last an hour. It's not uncommon for the meeting to go on for another half hour outside the doors between different people addressing different situations. So that whole—Networking opportunity."

"I think as a whole when you look at our healthcare community … we are a very giving community. [Previously], you couldn't pick up the phone and necessarily call a competitor, and ask for help or bounce ideas off of a certain patient, or something that was going on in a situation. And now I feel like that has changed a lot in our community. … One person can call another and they can have a conversation about it. And a polite conversation. Two hospitals can actually talk. I think I have seen that change and improve over the years, which is nice."

"They don't always want to listen to [organizations that have] a lot of resources and it's hard to get to the right people to tell them this. They don't want to make the time, they don't have the time, everybody's running in ten different directions."

"I feel like we're kind of siloed a little bit… sometimes we don't talk and we don't know what everyone does or what capabilities other people have and so it's kind of like a siloed effect."

"People want to come to the big boss because it makes them feel good, but it's the wrong person. You're not going to get the job done. I'll be honest. You've got to get to people on the floor."

"I think we'd love to maybe just do a little meet and greet with them on a lunch, or a lunch and learn, or something like that where we just kind of have a quick little side minute, 'Here is the services we offer and here is what kind of patients we can do for them' kind of thing. And that would be great honestly if they have things like that, just a quick little flyer that we can post up on a board. We always have tons of things there because yeah, I think a lot of times it gets lost in

the shuffle or we may not know about them and it's nice to just have that in our ear. So we'd love that."

When providers were not aware of the other services and supports being offered to community members, they oftentimes found out that services were being duplicated and resources were not being expended in the most efficient manner.

"So you had the same group of people, the high flyers, having ten people come out to them at once. And so it just became overwhelming and so they kind of pushed everybody away. … Instead of the community coming together and say, 'Okay, how can we each take a piece of it to make it successful?' everybody did the exact same thing. So you would call somebody like, 'I just got four phone calls for the exact same thing.' So as a community, are we duplicating processes or are we each taking our piece? Because there is such a great need and there is so many different aspects if we all take the exact same piece, we don't move forward as much as if we all said, 'Okay, let's all work together.'"

Even if providers and community members were aware of available services and resources, many residents still faced significant barriers that limited or prevented them from accessing them, including lack of transportation, inadequate availability of services in the local community (travel distance), and cost.

Transportation Barriers

Participants were acutely aware of the transportation barriers that many community members faced when attempting to access needed services and resources. Some individuals relied on public transportation that wasn't always available when needed (or public transportation wasn't available at all), while others only had access to a vehicle sporadically (e.g., because the vehicle was unreliable, the person needed to share a vehicle with another family member, or the person could not afford gas).

"We have an issue letting people know what services are available. But I think we also have an issue with the local population, a lot of whom especially the low-income folks … They're not as plugged in as maybe they could be and also there are a lot of transportation issues. It's pretty common amongst the low-income populations that we're familiar with that they don't have reliable transportation. So then again, even if we have the services available and they're aware of the services, can they even get to our building? So it's a lot of things that play into it."

"It's more so do people have cars? I think a lot of times, I think at least a couple times a week, people say, 'Well, I don't have a car this week' or, 'My car broke down.' And they can't afford to get it repaired and so they're stuck. And I think that's the biggest thing. And they don't have a couple—I mean they don't have any money to get an Uber or pay for the $5 to get transportation somewhere. And I have had a couple people I think per month are saying they're walking five miles to work or to the grocery store or something like that. So I think that's probably the biggest barrier for a lot of the people in the area there, too."

"A lot of big families often say that they are socially isolated, especially mothers at home because, and transportation is a big piece of that. They don't have the finances or financial means to go anywhere or they just don't know anybody and I think people are online more socially instead of out in the community. But they feel very isolated."

"We don't have a transportation system here in our county. We're rural. And so I think sometimes it's hard for people while they may have interest, it's hard to have them be able to access what may be offered just because of transportation barriers or because of the time offered."

"There is more medical transport that are less expensive now than I think there used to be, but we're still finding it. We have seven out-patient clinics in the Lansing area … Only two are on the

CATA route. So the others, it's a barrier for those. … Outside of Lansing proper, there is a problem [with transportation]. You're absolutely right."

"We have a lot of our patients set up with the Spec-Tran that takes 'em to the doctor's appointments and. … Which is good, but I also heard on the flip side that if you're a minute late coming out of the doctor's and you miss your pickup, they'll leave you. … They'll leave you, mm-hm. But we just tell the patient or the office to call them. And unfortunately, then on that side, the patient has to wait longer, but you can't make your cab to pick up until you're closer to knowing when you're going to go because that's what was happening. They would make their cab to pick me up at 5:00 and they're still waiting in the—and CATA has worked with them more, Spec-Tran, or whatever, knowing that they're at an appointment and they're going to call you. Because normally you're supposed to make that appointment 24 hours ahead of time, but it's just no way of knowing when that physician is going to get you in. So they have been better at letting the office call them for the pick up like 30 minutes beforehand. However, I have heard patients saying they end up waiting maybe an hour or two now to go home. So it's not ideal, but at least they are getting there and they're getting home."

"It's an on-demand system, but it's slow and vulnerable people, people with mental health issues, or things like that just have a really hard time accessing it and sometimes you can get to a medical appointment in Lansing on the bus, but then you can't get back. And so people don't use it nearly as much as—in proportion to what the demand for the transportation is."

Other community members, particularly in rural areas, faced barriers related to the amount of travel (distance) required to access services regardless of whether or not they had access to a personal vehicle or other mode of transportation. Some rural residents were not familiar with the larger, urban areas in the region and were not comfortable traveling to them to access care and other services.

"You have our folks that are in our rural communities that they don't really—they may be on dirt roads, living on dirt roads, and they're way out there and in the winter they're not going to drive in."

"There are people that live here that have never went to Grand Rapids. I mean I have a friend and she has never been to Grand Rapids. She don't want to go to Grand Rapids!"

"Part of it is just the rural mindset, but if you talk to the average farmer … Lansing is just about—is this side of the moon as far as they're concerned. Right, they're not willing to travel that far. … And so over time, that causes problems because they don't actually get the care they need to and then they have—when they need to see a specialist, they just don't do it. And then their health suffers from that."

These transportation barriers meant that some community members were forced to cancel appointments or delay care when they did not have access to a vehicle or the public transportation resource they rely on. Sometimes, this resulted in healthcare conditions worsening before someone was able to see a healthcare provider or in the inappropriate use of the emergency department.

"Endo[crinology] is huge. They cancel endo a lot. Or even those that can go … you have to have that transportation. Someone if it's not by some public thing, it's family members. … But a lot of family members don't have that all the way up the scale. It's either you all have to do it or you all can't."

"Having a local hospital there is huge. Because it is providing very timely care, which—we'll just be real honest. If some people had to travel out of their community to get care, they're going to wait longer, they're going to hesitate, and they're going to be worse off by the time they get there. So having accessible care in their community is providing an opportunity for earlier access to

treatment and care. So it's not only valuable; it's essential to have the hospital in the community there."

"So some of the insurance companies for the Medicaid will have a driver for them. It's pretty cumbersome and it takes—if it's an appointment a month or so out in advance, sometimes they can help. If it's an acute thing or an emergent thing, a lot of—some of the patients just call 911 and get an ambulance ride to the emergency room because they have no other way to get in to see a provider, which is a colossal waste of resources."

Recommendations to Reduce Transportation Barriers

Despite these significant challenges, participants provided a variety of recommendations aimed at reducing transportation barriers across Sparrow Health System's service area. Some favored an approach in which services were brought to community members or transportation was provided to facilitate access to needed services and resources.

"Somebody comes in and does eye tests. Because not all the kids' parents take them to get their eyes checked and all that. … So that's something they have that's beneficial. Now if they can afford the glasses and transportation to get them is a whole different issue. But at least something—it's identified as a screening. … They do that and hearing. … We'll have it at 'Kids' Day' as well. There's dental in there as well. And they accept the uninsured as well."

"For school-aged children I would say there are things that probably the locals are doing or could be doing partnering with healthcare organizations, dental care, maybe even clinics, maybe drop-in type things, maybe having a time and location within the schools for medical professionals to come in and maybe even have family appointments. I know some rural areas have partnerships with healthcare systems where there is almost a clinic right in the schools themselves. I am not sure that that is something our locals are interested in because there are one or two options in every town that I am aware of for healthcare, but I don't know for those that don't have health insurance, or quality, affordable insurance, I should say. I know we're all supposed to have insurance, but I still think there is probably an education piece on that when you should go, what type of things to be seen for, how to use and access the system, those sort of things."

"That's mostly for people that are home bound. So yeah, for patients that they would require an ambulance to be seen or something like that. But when we do house calls—so I'll do one or two a month on my lunch hour. I couldn't see all the patients that have trouble with transportation as house calls."

"Which goes back to a transportation issue. Have the school put out a bus and pick up these kids so their parents don't have to because that is huge. Some people are holding down three jobs and trying to support their families."

"[The healthcare provider] will go like to the schools and pick the child up from school because transportation is an issue. And if they miss the third appointment, it's three strikes you're out for most dentists because it is a problem of no show for their appointments."

Health and wellness fairs were also favored and well-received by community members. Participants noted that these events increase social connection as well as access to important screenings (i.e. dental, hearing, vision, blood pressure, flu shot clinics) in a way that is both fun and engaging. These opportunities may increase the degree to which community members are comfortable with and willing to access other healthcare services in the future.

"The hospital sponsors several events that are helping with I think with the keeping our community healthier. They do car seat checks for children, they sponsor a lot of programs and events, bicycle

helmets. So yeah, I think there is a lot going on that's positive to promote health and wellness in our area."

"We did something for breast cancer awareness and it was like a silent auction and this whole hospital was pink. I had won a picture frame with a bunch of stuff in it that I still have hanging up in my bedroom at home. And I just—things like that made the hospital feel like part of the community again, feel like they cared again, rather than just being a number or something."

"Even having another one of those little health days and it invites people into the hospital so you get more—I don't know. It's like going over to a friend's house. The first time you go, you don't want to eat any of their food, you're, 'Yes, Ma'am,' and you're very polite. But the more you go, the more comfortable you get, and the more you see the people. So it's no longer, 'I'm not going to eat out of your fridge.' It's like, 'I'm going to walk into your door and I don't care. We're now family.' So doing something like that would be really cool to see again."

Others explored ways in which telehealth could be utilized to provide services to those who face a variety of transportation barriers as well as to address the limited availability of certain types of resources within the local community. However, participants remarked that telehealth may not be appropriate in all situations and for all types of service provision.

"So telemedicine I think is a love-hate thing for me. I don't like it for things like urinary tract infections, and sinus infections and all that, just because I think you really need to lay your hands on people to make an appropriate diagnosis and antibiotics shouldn't be prescribed without touching a patient. But for things like chronic care, things like rechecking mental health, discussing things like, 'How's your diabetes? Let's talk about your sugars' over the phone. I think that's actually a great thing because those kind of things you're counseling someone, you could do that from a telephone call, or from a video chat, or those kind of things where you don't necessarily have to lay your hands on a patient, but you can just discuss with them what side effects can be and how they're feeling overall so that's something that maybe somebody who's sick or maybe home bound, you could maybe help them and not have to worry about transportation. So that I'm a pretty big fan of if you've got more long-term chronic care management where you know they're stable and they're not having an acute exacerbation of whatever problem they may be having and doing it more as a follow up visit. I think that's a pretty good idea and it can be really well utilized, especially for our people and especially in our area where transportation, finances could be a hindrance for them wanting to come in. And so instead of coming in, they cancel because they don't have time to get up and leave or can't afford to come in for another office visit."

<u>*Cost of Healthcare Services or Prescription Medications*</u>

In other instances, health insurance status, the cost of healthcare services, and/or the price of prescription medications limited the ability of community members to access the care they needed to maintain or improve their health. Despite the implementation of the Patient Protection and Affordable Care Act, respondents indicated that a lack of or limited insurance coverage was a persistent barrier to accessing care. Some participants noted that medical providers were instrumental in helping them access the resources that they needed. Unfortunately, all community members did not receive this level of assistance and, as a result, they were faced with a difficult choice between getting the care they need and paying for basic necessities.

"So I think if you're underserved or unable to pay, you definitely do get less care. And a lot of these people are very conscientious and they don't want to run up bills that they can't pay. I mean it's not that they want to avoid the care; it's just that some of them don't want to run up bills that they can't pay and then get in financial problems. I mean a lot of people are living day-to-day on their income. It's a choice of paying the rent and eating or going to the doctor's office. And what is my choice? Because if they're under-insured or uninsured, which they're not supposed to be now, but I don't believe it's true. But it's very difficult for them and healthcare comes last. Unless they're really sick, healthcare is—and that's the problem—unless they're really sick and that's—

and then they really do see the costs go up. But I think people shy away from healthcare unless they're really sick."

"We prescribe [medication] but if they can't afford it, then they don't improve, and then they just end up getting worse and eventually showing up with more major medical problems. So I don't know how there's a way to fix that. I guess if there was better insurance coverage up here in rural America, that would help."

"I called the office and I said, 'Hey, I need a care package.' That's what I call it. And I say, 'Have you got any [medication] samples you can spare me?' … And I can get a month's supply because that stuff is expensive."

Availability of Healthcare Providers

Community members' access to healthcare services was also impacted by the local availability of primary care and specialty care providers.

Recruitment and Retention of Healthcare Providers

Both community members and healthcare providers alike commented on the challenges associated with recruiting and retaining medical professionals to work in rural areas. In general, participants believed that rural communities needed to have stronger school systems, desirable housing, and greater opportunities for social engagement to entice these professionals to move to and stay in less populous areas of the state.

"The school system brings the people in and when you've got educated people like doctors and nurses—and I don't care who they are—they want a good education for their child today. And so our school is hurting very, very bad. Now—so that's where you need to start is at the school. That needs to get changed. Then the hospital. And so I think at the school, because I know with all the doctors that I have worked with here and the financial people, all of 'em, they wanted good schools. They wouldn't move here."

"—the same with doctors. We don't have the people coming in to our smaller community. Maybe their different ideas or if they excelled in college or whatever and they're going to those bigger towns where they can make some more money."

"But and doctors would come and they'd leave because there's nothing here. You have to remember when doctors come in, they're coming in from a big city. And usually the wife—sometimes the husband, but usually the wife—they like that big city stuff. And so to get 'em to stay, it's very, very hard to get 'em to stay, number one. Number two, there's only really two decent places that they can live when they come here. ... So it's hard to get doctors to come in as it is. And you have to pay 'em a little bit more."

"It's hard in the small communities bringing those doctors in to a community that all the pieces of the pie aren't there. They want to live in Lansing and Grand Rapids because their social lives are a little bit different there. So it's hard to keep up. We can get some really good ones, but it's hard to keep 'em in the small communities. It's just bringing 'em out into a rural hospital is tough. You've got to love it to come out here."

Despite these barriers, some participants noted that loan repayment programs do seem to help draw certain medical professionals to practice in rural areas.

"The area has been able to attract primary care physicians probably mostly because of the loan repayment systems that the federal government and state government run. And then people then often stay. … In general, they have been able to get—keep primary care fairly well covered. … I think the loan repayment draws them and then the people that like small, rural towns end up

staying. But it's difficult to hire a family physician out of Detroit to come here unless they already have a bias towards small towns. … So I think the small town is a—attracts a certain type of physician to the small town."

When healthcare providers choose not to stay in a rural area, or don't choose to practice there in the first place, residents living in those communities can experience difficulty accessing both primary and specialty care services.

Primary Care Services

Limited access to primary care services affected both local residents and the overall healthcare system serving the area. Community members expressed frustration when they felt as if they were not able to reach someone at their primary care provider's office in a reasonable amount of time. Delays in accessing care resulted in some participants deciding to go to the emergency department to be able to speak with a healthcare provider instead of waiting to hear back from their primary care provider.

"I think critical would be access to primary care, making sure that there is real time appointments and not down the road, you call and you can get an appointment in three weeks. You need to get it today or tomorrow. And I think really preventative medicine is vital so we don't get people in the states where they are really very, very ill."

"I think as a patient—and I get into my office fairly quickly—but I think one of the most frustrating things for me is that I can't sit on hold in order to make an appointment. It goes to a voicemail and the voicemail says, 'We'll call you back within a certain amount of time.' To me, I would rather sit on hold for 20 minutes and get through and make sure I've got an appointment."

"Not having real time access to physicians. So then you go to the emergency room, which is not preventative or that's not the way it should go. So having the availability and access to primary care physicians I think is a factor."

"[It's difficult] when you can't talk to somebody. That's why I say, 'To heck with that. I'm going to the emergency. I can get somebody right away there.' Sure, sure, it costs me an extra $75 or whatever. But so what?"

"Well, from my experience anyhow, what you wind up with is a lot of people in the emergency room that probably should see a primary care physician or at least go to an urgent care or a walk-in center rather than the emergency room. And what happens is traumas come in, they take precedence of course, and people wait three, four, five hours. And you may have some people in the waiting room that are really sick that need immediate attention or at least urgent attention. And they wind up in the mix, too, waiting and it may be behind somebody who has a cold. And they use the emergency room as a doctor's office. I mean there are many patients that use the emergency room as a doctor's office. And … the emergency room is the most expensive part of patient care. I mean because it's staffed 24 hours a day with specialists, and equipment, and so forth, and it's just a very expensive area to be seen in. And we could reduce costs extremely well by getting people off to private, or an urgent, or a walk-in clinic. Which people just don't seem to want to go to all the time."

A number of participants had difficulty refilling their prescription medications when they were unable to reach their healthcare provider and indicated that they felt as if their concerns were not addressed in a timely manner when they were told that they had to make an appointment to be seen before the request for a refill was granted.

"I have to tell you that you don't get past the girls that answer the phone. They block it like you don't get to speak to the nurse practitioner. You can say would you leave her a message, but it's always, 'You have to see the doctor or come in and see her and we don't have any appointments for a day or two.' … I came from a doctor that I had been to forever and I could call and ask for

anything and she respected my knowledge and if I needed a refill on a script, there was no problem with that being sent to the mail order company or calling the drug store. But here, you have to make a visit to the doctor to get a refill order on meds. That I think is a money maker. I think that's offensive."

"It was a big shocker when I had to be told, 'Well, we can't—.' The attitude that she had when I asked about it was terrible, 'You can't just call in here and ask for a refill!' I mean really a bad attitude. 'You've got to make an appointment.' And I'm like, 'Oh, well, I'm sorry,' but a very bad attitude with me. And I don't like that because I don't have bad attitudes with people."

Primary care providers made an effort to encourage patients to make use of the services offered at their offices by scheduling primary care follow-up appointments for patients before discharge from the emergency department or an in-patient hospital stay, reaching out to patients after hospital discharge, increasing community members' awareness of alternate after-hours care options (e.g., an urgent care or walk-in clinic), and facilitating communication between urgent care and primary care providers.

"Most of the physician offices have their own coordinators that call them [patients who are discharged from the hospital]. They really are probably best positioned to be the primary case manager, but nobody recognizes 'em that way and they should."

"The nurses will call and set up an appointment at our office for the patient before they leave the hospital. We always do follow up phone calls after they're discharged and we always encourage them to follow up with their primary. But a lot of times when they're home already, they're, 'Oh, I feel fine now. I don't need a follow up with my [primary care provider].' So if they have an appointment already scheduled, they're more likely to come in and follow up with their primary."

"I think before I left the hospital, they had already made the [follow-up] appointment for me [with my primary care provider]. And I wasn't one to just say, 'I'm not going to go.' After all, they're only thinking of your best interest, I'm sure. Even though it's another $10 or whatever."

"Hospitals are now starting to put out urgent cares and walk-in clinics, which is ten years ago you wouldn't have seen too many of those. Physicians I think, partially because they're now mostly affiliated with hospitals and not in private practice, now see more of the indigent patients than they used to. Maybe because they're not allowed to turn 'em away. And I think those programs have helped where you have family practices and so forth that are affiliated with hospitals that you see that they need—patients have better access to healthcare that way."

"The thing I understand about the walk-in clinic is if you go there and you don't have an established primary care physician, they will help actually connect you with somebody that's accepting patients so I think that's a really valuable tool to our community because there are a lot of people that just don't have a doctor."

"I think our urgent care is utilized all the time. Especially right after around the 7:00 hour it seems like it's used quite a bit and on the weekends it is, too. It's a great service to have, especially when people are calling and they're not sure what's going on on a Saturday morning. … It's great and we get instant communication from them through EPIC so yeah, it's used a lot and I think it's used appropriately, too, which is nice. I mean you don't see people going in there for medication refills or anything like that. I mean it seems to be things that are more of a fast care kind of a thing and it's very nice for patients and it's very convenient."

"We can do a lot of things in the office, so we actually run IV fluids in our office. And a lot of our patients don't know that. So when they get dehydrated, they think, 'Oh, I need to go to the ER. My doctor's office isn't going to do anything for me.' And so one thing that the RNs at the office

do is we try to educate, 'Oh, I see you went to the ER for a dehydration. Do you know that we can do IV fluids here in the office?' And so we try to educate them."

"I think one thing that would be helpful is when patients go to the ER for something that could be seen in the primary, a lot of times the ER will encourage them to come back to the ER if these symptoms. And I think if they educate a little bit more, 'Make sure you follow up with your primary care doctor if you have these symptoms' and that sort of thing just kind of encourage them. Because I think we're—I think both the primary care and hospital, we're both trying to work on trying to decrease readmissions and stuff like that. And so I think encourage them to follow up with their primary would really help."

Specialty Care Services

The lack of specialty care providers in rural areas placed a significant burden on community members who needed to access this type of care. Some community members did not have access to transportation resources that would allow them to travel to a more urban area to receive care, and others were not comfortable leaving the local community. Participants noted a need for a variety of specialty care services, including, but not limited to, orthopedic surgery; urology; gastroenterology; obstetrics; neurology; cardiology; endocrinology; and pediatric subspecialties.

"Subspecialty care is the huge problem and because of transportation issues, people don't really want to drive to Lansing, or Saginaw, or Grand Rapids. So there is a huge need for … another orthopedic surgeon that does all types of cases. A gastrologist and we clearly need a urologist, and an ear, nose, and throat, which [the area] lost in the last year and is in desperate need for.

"It's not meeting their needs. There is an orthopedic surgeon there and there is a nephrologist, a kidney doctor, there. Which there doesn't need to be one in [one rural city] if there's one there. There wouldn't be enough business for two of 'em. But there is some specialties in [one rural city] that are not in [another rural city] and vice versa. But it still doesn't cover everything."

"There is a lot of people who have—when I worked in the ER, like one of the questions is, 'Have you traveled outside of the country in the last 30 days?' or whatever. I cannot tell you how many people are like, 'I haven't even traveled outside of the county! I have never—' like literally in their lifetime, they have never gone to Grand Rapids or Lansing. Never in their life. … So having resources in the community so they don't have to go [to another county to see] the eye doctor, the orthopedics, cardiology so they don't have to is huge."

"Where we're at here, we have Lansing and we have Grand Rapids, but a lot of people they get by with one car, one person in the family works, and we don't have anybody—not a lot of people want to leave [the county] and we have a very great general surgery and a couple of really great ortho people, but outside of that, we're very limited in what we have for specialists. So people have to choose where they're going and we have a cardiologist, too, but a lot of times people are kind of picking and choosing and choosing not to go anywhere so we don't have anything. We would need an ENT, and we would love to have an ob that could deliver or perhaps even two, and I mean especially an ENT I think would be a really great service to come into [the county] for our kids, too. And just to have them have someone right in [the] hospital. That would be so nice."

"I like the endocrinology portion of it. We have a lot of non-compliant diabetics that could truly use that service. Like those are the diabetic experts like they could help. Like being managed by your primary care doctor is one thing, but actually being managed by a specialist is a completely other—it brings you up. … Which we do set 'em up [with appointments in another county], but they cancel because of the transportation."

"We need the space. But if we had just the space designated, pulmonology could come in one day a week, respiratory or endocrinologist could come in once a week. You could have those different specialists. … Neurology and vascular."

When specialty care services aren't available, participants noted that patients either had to be transferred to another city for care or patients' healthcare conditions often had deteriorated significantly by the time they were able to see a provider.

"What would be nice is if they have privileges because then we wouldn't again have to transfer out. They could consult here. But we have to transfer out with people. I don't know the works for that, I don't know the legalities, I don't know the licensure. But I'm just saying the doctors that we do have around here, if we could—and I don't know how that works—if it could be a license that would be great because we have to transfer out with some of the stuff."

"I woke up on a Saturday morning and I said to myself, 'Something's not right.' And I couldn't put my finger on it. And it affected my vision again. So I went to the emergency and right away they sent me down to [Lansing] because they've got the what—the neurologist is it?—and they wanted me to do all these different, 'Raise your arm, raise your hand.'"

"We have a lot of COPD/CHF. A lot of breathing issues here … One thing that the bigger campuses have … they have CHF clinics and they have COPD clinics. And those are huge. And our patients—patient issues cannot get to those clinics because the 101 for respiratory is like three-four times a week. And it is just not doable."

"The doctors' offices are slow due to vacations or people leaving. So you can't get in [for CHF exacerbations]. By the time you can't get into your doctor's appointment and you've already gained ten pounds and you're in the ER … So everybody does the best they can with what they have to work with and what we have to work with is minimal."

"Any sick kiddos, they're even going in to Lansing or they're going into Grand Rapids, too, if they have to go in for anything. So I think I know we're a small hospital, but we need a little bit more to the area and no one wants to travel and so people tend to stay home and just suffer a little bit honestly and then we see them in the office and they're a little bit too far gone sometimes."

While community members stated that they faced persistent challenges, some thought that bringing specialty care providers in to a rural community on a rotating basis could help reduce the impact of transportation barriers and facilitate access to needed care.

"[The hospital] has developed partnerships and opportunities where they're bringing the specialists to the hospital like one day a week, that they may have office hours one day a week or two days a week, like we have a podiatrist that comes, urology is coming, and having some of those specialties."

"Like our three orthopedic surgeons, our patients don't have to travel. The urologist that comes two days a month, the patients don't have to travel. The oncologist. You know what I mean? … We have centralized services so it's patients don't have to travel outside of the county to get the services that they need here."

"I think part of it is that the hospitals are going to have to subsidize those specialty physicians for a period of time until they can get their practice established. And there is probably not a need for a full-time urologist … but a part-time even one day a week would certainly be incredibly helpful. And so if there's a way to incentivize from the hospital's standpoint to have the urologist come once a week, that's probably the kind of—that's sort of a realistic thing. To try to think that we're

going to hire a full-time urologist for five days a week, they probably can't keep them busy enough."

In addition to transportation barriers, community members were also impacted by specialty care providers' willingness to accept all types of insurance. Some providers may not accept certain types of insurance, such as Medicaid, at all while participants noted that other providers had drastically different appointment wait times based on the type of insurance coverage a patient had.

"The other issue is your Medicaid population through the Affordable Care Act. They do have insurance for the hospital, but trying to find them a doctor to take them and make a follow up appointment is next to impossible. And you'll hear right away, 'No, we're not taking Medicaid now.' So they're running into that problem or they'll tell you, 'I have an appointment, but it's four or five months away.' And it's a reality because I tried to make an appointment for my granddaughter who has McLaren, and it's not Medicaid but they assumed it was, for a dermatologist and they were like, 'Oh, nope, we don't have any spots for six months.' And she said, 'Well, what's the insurance?' And I said, 'McLaren Commercial.' I got an appointment the next week."

Special Populations

Numerous concerns were raised about the lack of services and supports available in the local community for a variety of special populations, including children and adolescents, older adults, pregnant women, and individuals experiencing homelessness. When resources were offered, participants often noted that they were not available in the frequency or amount that would be required to meet the needs of all community members.

Children and Adolescents

Children and adolescents living in both rural and more urban settings could benefit from additional opportunities for mentorship and the presence of a safe, educational space to gather in the community. While some programs were available, they may not be specialized enough to meet all needs (i.e. the needs of children with a parent who is incarcerated) or offered as often as they may be requested. Overall, participants wanted to see children and adolescents encouraged and given the supports they needed to become successful young adults.

"[The teen center] gives the kids something to do to stay a little bit out of trouble. A lot of them don't want to go home. There is stuff going on. The families are broken in one way or another, so it gives them someplace to go. It gives them a safe place. There is a lot of the adults there that are trying to be like mentors if they need something, they're there."

"Those kids want to be there every single day. They're like, 'Can we do something more often?' Because their life at home just isn't—they'd rather be there than they would with their own families."

"Is there a Big Brother program in place in the community for those kids that's fathers are incarcerated? … Because there is a nice program that we have over in my area for kids that are divorced, or their dad is not active in the family, or—there is a prison over by me, too. So they're everywhere, but I was divorced so my son was with a big brother and it was really nice for him because men do different things with boys than women do, so they'd take them out to the community, take 'em to the beach, or wherever, and take 'em for an ice cream cone. And it's a really highlight for them."

"It's like a mentoring program. It's like a church-based one, but they go into the schools and it's similar to a Big Brother and Big Sister, but they do it during school hours and they have access to children at-risk, and they go in and make friendships, and visit 'em on a weekly basis throughout the years."

"Graduating seniors go back to the elementary school they graduated from and they walk through the halls and those kids are sitting in the hallways just cheering 'em on. But I think those kids as they see that each year, these seniors walk through, it's kind of a, 'Someday I can graduate and do this.' It gives them that encouragement to graduate. … So I mean that it's little things like that, but it costs nothing really to encourage our kids to finish."

<u>*Older Adults*</u>

As families become more geographically spread out, some participants noted that fewer vulnerable adults and seniors had the near-by support they needed to live safely and independently at home. When additional care was needed, seniors and their families may not be aware of the in-home and out-of-home options available to them while others found that they were not eligible for or could not afford the type of care needed. In addition, several providers commented that seniors may be left out of the discussion altogether and, as a result, were unable to take an active role in their care planning. Increased awareness of senior care options becomes increasingly important as people face more complex health conditions that are more frequently being treated in an out-of-hospital setting.

"They're there four days and they're very sick when they're there. Every single patient that's allowed to be in inpatient is so sick that they're like critical. And so then they're coming out and going to sub-acute many times if they're old. And even if they're young, they need help. They're not ready. … There's hardly any of 'em [that aren't a fall risk] unless they're out there for out-patient surgery for some reason or something. And even then, they're still barely recovered before they're kicking 'em out the door."

"Even with elderly sub-acute rehab, they go home, they have home care for a little bit, six months later they're back in that same place. ... But unless you're in a long-term care program, we just keep band aiding everything. So it's finding some way to do things in the home to follow these people after you get 'em safe, send 'em home with other things, too."

"They don't understand even just some of those simple terms as long-term care. When people hear SNF or AFC, HFA, home care, private duty, that's a whole new, I mean, maze. You see these presentations, 'The Senior Housing Maze,' and figuring it out so they can kind of prepare when they're going to the hospital. 'You're going to end up with one of these categories' so they can kind of feel educated about their choices and that doesn't seem to happen."

"We see a lot of people that are just not educated on how to get insurance and what they need to qualify for insurance. And there are times when a patient comes in with let's say they're 65 and so they have Medicare. They don't have Medicaid and they qualify."

"These folks are now comfortable living in their homes. They all tell you … 'I don't want to go to a nursing home.' … I think some folks are eligible for home health and some people can afford in-home aides. But a lot of folks aren't eligible for one and can't afford the other."

"I also think that for the elderly folks specifically, it would be nice if they—when they needed assistance, they wouldn't automatically be pigeon holed as being—having deficits. I see so many times that once you need help with either home care, or hospice, or even a facility-based care, suddenly people stop talking to you and they start talking to your family only and you become like a non-person. And I think that's so awful to see that happen so often. … I think that we all need to be better aware of that and keep the patient involved in it at their highest capacity no matter where they're located and it's so easy to fall into that trap of not doing it."

<u>*Pregnant Women*</u>

In rural communities, many participants were acutely aware of the lack of obstetric and gynecology services in the area. In some cases, there were no remaining options available for pregnant women to deliver their children

in their county of residence and they stated that they would have to travel to a larger city to do so. The travel distance raised concerns among community members about their ability to reach the care they needed in time.

> *"We need ob/gyn services. Up until recently, we only had one ob/gyn for the entire county. Right now we have two, so that's better than it used to be, but I think we need more."*

> *"No more ob. … I am totally beat and like upset about that to be totally honest. My husband and I have talked about having kids and what am I going to do? Drive to Grand Rapids? 'Oh, hold on. Don't come out.' … So and with ob. I'll say it again. What am I going to do? It's not like you can say, 'Hold on' when you're in labor. I don't want to have to worry about that. So I'd almost move just so I was closer to a hospital if something happened."*

> *"If you're going to take away our ob, give something back. … They've taken away everything and given nothing back."*

Individuals Experiencing Homelessness

Community members who were experiencing homelessness faced a number of unique challenges when attempting to access healthcare services, including difficulty managing chronic health conditions and following up with primary care providers, due to the lack of stable housing. Several providers noted that it was tough to connect individuals in need with appropriate housing resources and referrals because they were largely unavailable in the local community and affordable housing options were incredibly limited. As a result, individuals were typically discharged from the hospital without the supports needed to help ensure they would be able to access follow-up care and necessary prescription medications, which ultimately lead to frequent emergency department visits.

> *"There are so many people who are living out of their cars, or in a tent, or with somebody else here and there, and without a home base, it's really hard to do anything beyond that. … There is a real shortage of affordable housing for one thing. And low-income housing or Section 8 housing or something like that. If there were more of that, that would help."*

> *"I mean they are often the homeless community, again, they are vulnerable adults in our community and the majority of them have different psych issues that make it difficult for them to either maintain a job, or get housing, and those kind of things, or follow up with physicians, or continue on with medications, that kind of stuff. So I mean it's that part's sad and you just—you're basically I feel like sometimes we're up against a wall where it's like there isn't a good place. I mean you try to find the best place that you can."*

> *"It's challenging because when they come to the ER, we just discharge them right back on the streets. We have no resources to follow up with because again, it goes back to transportation. They have to figure out how they can get to a primary care doctor to follow up to keep their chronic diseases in check before they come back into the ER and it creates readmission issues and all this other stuff."*

> *"It's hard to get medication to people who are homeless. You can't get UPS or FedEx to deliver to a non-address. So sometimes our office runs it to 'em and picks it up at the pharmacy."*

Mental Health

Both community members and providers throughout Sparrow Health System's service area voiced numerous concerns related to the general level of awareness of and screening for mental health issues as well as the local availability of appropriate services. Across the board, participants noted a community-wide need to become more trauma-informed and knowledgeable about the impact of adverse life experiences on mental health, resilience, and coping skills.

"Despair. There is a lot of people who are extremely stressed out and overburdened. And I think it goes back to the mental health issues, but there is just a lot of people stressed out."

"Trauma impacts so much, whether it's your health or your outlook, whether you're participating in substances later and all of that. So to deal with the trauma as it's going on, whether it was a car accident, or a parent going to prison, or a divorce, or a domestic violence situation, or the health of a parent can be really traumatic for a child. So taking those things into consideration and trying to address the trauma that the children are dealing with so that they don't carry that into adulthood."

"I mean I think we've come far enough that I mean that's well recognized if people are living with toxic stress. … There is a very active effort in this community to look at trauma-informed initiatives, and ACES scores, and those kinds of things. And we know that that impacts people's health behaviors and, in the long run, the development of chronic health conditions."

"Individuals with serious mental illness and developmental disabilities, are at great risk for having chronic health conditions. And studies have shown that these individuals die sooner than their counterparts in communities. So what we have been doing … is really looking at how we can treat the whole health of individuals that we serve. ... We do that by taking a team-based approach, so not only do they have a mental health professional that works with them. We also have nursing staff that we have embedded on our teams and we use a lot of peer supports who are trained as health mentors."

"In our primary care doctors' offices, lots of them I believe are founded on rural health clinic kinds of principles. We've got lots of mid-level practitioners in this county, but we've got people with very complex health needs. So having those resources in place and looking at beyond what that person comes in for on that day with their physical health complaint, what other factors are contributing, and how can the primary care doctor's office be screening for things like depression, like domestic violence issues, and those kinds of things, and having a good sense of what the supportive resources are in the community and connecting them makes a huge difference."

Despite this growing recognition of the significant and far-reaching impact of mental health on overall health outcomes, needed mental health resources remained incredibly limited in both rural and urban communities. Providers noted that many patients had one or more mental health diagnoses and that mental health resources were increasingly limiting their services to those with more severe needs due to the lack of mental health providers. As a result, community members with mild or moderate conditions were often unable to access services.

"I think it's part of the peril of living near an urban area but not being the urban area because there's benefit to having the urban area's [mental health] resources right next door. But the resources aren't right in your community like you'd really like 'em to be."

"It seems like every patient that we're working with or placing has some type—some form of mental health. If it's not bipolar, it's alcoholism, or drug abuse. It's like it's just it seems like—and I have been doing this for so long, but it's becoming more and more frequent that you're seeing CMH involvement, some type of psychiatric, as well as depression and suicidal. And then you add the dementia and I mean it's huge. Psych is a huge component of patients now. And it's not limited to race, economic status. I mean it doesn't matter. … It's not limited to just this group or that group. It's all over, young and old."

"Mental health is another issue that's looming. And there aren't very many inpatient mental health services available to the public anymore. And out-patient is hit and miss. And because of the type of patient it is, compliance with being taken care of is not very good either, so it's an issue. It's a

community issue and I guess I think it relates to crime that these people don't always know right from wrong. And it's not them; they have a mental problem and they have a health problem."

"We seem to have a lot of people that don't end up—I don't know—qualifying for services, and I'm not sure what makes them qualify or what doesn't. We have had a couple people come back saying, 'Well, they said I wasn't sick enough to meet criteria for them.' And I know they're probably—the same thing—they're just overwhelmed and so they're having to kind of treat the sickest of the sick. And I think that's the problem and I know it's hard to recruit psychiatrists out to the area here, too. I think maybe even if we had video psychiatry in the area, that might be a good resource or having social work in our offices would be a really nice go-between, too, so at least we could have a psychologist or social work come out to our outlying offices … and just to have a counselor perhaps come and talk with some of our patients weekly, or a day, or a half a day so that we could have some kind of mental health access points for some of these patients who are really struggling. I think we always say about half of our day is mental health and it's, I think most of our patients if you look down their medication list are on some kind of anti-anxiety medication, antidepressant."

Socioeconomic and insurance status also played a significant role in determining whether or not an individual was able to access mental health care services. Cost and high insurance deductibles could discourage some community members from accessing services as it often meant they would have to forgo other basic necessities to be able to afford mental health care.

"There's a stigma with mental health, so I mean that's a problem. The wealthy can go out of town; I don't worry about them and mental health. I mean they still have mental health problems … but they have the ability to do it. It's the indigents that I really am concerned about because the wealthy can get the services they want. If they want 'em."

"The hard thing about the community mental health is it's just for the uninsured or the Medicaid. Like so we're basically like separating them like, 'Okay, you are self-pay. You have Medicaid. You can go see a psychiatrist and get the help you need, but you have insurance, so I'm sorry. I have nothing to offer you in the community.' So it's like it's really hard because I just want everyone to have the same opportunity, the same connection to a place to get the help that they need but it literally is just segregated and it's hard. … So you could have a $5,000 deductible, but still it doesn't matter. You still have insurance. It's hard because like I said, it's so segregated. I want it to be the same so that way everyone gets the help that they need to—we see a lot of mental health patients in the ER. Like on a daily basis and it's hard because they're totally separated."

Due to the limited availability of services, patients often end up in emergency departments that are ill-equipped to provide the level of care needed.

"We've got to get it to where there is acceptable—I hate to use the word "diversion", but basically allow ambulances under medical control's direction, but to transport to someplace besides an ER because an ER doesn't help that person with suicidal ideations, or hearing voices, or seeing things. They're not equipped to handle 'em either. So they medically clear 'em and then hopefully they find someplace to send 'em and what it boils down to is they get tossed into that machine that's understaffed and underfunded."

"So there's days that there are people that stay in—psych patients that stay in the ER for five or six days waiting for placement at psych facilities. And that obviously is not getting the patient the care that they need. It's escalating. It's putting hospital staff, other visitors all at risk for this patient being in this room for seven days. It's a huge problem."

"They end up in the hospitals. And that's not a very good place for them to be either. So a lot of them need some type of inpatient program that's long-term and a residential program. And there

is no—I mean it's not safe in their own home and it's not safe in the hospital really either because we're not giving the right treatment."

Participants noted that it was particularly challenging to find appropriate placements in the community for children. As a result, primary care providers attempted to fill the gaps in care and children frequently went without the needed level of services when in-patient treatment was not available or families did not have the resources to access care in another community.

"Probably at least three or four times a week [the doctor] comes by our office and she's like, 'You just won't believe it. I am taking care of this 14 year old that tried to commit suicide last week.' And she goes, 'I went into pediatrics to help healthy children' and she is like, 'I am a psychiatrist now.' And she's like, 'That's not what I want.'"

"I don't even know what we're doing with our children when they enter the hospital and there is nowhere for them to go but home, and put 'em back in the parents' responsibility and then they can't handle it. … And we have discharged 'em home from the hospital just because we couldn't find a place and the parents were finally, 'Let's just go home. We'll put 'em in out-patient' when they felt they were medicationally-managed enough where the family could handle them."

While barriers to accessing care were significant and numerous, participants did mention a variety of supports that had the potential to increase community members' resilience and protect them from experiencing worsening symptoms or developing mental health conditions in the first place. Community members and providers alike hoped to see additional support groups offered on several different topics throughout Sparrow Health System's service area. Others mentioned that many community members turned to their faith communities for support.

"Like with that ACE initiative, it's relationships within the community and not just in the family. Just one person can make the whole world of difference for one child just building a relationship with that child."

"Support groups, too. I have heard people ask me about grief support groups. You get 'em around the holidays but there is no timeframe for grief and I know holidays are big around Christmas, but I have had people throughout the year ask. And it just—support groups maybe for other things."

"They do a lot of other support groups but there might be a stigma of it's coming from the Community Mental Health of like, 'If I go there, there is something wrong with me.' I don't know. Because they send us out their flyers, but I never see the flyers or the announcements like in the community."

"The mental health system in the whole United States. I guess I can't say it's just Michigan because as they close hospitals down and they close a lot of those programs down, what we run into it all the time, what—where do these people go? They go to—if they are affiliated with a church, at least they can maybe go talk to someone there. But not everybody's there."

"We have actually a lot of good church programs, too … honestly it's keeping them spiritual and I think our patients, a lot of them, are quite religious and I think that's good, too, because it can help them—speaking of that mental health, that's one of the things a lot of people do to avoid severe depression, too, because we ask them about, 'What's keeping you from being severely depressed?' And they'll say their faith so that's a really good one for most people there, too."

Substance Use/Abuse

Participants noted that substance use and abuse were both prevalent throughout the entire region served by Sparrow Health System and that these issues affected a growing number of community members. A few participants noted that individuals may be ready to seek treatment on varying timelines; however, participants

generally believed that treatment resources were a valuable resource to have available in the community if and when that time came.

> *"I think it's probably about 50% of our patients honest to goodness are—we'll see some marijuana use, too, so it's a lot of either tobacco or marijuana use. And then there is a lot of alcohol use as well, heavy alcohol use, too, so I think there is some of those social conditions are probably impairing health as well there, too."*

> *"We have a couple of really good AA [Alcoholics Anonymous] groups and everything, too. Whether or not people are ready and willing to do those is a different story. But yeah, that's a highly prevalent problem that we're dealing with these days."*

> *"I couldn't believe the problems like that are happening just here. It's a small town and you expect it to be a little bit better. But the kids that come to school drunk every day and are in middle school. Like that just blows my mind that we have all these sort of problems going on."*

> *"I know we had some meth raids and that seems to be an ongoing issue and we see that in the newspaper time to time about the meth busts that they're doing. And so we do have active surveillance going on and we're seeing that is being addressed. Nobody wants to think it's in their community. But unfortunately it's there and we're not the only one that is dealing with it, but knowing that we're hearing about these and that they're in the paper tells us that we do have active surveillance going on to address this issue, which is huge."*

While both community members and providers were aware of a number of substance use treatment services in several of the local communities, participants agreed that the current availability of services was not great enough to meet the increasing demand in mid-Michigan. In some instances, barriers to accessing services in another community, including transportation issues, were so great that community members went without the services they were interested in accessing.

> *"The fact that we do have a methadone clinic in town, which I kind of heard that through the grapevine, but that we have that, people may not understand the value of it, but it's very much needed. It's very much needed, which is huge."*

> *"We also have a peer recovery coach that works with the [Substance Use Disorder] SUD population and goes as any peer would through whatever that person is going through at that time be it in the community or in like treatment in our agency. We also have SUD services provided in the jail. We have a group there that is offered for both males and females once a week that any of the incarcerated can attend for SUD."*

> *"It's very much the lack of treatment resources for the substance abuse and the mental health, who you send them to. There's nobody that—everybody is overwhelmed. Like I said, if you send 'em into the system, the system spits 'em back out."*

> *"We really do need more substance abuse treatment providers. And we need more inpatient facilities if not in this county, then in relatively easy driving distance. And right now, we just don't have enough of either."*

> *"You have people that want to go to treatment but because of work or whatever, cannot go into inpatient or a partial because partial you have to actually drive to, which I go back to the transportation issue of getting to these partial and intensive outpatient type services. We have counselors, but it's not the same."*

> *"More and more people that we see are suffering from like addiction or from just the treatment that they are trying to access to work with what they're going through right now. We also see like*

a big veterans' population that is trying really hard to access services through the VA but doesn't necessarily have all the steps in place to do that. So we've stepped up our service array for veterans in trying to link and coordinate services for that population."

"I mean we get visiting kinds of services that come in, but that is one of the problems in our community is that people have to travel to Grand Rapids, to the Lansing area for specialty access for care. When you talk about the substance abuse stuff, I mean one of the areas that I think primary care can make a huge impact in things is I'd like to see more Suboxone prescribers in this community, more knowledge on primary care physicians' abilities. But them working at and pursuing the knowledge to be able to prescribe and treat those kinds of conditions."

When the appropriate level of services was not available in the local community, individuals often suffered adverse health outcomes, such as overdoses, and then did not receive referrals to appropriate follow-up care to prevent ongoing and reoccurring issues related to substance use.

"So we have the crisis point, put the band aid on it, and then send people home … So we could put somebody in a drug rehab program or a mental health program. They get clean, they get sober, and then they go right back to their home environment. So I think if we don't start sending people to their homes to follow up and continue that whole process, we just keep cycling over, and over, and over."

"We go treat an overdose … and hopefully we bring them back around with [naloxone] and we take 'em to the hospital. Sometimes they're out the hospital faster than we are. We're not even done writing the report and they're already checked out. And where are they going? To go back home to do it again. And so we don't have a good place to send them. Yet."

A few participants noted that there were some limited prevention resources available in local communities, including locations where community members could dispose of unused prescription medications. Unfortunately, there were varying degrees of awareness and availability of such resources. In other instances, prevention initiatives, such as efforts to reduce the prescription of opioid medications, may have unintended, negative consequences that leave at-risk individuals without appropriate referrals to treatment resources.

"I know we do the drug collection at this event where you can bring in your prescription drugs, which is important when we are talking about the opioid misuse. And that they have the collection there. Now recently I am hearing chatter among my circles that I am in that they are wanting to turn in their prescriptions and such-and-such place isn't doing it anymore, and you're limited here, limited there. And that's something that maybe we can communicate better on where these drop out locations are where you can bring your prescription drugs. Because that is an essential component to dealing with this opioid misuse. Because if they're not available, that's going to help."

"Substance abuse is a major one. So coming together to develop strategies around initiatives to reduce things like overprescribing and develop more treatment strategies, I think emphasizing the physical health and wellbeing in our community is important."

"And the sad thing is, is as the government is cracking down on hospitals to stop dispensing narcotic pain medications, you're just going to draw those people right straight to the streets. … Because we haven't done anything to fix their addiction. We have just said, 'No, you can't have it.' 'You can't have it,' right. 'I have given you a number. That's the resource I am giving you.'"

Community Input

This section provides perspectives on health gathered from two community outreach activities: a survey for community members and a survey for health care providers.

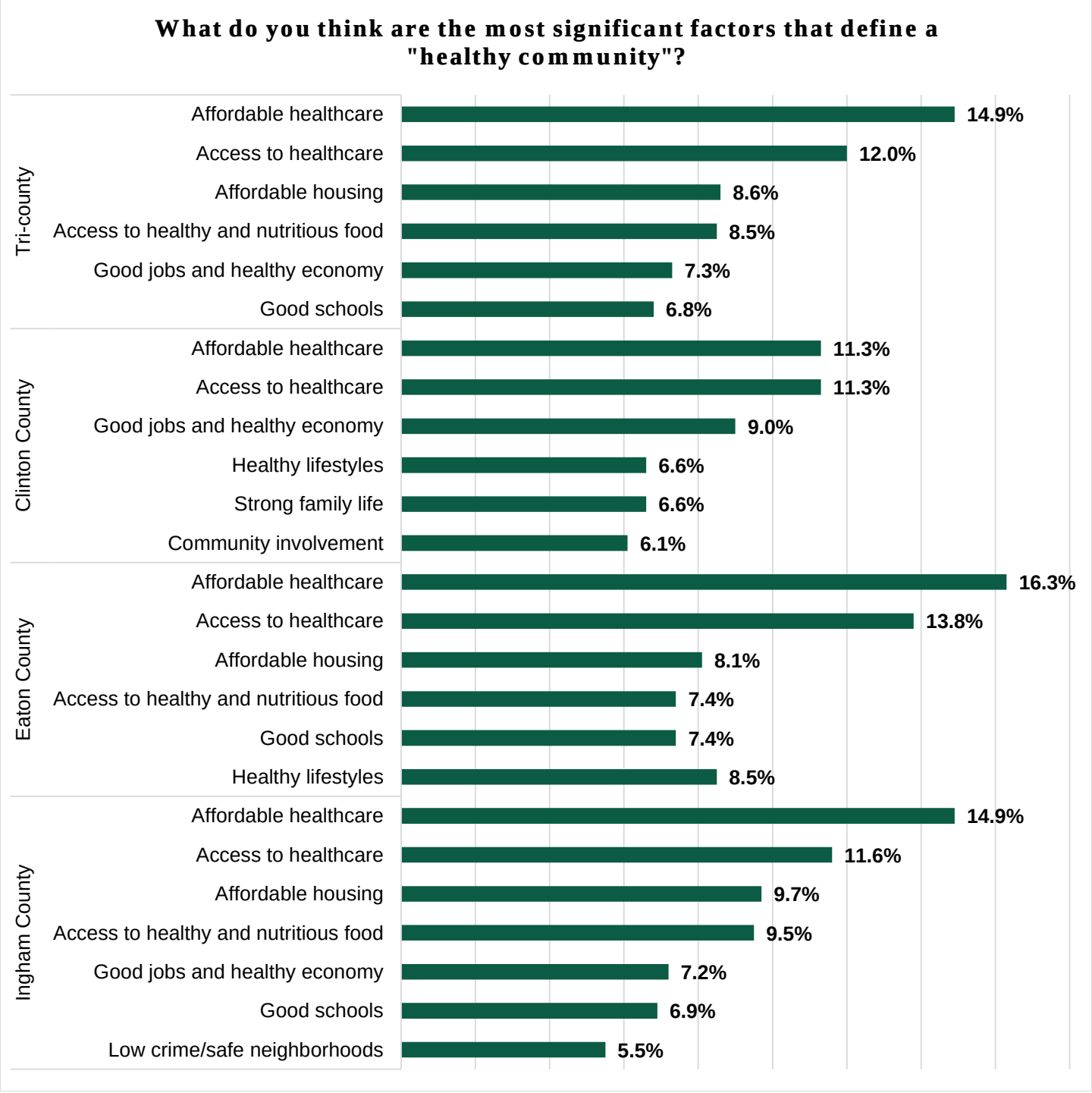
COMMUNITY SURVEY

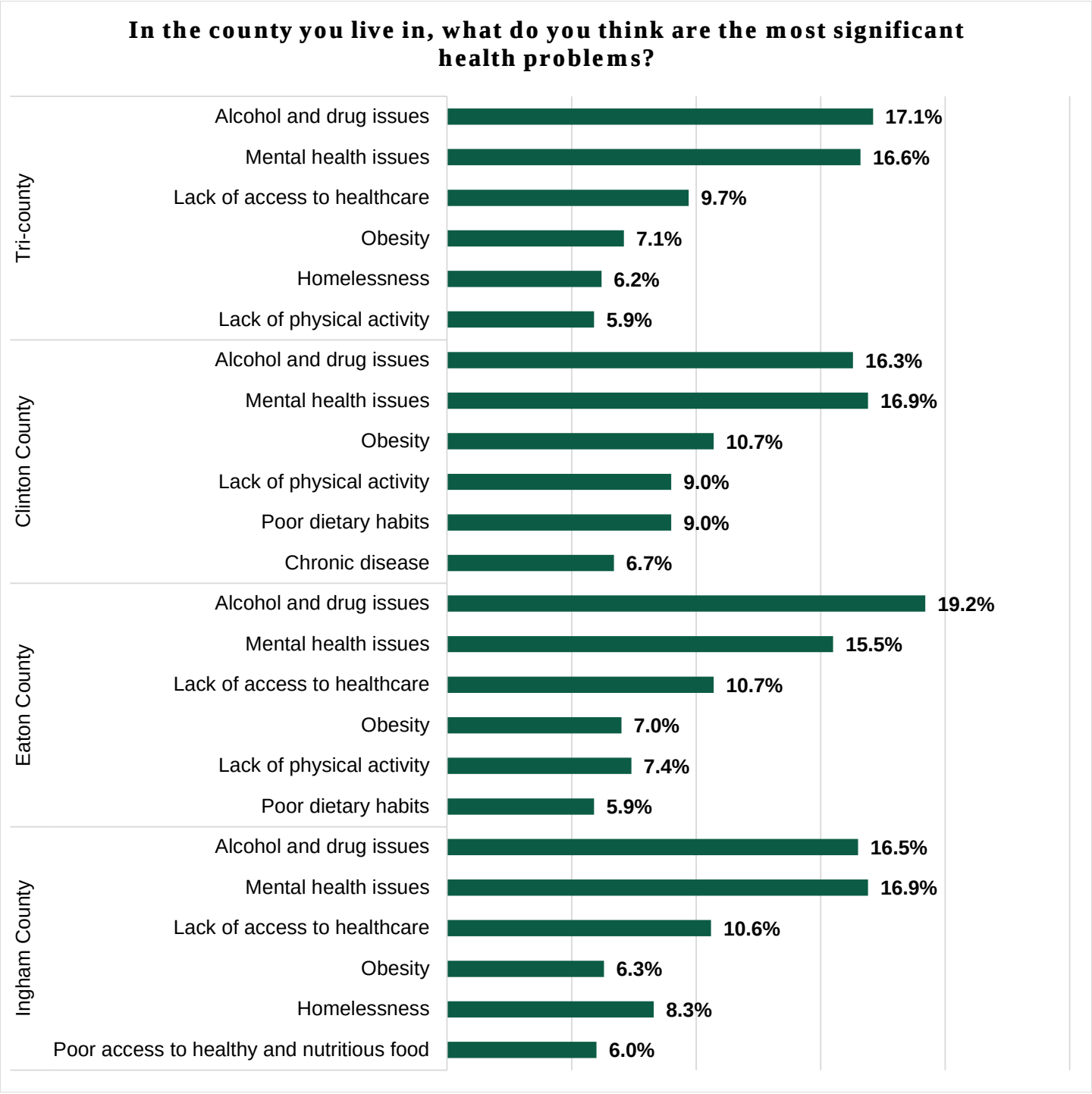
It was important to the Healthy! Capital Counties Workgroup to provide an opportunity for anyone living or working in the region to give their input about the health of the tri-county area. Interested community members were asked to respond to ten question online survey about the defining characteristics of a healthy community, the most important health problems in their county of residence and county of employment, access to health resources, social needs, and health care barriers. Participation was solicited via the following methods:

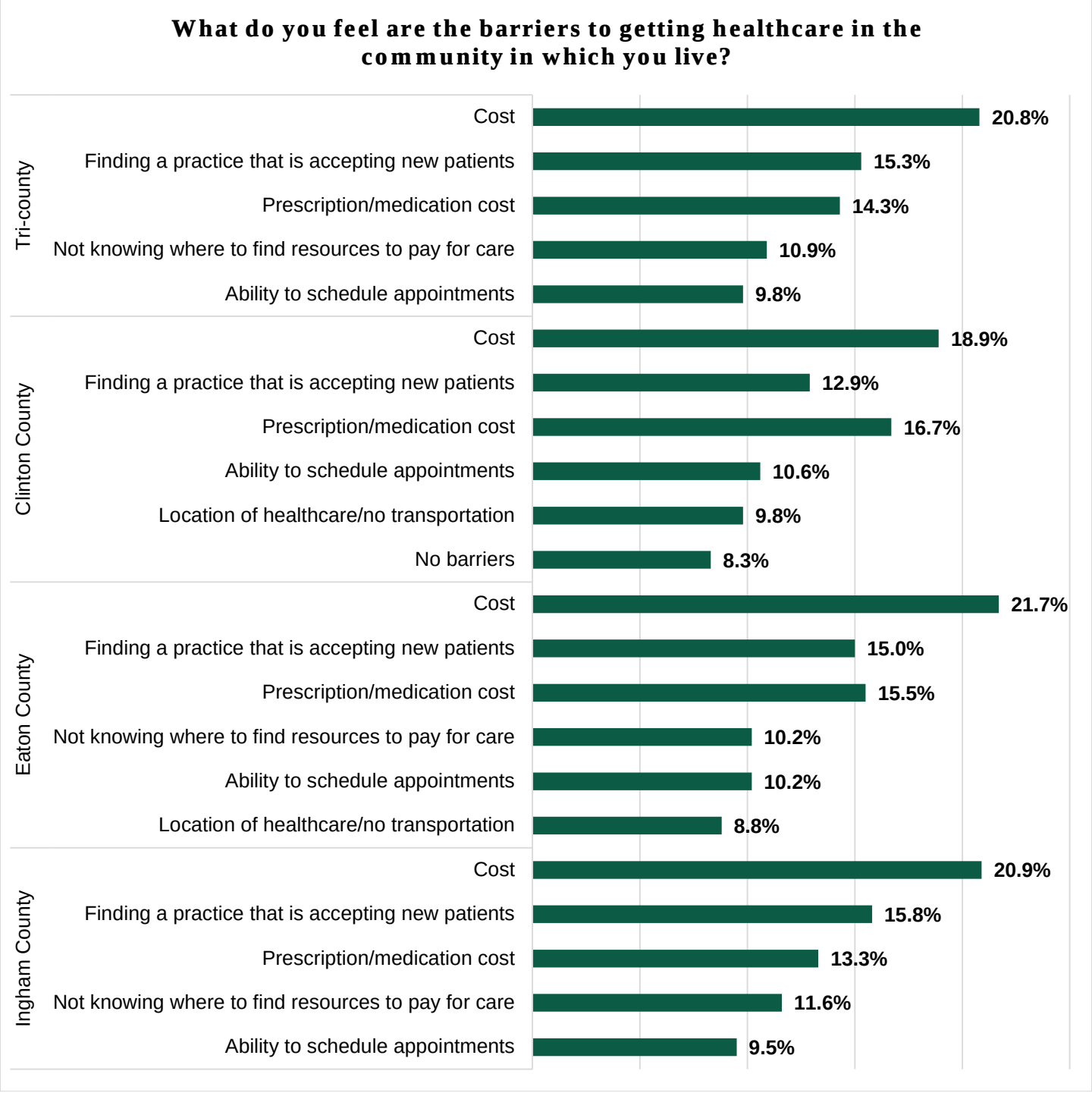
- Posting on the Healthy! Capital Counties website;
- Email invitation to the Healthy! Capital Counties list serve;
- Email and personal invitations to various partner agencies and coalitions within Clinton, Eaton, and Ingham counties;
- Facebook posts on health department and hospital partner websites;
- Boosted Facebook advertising within the tri-county area;
- Printed handouts at various coalition meetings, community events, and health department locations; and
- A press release.

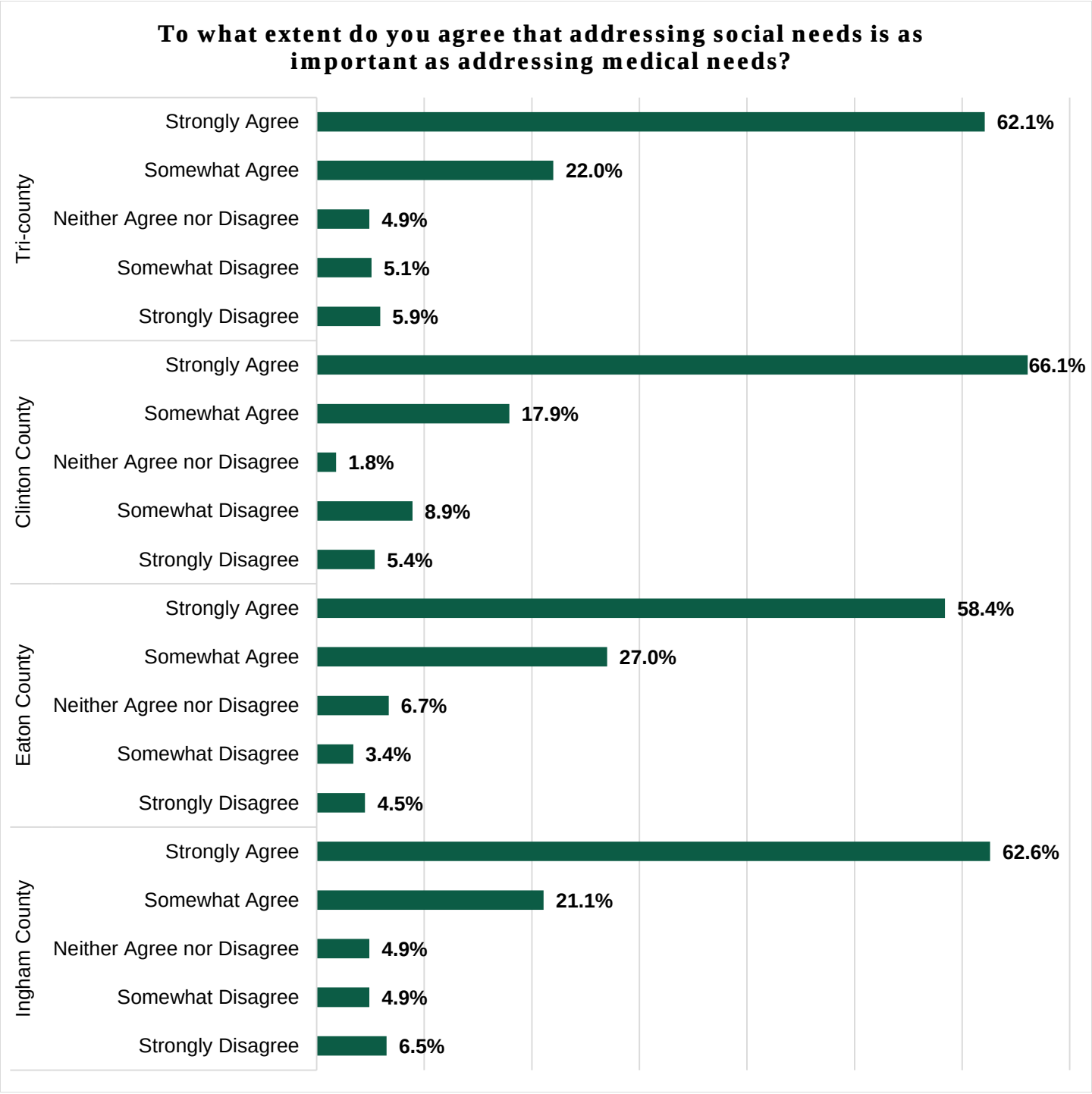
Participant Demographics:

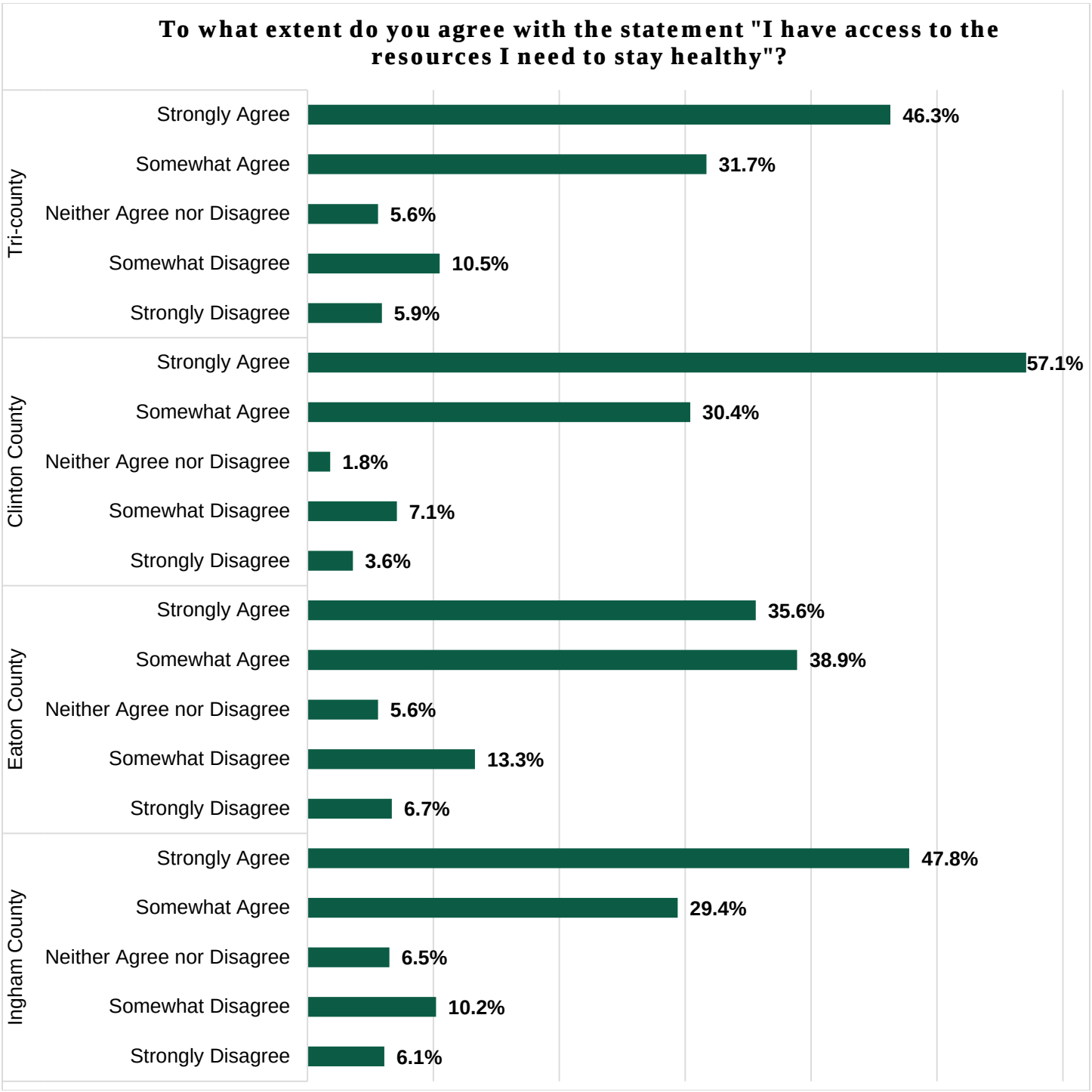
A total of 451 people who lived or worked in Clinton, Eaton, and Ingham Counties participated in the survey. Of those, 92.2% reported living in Clinton, Eaton, or Ingham Counties; counties of residence for participants who reported only working in the tri-county area included Jackson, Shiawassee, Gratiot, and Ionia Counties.

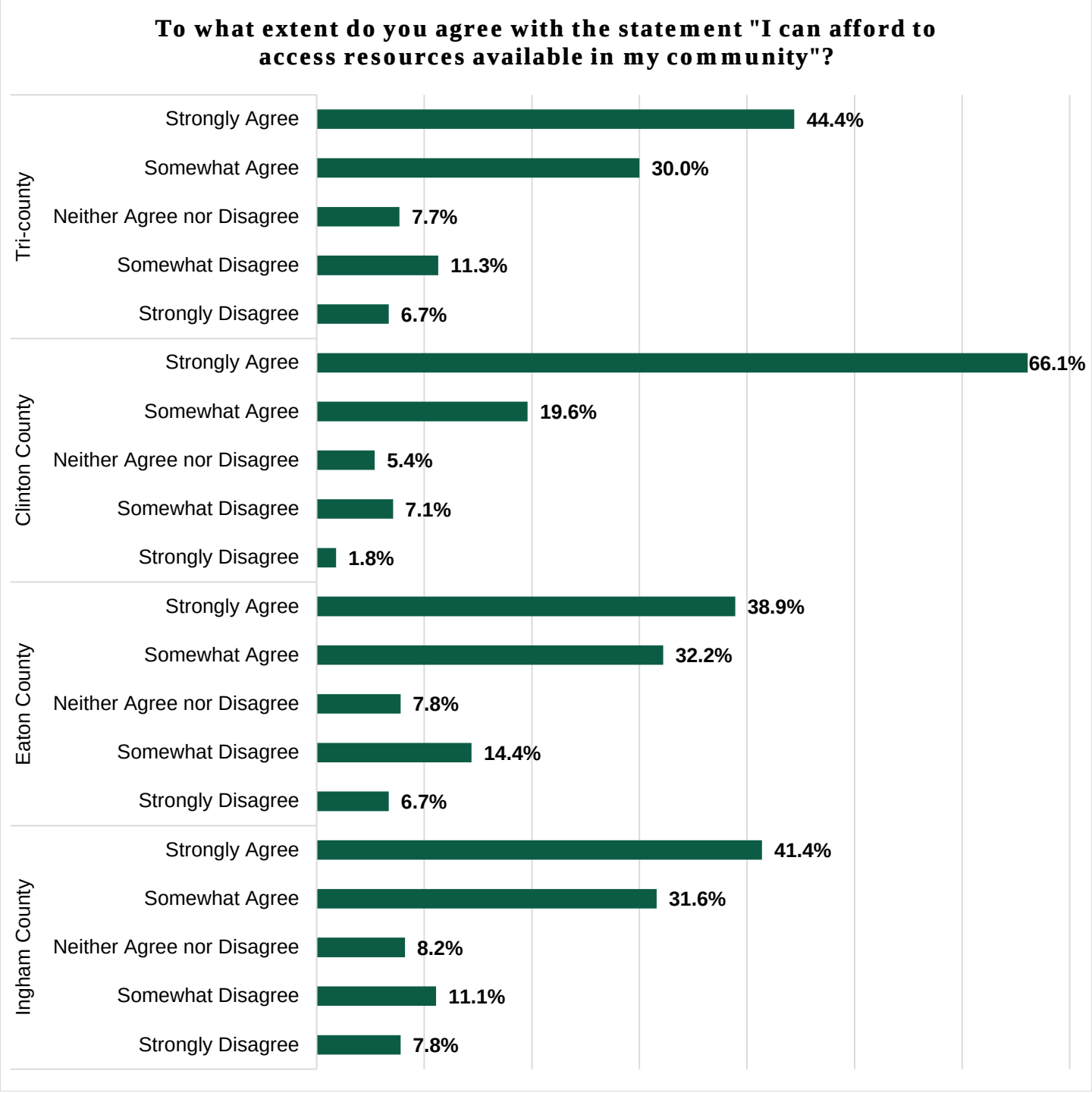

What do you think are the most significant factors that define a "healthy community"?
Tri-county
Affordable healthcare 14.9%
Access to healthcare 12.0%
Affordable housing 8.6%
Access to healthy and nutritious food 8.5%
Good jobs and healthy economy 7.3%
Good schools 6.8%
Clinton County
Affordable healthcare 11.3%
Access to healthcare 11.3%
Good jobs and healthy economy 9.0%
Healthy lifestyles 6.6%
Strong family life 6.6%
Community involvement 6.1%
Eaton County
Affordable healthcare 16.3%
Access to healthcare 13.8%
Affordable housing 8.1%
Access to healthy and nutritious food 7.4%
Good schools 7.4%
Healthy lifestyles 8.5%
Ingham County
Affordable healthcare 14.9%
Access to healthcare 11.6%
Affordable housing 9.7%
Access to healthy and nutritious food 9.5%
Good jobs and healthy economy 7.2%
Good schools 6.9%
Low crime/safe neighborhoods 5.5%


In the county you live in, what do you think are the most significant health problems?
Tri-county
Alcohol and drug issues 17.1%
Mental health issues 16.6%
Lack of access to healthcare 9.7%
Obesity 7.1%
Homelessness 6.2%
Lack of physical activity 5.9%
Clinton County
Alcohol and drug issues 16.3%
Mental health issues 16.9%
Obesity 10.7%
Lack of physical activity 9.0%
Poor dietary habits 9.0%
Chronic disease 6.7%
Eaton County
Alcohol and drug issues 19.2%
Mental health issues 15.5%
Lack of access to healthcare 10.7%
Obesity 7.0%
Lack of physical activity 7.4%
Poor dietary habits 5.9%
Ingham County
Alcohol and drug issues 16.5%
Mental health issues 16.9%
Lack of access to healthcare 10.6%
Obesity 6.3%
Homelessness 8.3%
Poor access to healthy and nutritious food 6.0%


What do you feel are the barriers to getting healthcare in the community in which you live?
Tri-county
Cost 20.8%
Finding a practice that is accepting new patients 15.3%
Prescription/medication cost 14.3%
Not knowing where to find resources to pay for care 10.9%
Ability to schedule appointments 9.8%
Clinton County
Cost 18.9%
Finding a practice that is accepting new patients 12.9%
Prescription/medication cost 16.7%
Ability to schedule appointments 10.6%
Location of healthcare/no transportation 9.8%
No barriers 8.3%
Eaton County
Cost 21.7%
Finding a practice that is accepting new patients 15.0%
Prescription/medication cost 15.5%
Not knowing where to find resources to pay for care 10.2%
Ability to schedule appointments 10.2%
Location of healthcare/no transportation 8.8%
Ingham County
Cost 20.9%
Finding a practice that is accepting new patients 15.8%
Prescription/medication cost 13.3%
Not knowing where to find resources to pay for care 11.6%
Ability to schedule appointments 9.5%


To what extent do you agree that addressing social needs is as important as addressing medical needs?
Tri-county
Strongly Agree 62.1%
Somewhat Agree 22.0%
Neither Agree nor Disagree 4.9%
Somewhat Disagree 5.1%
Strongly Disagree 5.9%
Clinton County
Strongly Agree 66.1%
Somewhat Agree 17.9%
Neither Agree nor Disagree 1.8%
Somewhat Disagree 8.9%
Strongly Disagree 5.4%
Eaton County
Strongly Agree 58.4%
Somewhat Agree 27.0%
Neither Agree nor Disagree 6.7%
Somewhat Disagree 3.4%
Strongly Disagree 4.5%
Ingham County
Strongly Agree 62.6%
Somewhat Agree 21.1%
Neither Agree nor Disagree 4.9%
Somewhat Disagree 4.9%
Strongly Disagree 6.5%


To what extent do you agree with the statement "I have access to the resources I need to stay healthy"?
Tri-county
Strongly Agree
46.3%
Somewhat Agree
31.7%
Neither Agree nor Disagree
5.6%
Somewhat Disagree
10.5%
Strongly Disagree
5.9%
Clinton County
Strongly Agree
57.1%
Somewhat Agree
30.4%
Neither Agree nor Disagree
1.8%
Somewhat Disagree
7.1%
Strongly Disagree
3.6%
Eaton County
Strongly Agree
35.6%
Somewhat Agree
38.9%
Neither Agree nor Disagree
5.6%
Somewhat Disagree
13.3%
Strongly Disagree
6.7%
Ingham County
Strongly Agree
47.8%
Somewhat Agree
29.4%
Neither Agree nor Disagree
6.5%
Somewhat Disagree
10.2%
Strongly Disagree
6.1%

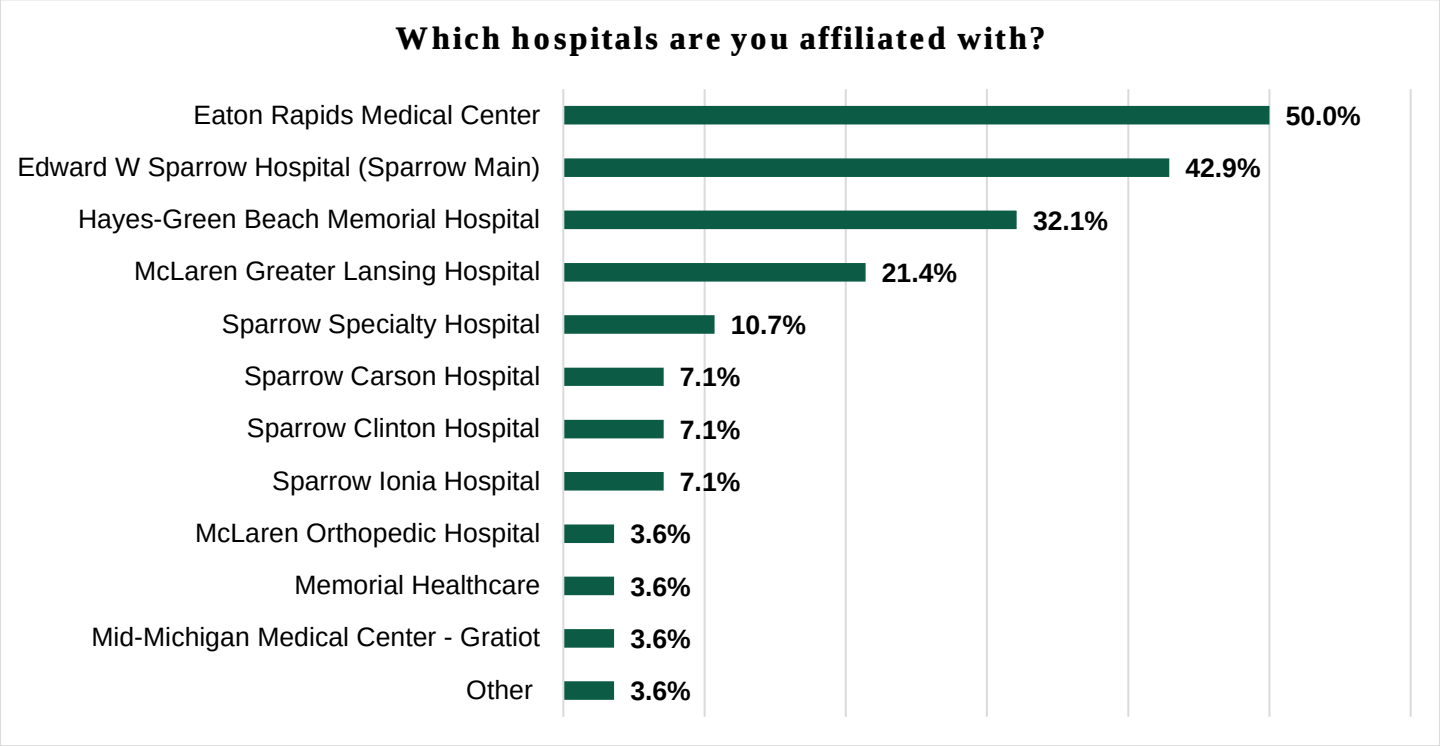

To what extent do you agree with the statement "I can afford to access resources available in my community"?
Tri-county
Strongly Agree 44.4%
Somewhat Agree 30.0%
Neither Agree nor Disagree 7.7%
Somewhat Disagree 11.3%
Strongly Disagree 6.7%
Clinton County
Strongly Agree 66.1%
Somewhat Agree 19.6%
Neither Agree nor Disagree 5.4%
Somewhat Disagree 7.1%
Strongly Disagree 1.8%
Eaton County
Strongly Agree 38.9%
Somewhat Agree 32.2%
Neither Agree nor Disagree 7.8%
Somewhat Disagree 14.4%
Strongly Disagree 6.7%
Ingham County
Strongly Agree 41.4%
Somewhat Agree 31.6%
Neither Agree nor Disagree 8.2%
Somewhat Disagree 11.1%
Strongly Disagree 7.8%

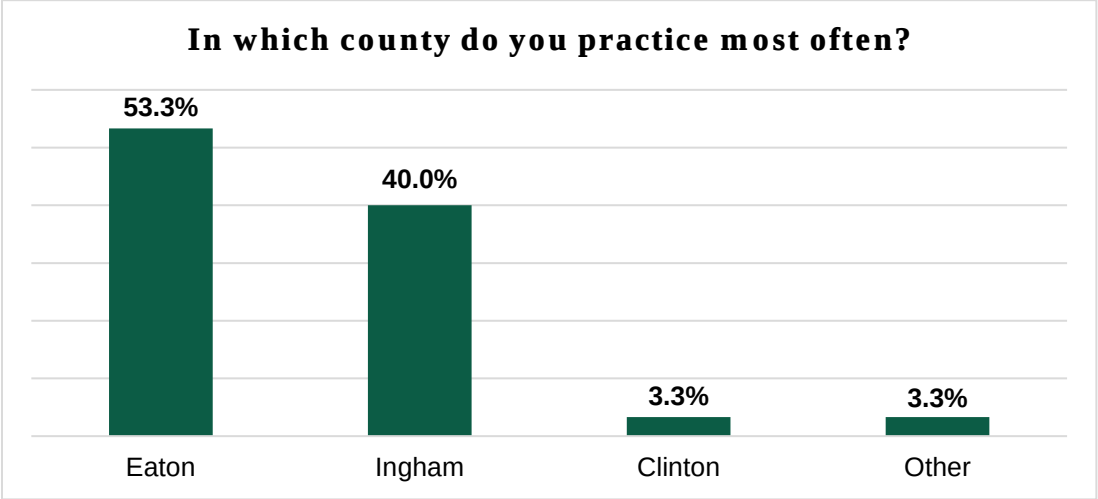
Provider Survey

In addition to the community survey, a specific effort was made to gain insight about the health of the community from local health care providers. Health care providers affiliated with the four hospital systems (Sparrow Health System, McLaren Greater Lansing, Hayes-Green Beach Memorial Hospital, and Eaton Rapids Medical Center) taking part in the Healthy! Capital Counties collaborative were encouraged to participate in a seven question 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, referrals to other community resources, social needs of patients, and health care barriers. Health care providers were invited to complete the survey through communication from their hospital system. The provider survey was available from May 1, 2018 to June 29, 2018.

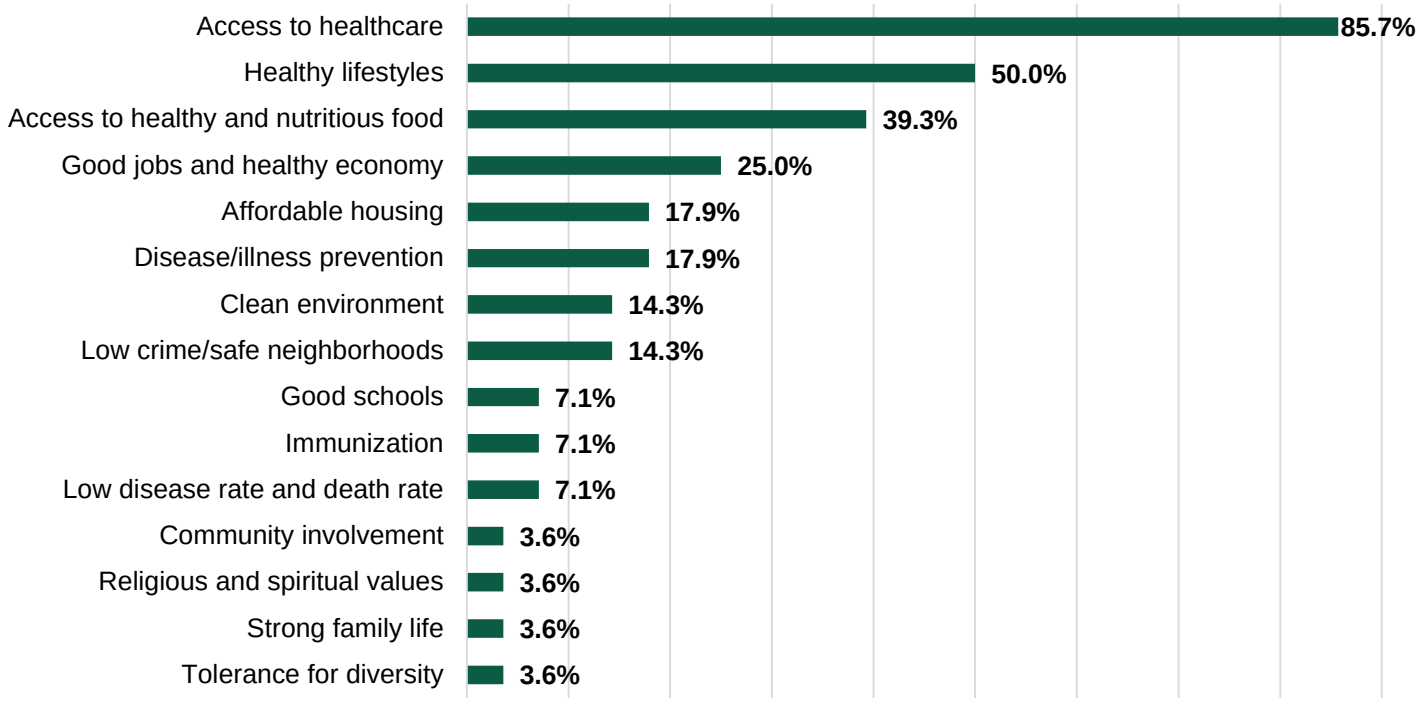
Participant Demographics:

Thirty providers responded to this survey. It is common for providers to be affiliated with multiple hospitals, but respondents were instructed to complete the survey only once.

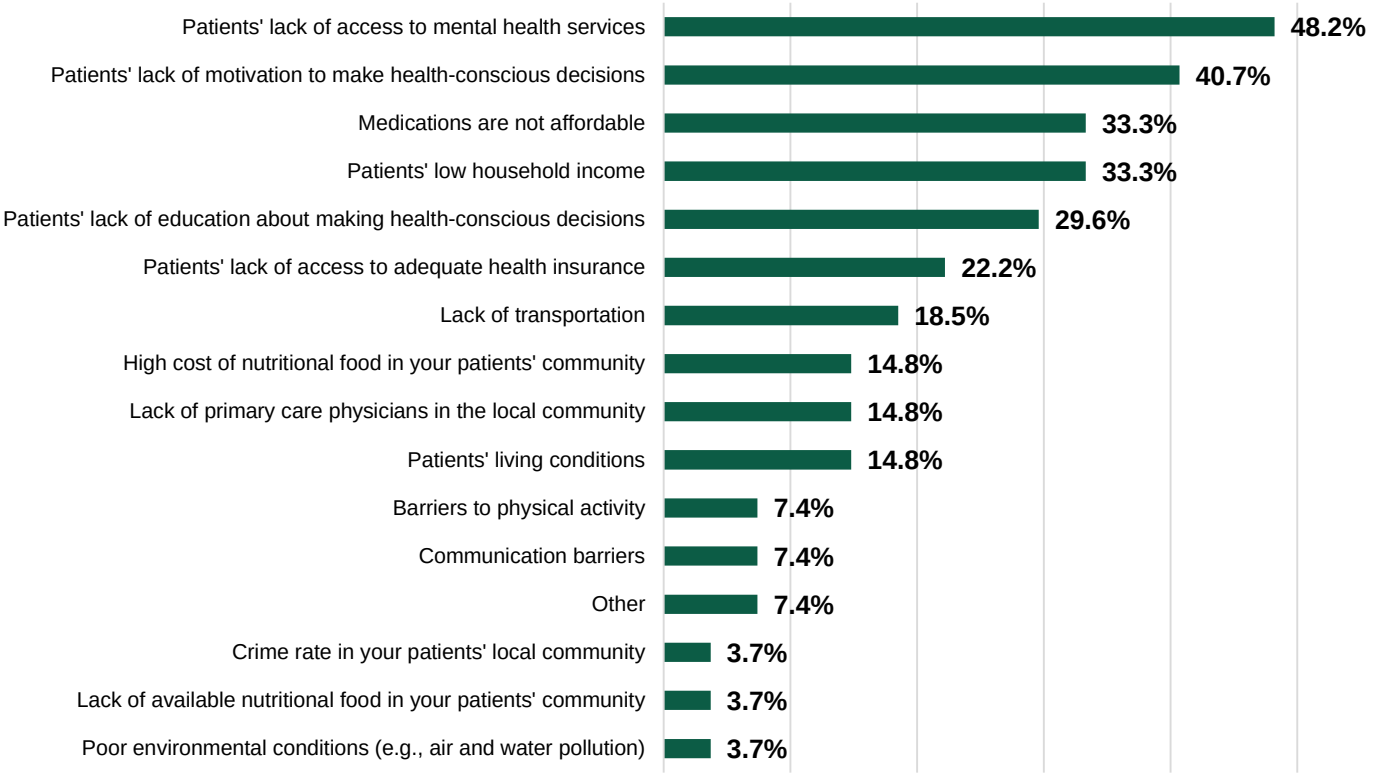


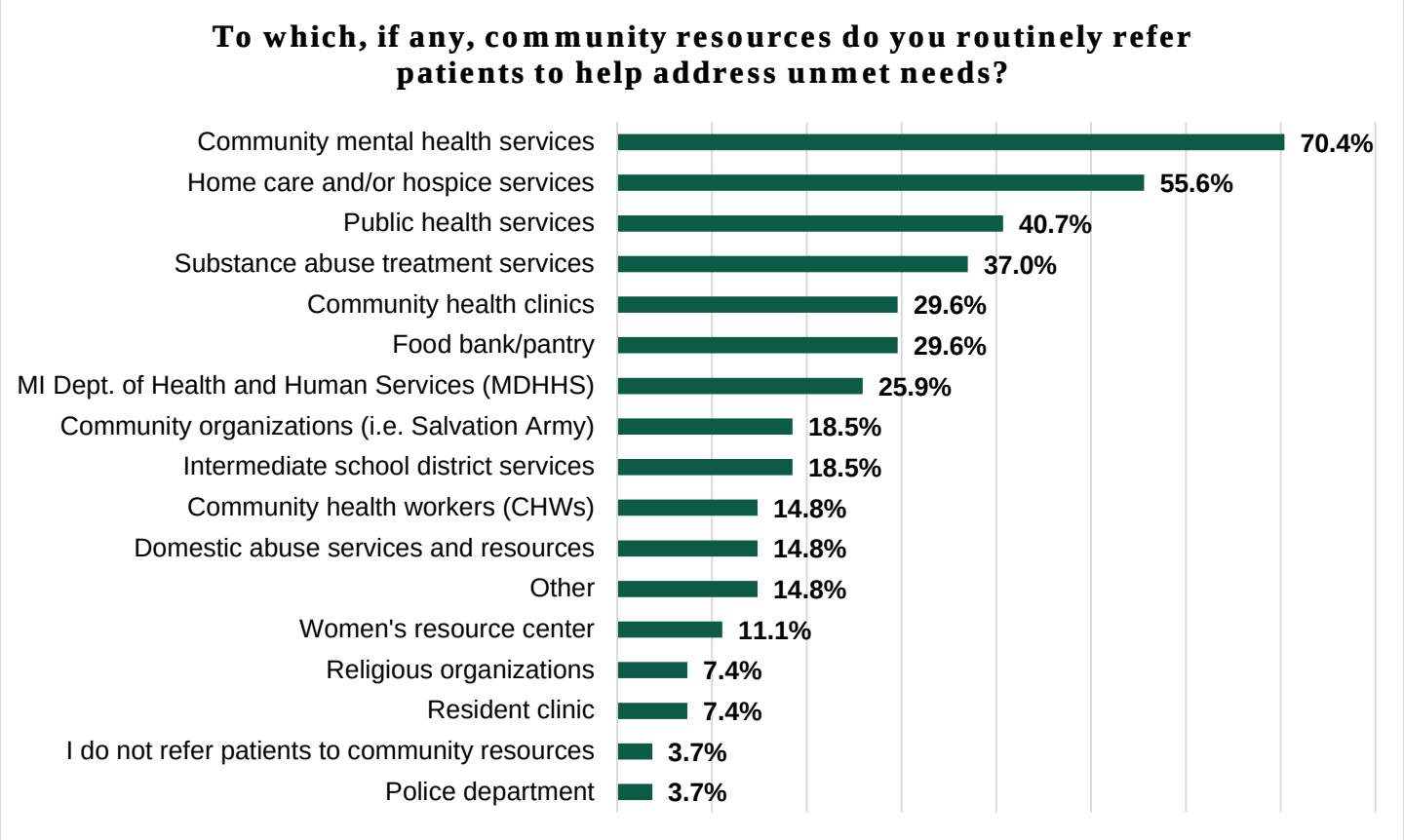


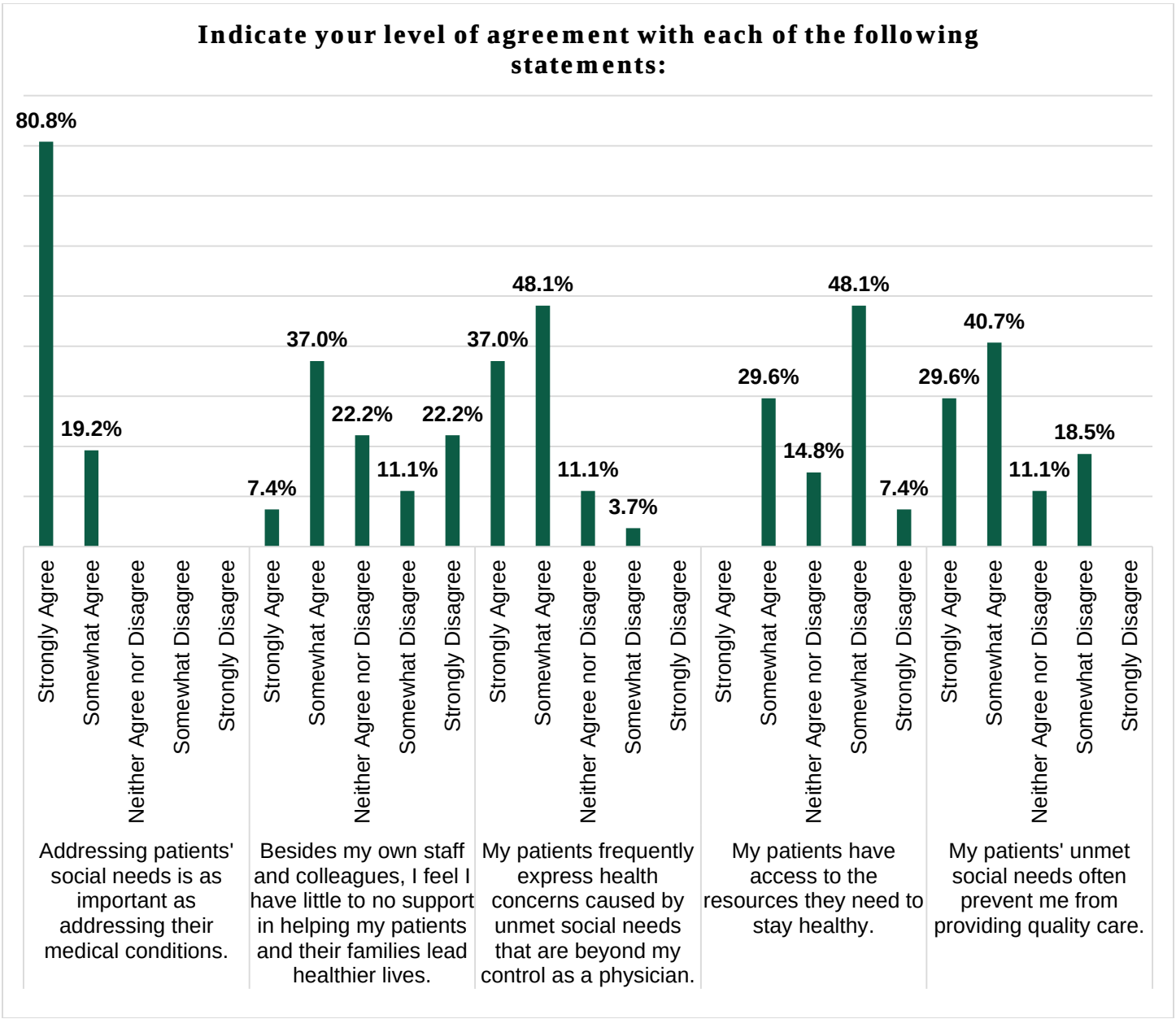
What do you believe are the three most important factors that define a "healthy community"?



What do you believe are the top three factors that negatively impact your patients' health?




To which, if any, community resources do you routinely refer patients to help address unmet needs?
Community mental health services 70.4%
Home care and/or hospice services 55.6%
Public health services 40.7%
Substance abuse treatment services 37.0%
Community health clinics 29.6%
Food bank/pantry 29.6%
MI Dept. of Health and Human Services (MDHHS) 25.9%
Community organizations (i.e. Salvation Army) 18.5%
Intermediate school district services 18.5%
Community health workers (CHWs) 14.8%
Domestic abuse services and resources 14.8%
Other 14.8%
Women's resource center 11.1%
Religious organizations 7.4%
Resident clinic 7.4%
I do not refer patients to community resources 3.7%
Police department 3.7%


Indicate your level of agreement with each of the following statements:
80.8%
19.2%
7.4%
37.0%
22.2%
11.1%
22.2%
37.0%
48.1%
11.1%
3.7%
29.6%
14.8%
48.1%
7.4%
29.6%
40.7%
11.1%
18.5%
Strongly Agree
Somewhat Agree
Neither Agree nor Disagree
Somewhat Disagree
Strongly Disagree
Addressing patients' social needs is as important as addressing their medical conditions.
Besides my own staff and colleagues, I feel I have little to no support in helping my patients and their families lead healthier lives.
My patients frequently express health concerns caused by unmet social needs that are beyond my control as a physician.
My patients have access to the resources they need to stay healthy.
My patients' unmet social needs often prevent me from providing quality care.

Health Needs Prioritization: Setting a Shared Course

Prioritization Methodology

The 2018 Healthy! Capital Counties Community Health Profile and Health Needs Assessment process highlighted the health issues of the tri-county area utilizing a variety of both quantitative and qualitative data sources. A multi-disciplinary group of stakeholders used the resulting report to prioritize which health needs to address through the development of a Community Health Improvement Plan. The priority health needs were selected using the consensus criteria method, which involved:

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

Identifying the Criteria

Based upon the experience garnered from the 2012 and 2015 health needs prioritization process, the decision was made to use the same four criteria for evaluating the issues to be prioritized. Those criteria are:

- Seriousness (how serious is the health issue)
- Control (how much control we have to affect the issue)
- Capacity (our capability, as a community, to address an issue)
- Catalytic (how much an issue affects other health issues)

Selecting Weights for the Criteria

In order to identify a broad spectrum of priorities that reflected both the constellation of factors that influence health and the spheres of influence for project partners, a two-tiered weighting system was developed and first utilized during the 2015 health needs prioritization process. This system involved identifying two sets of weights to apply to the results of the voting process: 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. The following upstream and downstream weights were applied to the four criteria:

Criteria	Upstream Weight	Downstream Weight
Seriousness	4	4
Control	2	3
Capacity	1	2
Catalytic	3	1

Identifying the Issues to be Evaluated

This Community Health Needs Assessment report summarizes the data for a total of 35 quantitative health indicators. The Healthy! Capital Counties workgroup agreed it would be too cumbersome to vote on all 35 indicators during the prioritization process so the workgroup used consensus decision-making methods to combine all of the indicators into the following set of 17 health issues:

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

- Health Care Access and Quality
- Physical Activity

ENGAGING STAKEHOLDERS IN SELECTING PRIORITIES

All Healthy! Capital Counties project partners were encouraged to invite key stakeholders and community representatives to take part in the prioritization of the 17 health issues outlined above at a "Measure Madness" event. Registration for this event was also advertised on the Healthy! Capital Counties website, Facebook page, via email to the project email listserve, and at local coalition meetings as well as on project partner websites, Facebook pages, and other media outlets. A total of 53 stakeholders representing a variety of local partners, agencies, and coalitions attended the "Measure Madness" event held on November 5, 2018.

At the "Measure Madness" event, Healthy! Capital Counties project staff provided an overview of project progress to date and highlighted findings from the community health profile and health needs assessment report, including those from the focus groups, community and healthcare provider surveys, and asset mapping process. To familiarize participants with the quantitative health indicator data included in the report, attendees were asked to work with a partner to prioritize a subset of 16 of the 35 indicators. Each pair analyzed the subset of indicators they were presented with utilizing the four criteria (seriousness, control, capacity, and catalytic) and then prioritized the health issue of greatest importance to them using a sports bracket-style system. Attendees were then engaged in a discussion around the photos and associated captions from a Youth Photovoice project to learn more about the perspective of local youth on a variety of health-related issues occurring in the community.

Attendees were then presented with the list of 17 health issues that would be prioritized by all participants during four rounds of voting (one round for each of the four criteria). Each attendee was asked to identify and vote for three health issues that he or she felt were the highest priority during each round of voting. At the end of the process, each participant had cast a total of 12 votes. Project staff were available throughout the process to provide clarification on the voting method.

RESULTS OF THE PRIORITIZATION PROCESS

At the conclusion of the voting process, project staff tallied the votes and applied the set of upstream and downstream weights described above to each of the 17 health issues that participants voted on. Both the upstream and downstream weights put the most emphasis on the perceived seriousness of the health issue. The second highest level of emphasis was placed on catalytic (for the upstream system) and control (for the downstream system). The following top five priorities emerged after both upstream and downstream weights were applied to participant votes:

Upstream:	Downstream:
1. Behavioral Health	1. Behavioral Health
2. Healthcare Access and Quality	2. Healthcare Access and Quality
3. Obesity	3. Obesity
4. Financial Stability and Economic Mobility	4. Chronic Disease
5. Chronic Disease	5. Financial Stability and Economic Mobility

Both the upstream and downstream weights identified the same set of five health issues. As a result, all five will be addressed by the 2019-2022 community health improvement planning process for the tri-county area as a whole.

Next Steps

Sparrow Health System reviewed all of the data gathered by the Healthy! Capital Counties collaborative, the supplemental information collected by the Michigan Public Health Institute, the availability of existing community assets and resources, and the results of the health needs prioritization process to begin developing an Implementation Strategy specific to each hospital and its service area. Representatives from each of the five hospitals convened to discuss local health needs and priorities as well as strategies for addressing the identified needs. As a result of this process, Sparrow Carson Hospital chose to focus on the following health priorities:

- Access to Health Care/Quality Health Care; and
- Behavioral Health.

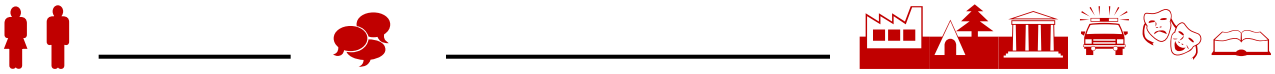
A separate Implementation Strategy document will be written for each hospital to address the above mentioned health priorities.

Appendix A: Community Asset Inventory

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. Community assets are grouped first by county and then by type of resource.

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.

Ingham County Resources

Health		
Medical		
Sparrow Health System	(517) 364-1000	www.sparrow.org
Care Free Medical	(517) 887-5922	www.carefreemedical.com
His Healing Hands Health Center	(517) 882-0056	www.hishealinghandsministry.org
Cristo Rey Community Center	(517) 372-4700	www.cristoreycommunity.org
Cedar Community Health Center – Child Health	(517) 887-4305	www.ingham.org/forparents/pediatricandadolescentcare/cedarcommunityhealthcenterpediatrics.aspx
Forest Community Health Center	(517) 887-4302	www.hd.ingham.org/seekingcare/communityhealthcenters/locationshours/forestcommunityhealthcenter.aspx
Willow Health Center	(517) 702-3500	www.hd.ingham.org/seekingcare/communityhealthcenters/LocationsHours/WillowHealthCenter.aspx
River Oak Community Health Center	(517) 244-8060	www.hd.ingham.org/seekingcare/communityhealthcenters/locationshours/riveroakcommunityhealthcenter.aspx
Dental		

Forest Community Health Center	(517) 887-4302	www.hd.ingham.org/seekingcare/communityhealthcenters/locationshours/forestcommunityhealthcenter.aspx
Care Free Dental	(517) 272-5053	www.carefreemedical.com/clinics/dental/
Healthy Smiles Dental Center	(517) 272-4150	www.hd.ingham.org/forparents/pediatricandadolescentcare/healthysmilesdentalcenter.aspx

Vision

Care Free Medical	(517) 272-5053	www.carefreemedical.com/clinics/optometry/

Mental Health

Community Mental Health	(517) 346-8200	http://ceicmh.org/
Community Mental Health - Mental Health Crisis	(517) 346-8460	http://ceicmh.org/services/cs

Substance Use

Mason-Capital Area Prescription Drug Task Force	(517) 887-4312	
Families Against Narcotics	(517) 898-3236	www.familiesagainstnarcotics.org/Okemos-Ingham-County
National Council on Alcoholism/Lansing	(517) 887-0226	www.mhweb.org/lansing/natcouncil.htm

Education

Children

Ingham Intermediate School District	(517) 676-1051	www.inghamisd.org/
Office for Young Children	(800) 234-6996	http://hd.ingham.org/Home/OfficeforYoungChildren.aspx
TEACH Early Childhood Michigan	(866) 648-3224	www.miaeyc.org/professional-development/t-e-a-c-h-scholarships/

Adults

Lansing Adult/Alternative Education	(517) 755-1391	
Michigan Association of Community and Adult Education	(517) 492-1367	http://macae.org/
Lansing Community College	(800) 644-4522	www.lcc.edu/
Michigan State University	(517) 355-1855	www.msu.edu/

Child & Family Services

Student Parent Resource Center – MSU	(517) 432-3745	http://studentparents.msu.edu/contact-us/contact-us-overview
Head Start	(517) 372-9405	www.cacsheadstart.org

Ingham Great Start Collaborative	(517) 244-1267	www.inghamgreatstart.org
Ingham Great Start Family Coalition	(517) 244-1267	www.inghamgreatstart.org
Kinship Care Resource Center	(517) 335-9600	http://kinship.msu.edu
March of Dimes	(517) 699-4863	www.marchofdimes.com/michigan/programs.html#
WKAR Education Services		http://wkar.org/topic/wkar-education-services
Willow Tree Family Center	(586) 806-WTFC	www.willowtreefamily.com
Housing		
Salvation Army	(517) 484-4424	http://salansing.org/
Haven House	(517) 337-2731	www.havenhouseel.org/
Capital Area Community Services	(517) 676-1065	www.cacs-inc.org/
Ingham County Society of St. Vincent DePaul	(517) 484-4228	www.svdpusa.org/
Clothing		
St. Vincent DePaul	(517) 484-5395	www.svdpusa.org/
Volunteers of America	(517) 484-4414	www.voami.org/
Food		
Expanded Food & Nutrition Program – MSU Extension	(517) 886-4588	http://www.canr.msu.edu/snap_ed/
Greater Lansing Food Bank	(517) 853-7800	www.greaterlansingfoodbank.org
Haven House	(517) 337-2731	www.havenhouseel.org/
City of Lansing Mobile Food Pantry	(517) 483-4477	www.lansingmi.gov/530/Mobile-Food-Pantry
Transportation		
Capital Area Transportation Authority (CATA)	(517) 394-1100	www.cata.org/
Job Placement		
Capital Area Michigan Works	(800) 285-9675	www.camw.org/
Peckham, Inc.	(517) 316-4000	www.peckham.org/
Disability Services		
Disability Network Capital Area	(517) 999-2760	http://www.dncap.org/

Clinton, Eaton, Ingham Community Mental Health – community services for the developmentally disabled	(517) 346-9560	http://ceicmh.org/services/csdd
Emergency Services		
Ambulance	911	
American Red Cross	(305) 644-1200	https://www.redcross.org/local/michigan.html
Fire	911	
Ingham County Sheriff's Department	(517) 676-2431	http://sh.ingham.org/
Poison Control Center	(800) 222-1222	https://www.poison.org/contact-us
Police	911	
Community Resources		
Parks		
Bunker Road Canoe Landing	(517) 676-2233	http://pk.ingham.org/
Burchfield Park	(517) 676-2233	
Hawk Island	(517) 676-2233	
Riverbend Natural Area	(517) 676-2233	
Lake Lansing Boat Launch	(517) 676-2233	
Lake Lansing Park North	(517) 676-2233	
Lake Lansing Park South	(517) 676-2233	
Soldan Dog Park	(517) 676-2233	
McNamara Canoe Landing	(517) 676-2233	
Libraries		
Capital Area District Library	(517) 367-6300	www.cadl.org/
Ingham County Library	(517) 676-8440	http://inghamcounty.org/resources/Library.html
Services for Senior Citizens		
Tri-County Office on Aging	(517) 887-1440	www.tcoa.org/
Meals on Wheels: Lansing, East Lansing, Haslett and Okemos	(517) 887-1460	https://www.tcoa.org/nutrition/meals-on-wheels/
Meals on Wheels: Holt, Mason, Williamston, Webberville, Stockbridge, Leslie, Dansville and Onondaga	(517) 676-2775	

EATON COUNTY RESOURCES

Health		
Medical		
Barry-Eaton District Health Department	(517) 543-2430	www.barryeatonhealth.org
Children's Special Health Care Services (CSHCS)	(800) 359-3722	www.michigan.gov/mdhhs/0,5885,7-339-71547_35698---,00.html
Eaton Rapids Medical Center	(517) 663-2671	www.eatonrapidsmedicalcenter.org
Eaton County Health & Rehabilitation Services	(517) 543-2940	https://echrshealth.org
Eaton Immunization Clinic	(517) 541-2630	www.barryeatonhealth.org
Eaton Community Hospice	(517) 543-5310	www.echospice.org/
Hayes Green Beach Memorial Hospital	(517) 543-1050	www.hgbhealth.com/
Michigan Department of Health and Human Services	(517) 543-0860	www.michigan.gov/mdhhs
Sparrow Health System	(517) 364-1000	www.sparrow.org
Dental		
My Community Dental Centers	(887) 313-6232	www.mydental.org
Vision		
Lions Club	(517) 543-7809	http://lionsofmi.com/
Mental Health		
Community Mental Health	(517) 346-8200	www.ceicmh.org/
Eaton County Counseling Center	(517) 543-5100	www.ceicmh.org/
Community Mental Health - Mental Health Crisis	(517) 346-8460	
St. Lawrence Mental Health	(517) 364-7650	www.sparrow.org/behavioralhealth
Substance Use		
Alcoholics Anonymous	(517) 377-1444	www.aalansingmi.org
Community Mental Health	(517) 346-8200	www.ceicmh.org/
BAD (Brotherhood Against Drugs)	(517) 484-3970	
Eaton Substance Abuse Program	(517) 543-2580	www.barryeatonhealth.org/health-services/substance-use-treatment-and-recovery

Sparrow Substance Abuse Program	(517) 364-7743	https://www.sparrow.org/?id=2632&sid=1
Education		
Children		
Bellevue Public Schools	(269) 763-9432	www.bellevue-schools.com
Charlotte Public Schools	(517) 541-5100	www.charlottenet.org/
Eaton Rapids Public Schools	(517) 663-8155	www.erpsk12.org/
Grand Ledge Public Schools	(517) 925-5400	www.glcomets.net/
Maple Valley Public Schools	(517) 852-9699	www.mvs.k12.mi.us/
Olivet Community Schools	(269) 749-9129	www.olivetstudent.org/
Potterville Public Schools	(517) 645-2662	http://pottervillepublicschools.squarespace.com/
Adults		
Michigan Association for Community and Adult Education	(517) 492-1367	http://macae.org/
Olivet College	(269) 749-7635	www.olivetcollege.edu/
Potterville Adult Education	(517) 645-4792	http://pottervillepublicschools.squarespace.com/adulted/
Child & Family Services		
WIC Program	(517) 541-2630	https://www.barryeatonhealth.org/women-infants-and-children-wic-program
Capital Area United Way (for Grand Ledge and Delta Area)	(517) 203-5000	http://ecuw.org/
Charlotte Public Schools Head Start	(517) 541-5180	
Child and Family Services	(517) 882-4000	http://childandfamily.org/
Ele's Place	(517) 482-1315	www.elesplace.org/
Head Start	(517) 543-3194	www.cacsheadstart.org
Life Skills Center	(517) 852-9414	www.lifeskillspsa.com/
Samaritas	(800) 896-9850	
Michigan Department of Health and Human Services	(517) 543-0860	www.michigan.gov/mdhhs
Foster Care Supportive Visitation	(517) 484-8444	
Parent Help Line	(800) 942-4357	
Housing		

Advent House	(517) 485-4722	www.adventhouse.com/
Housing Services Mid-Michigan	(517) 541-1180	www.hs-mm.org/
VFW National Home for Children	(517) 663-1521	www.vfwnationalhome.org/
Potterville Housing Commission	(517) 645-7076	
Homeaid America Lansing	(517) 646-2581	www.homeaid.org/
Greenpath, Inc.	(888) 860-4167	
Eaton Co. Housing Services	(517) 541-1180	
Siren Eaton Shelter – Emergency Shelter	(517) 543-0748	www.sireneatonshelter.org/
Siren Eaton Shelter – Transitional Housing	(517) 543-0748	www.sireneatonshelter.org/
Clothing		
Capital Area Community Services	(517) 543-5465	www.cacs-inc.org/
Lansing Rescue Mission	(517) 485-0145	www.lcrm.org/
Salvation Army	(517) 484-4424	www.salvationarmyusa.org/
Christian Services	(517) 394-5411	www.christianserviceslansing.com/
Food		
Greater Lansing Food Bank	(517) 853-7800	greaterlansingfoodbank.org/
Helping Hands of Charlotte	(517) 543-8737	www.handsoncharlotte.org/
Salvation Army	(517) 484-4424	www.salvationarmyusa.org/
Transportation		
EATRAN Transportation	(517) 543-4087	www.eatran.com/
Job Placement		
Michigan Works!	(800) 285-9675	www.michiganworks.org
Disability Services		
Disabilities Advocate	(616) 949-1100	
Capital Area United Way	(517) 203-5000	www.micauw.org
Community Mental Health	(517) 346-8200	www.ceicmh.org/
Emergency Services		
Ambulance	911	

American Red Cross	(800) 482-2411	www.redcross.org
Burn Center	(616) 774-3940	
Fire	911	
Michigan State Police		www.michigan.gov/msp
Eaton County Sheriff's Department	(517) 543-3512	www.eatoncounty.org/departments/office-of-the-sheriff
Poison Control Center	(800) 222-1222	www.aapcc.org/
Police	911	

Community Resources

Parks

Fitzgerald Park		www.eatoncounty.org/departments/parks-department/county-parks
Fox Memorial Park		www.eatoncounty.org/departments/parks-department/county-parks

Libraries

Charlotte Community Library	(517) 543-8859	http://charlottelibrary.org/
Eaton Rapids Public Library	(517) 663-8118	www.cityofeatonrapids.com
Holt-Delhi Library	(517) 694-9351	www.cadl.org/about/hours-and-locations/holt-delhi
Midwest Collaborative for Library Services	(800) 530-9019	https://www.mcls.org/contact
Grand Ledge Area District Library	(517) 627-7014	

Services for Senior Citizens

Tri-County Office on Aging	(517) 887-1440	www.tcoa.org/
Senior Community Care of Michigan	(517) 319-0700	
Social Security Administration	(800) 772-1213	www.ssa.gov/

CLINTON COUNTY RESOURCES

Health		
Medical		
Sparrow Health System	(517) 364-1000	www.sparrow.org
Hospice of Michigan	(888) 247-5701	www.hom.org/
McLaren Greater Lansing	(517) 975-6000	www.mclaren.org/
McLaren Central Michigan	(989) 772-6700	www.mclaren.org/
Michigan Department of Health and Human Health	(800) 359-3722	www.michigan.gov/mdhhs/
Dental		
Donated Dental Services of Michigan	(866) 263-4067	http://icc.edu/
Lansing Community College Dental Clinic	(517) 483-1458	www.lcc.edu/hhs/programs/dental/#view4
Vision		
Eye Care of America	(800) 222-3937	www.eyecareamerica.org
Mental Health		
Association for Children's Mental Health	(517) 372-4016	www.acmh-mi.org/
Community Mental Health	(888) 230-7629	www.ceimcmh.org/
Community Mental Health/Clinton County Counseling Center	(989) 224-6729	www.ceimcmh.org/
Substance Use		
Alano Club East	(517) 482-8957	www.onlinealano.org/
Alcoholics Anonymous-Central AA Office	(517) 377-1444	www.aalansingmi.org/
Education		
Children		
Bath Community Schools	(517) 641-6721	www.bathschools.net/
DeWitt Public Schools	(517) 668-3000	www.dewittschools.net/
Fowler Public Schools	(989) 593-2250	http://fowlerschools.net/
Great Start Readiness Preschool Program	(989) 224-6831	www.clintongreatstart.org/

Ovid-Elsie Area Schools	(989) 834-2271	www.ovidelsie.org/
Pewamo-Westphalia Community School District	(989) 587-5100	www.pwschools.org/
St Johns Public Schools	(989) 227-4050	www.sjredwings.org/

Adults

Capital Area Literacy Coalition	(517) 485-4949	www.thereadingpeople.org/
Great Parents Great Start	(989) 224-6831	www.clintongreatstart.org/
Lansing Community College	(517) 483-1957	www.lcc.edu/

Child & Family Services

Capital Area Community Services, Inc. (CACS)	(989) 224-6702	www.cacs-inc.org/
Chance at Childhood	(517) 432-6880	www.chanceatchildhood.msu.edu/
Child Help USA Information Center	(800) 422-4453	www.childhelp.org/
Michigan Department of Health and Human Services	(800) 359-3722	www.michigan.gov/mdhhs
Early On	(800) 327-5966	https://www.1800earlyon.org/
EightCAP, Inc.	(616) 224-6831	www.eightcap.org/
Ele's Place	(517) 754-9315	www.elseplace.org/
Highfields	(517) 887-2762	www.highfields.org
Head Start	(989) 224-3427	www.cacsheadstart.org
Michigan Protection and Advocacy Service, Inc.	(800) 288-5923	www.mpas.org/

Housing

Habitat For Humanity	(989) 227-1771	www.habitatclinton.org/
Michigan State Housing Development Authority	(517) 373-8370	www.michigan.gov.mshda/

Clothing

Goodwill	(517) 669-2914	www.goodwillcmh.org/
Habitat for Humanity Clinton County Restore	(989) 227-0000	http://habitatclinton.org/the-restore/

Food

Bath Community Center	(989) 227-3396	
Bath Farmers' Market	(517) 712-2171	www.bathtownship.us/
Food and Nutrition Program Helpline	(800) 481-4989	

Greater Lansing Food Bank	(517) 853-7800	www.greaterlansingfoodbank.org
Transportation		
Clinton Area Transit System	(989) 224-8127	www.clintontransit.org/
Job Placement		
Michigan Works	(989) 224-2000	www.camw.org/
Disability Services		
ARC Michigan	(800) 292-7851	www.arcmci.org/
Emergency Services		
American Red Cross (Mid-Michigan Chapter)	(517) 484-7461	www.midmichiganredcross.org/
Capital Area United Way	(517) 203-5000	www.micauw.org
Community Resource		
Parks		
Motz County Park		https://www.clinton-county.org/364/Parks-Facilities
Libraries		
Briggs Public Library	(989) 224-4702	www.briggsdistrictlibrary.org
DeWitt Public Library	(517) 669-3156	www.dewittlibrary.org/
Dolly Parton's Imagination Library	(865) 428-9606	www.imaginationlibrary.com/
Elsie Public Library	(989) 862-4633	
Grand Ledge Area District Library-Wacousta Branch	(517) 626-6577	https://grandledge.lib.mi.us/about-us/
Maple Rapids Public Library	(989) 682-4464	www.wplc.org/mrpl/
Services for Senior Citizens		
C.A.C.S. Senior Information & Assistance Offices	(989) 224-6702	http://www.cacs-inc.org/
Tri-County Office on Aging	(517) 887-1440	www.tcoa.org/
Clinton County Senior Center and Drop in	(989) 224-4257	http://clintoncountychamber.org/business-directory/444/clinton-county-senior-center/

Health		
Medical		
American Cancer Society	(800) 227-2345	www.cancer.org
Ask a Nurse	(734) 434-7509	
Shiawassee County Health Department	(989) 743-2355	http://health.shiawassee.net
C.A.C.S.	(989) 723-3115	https://cacs-inc.org/
Child Health Screening EPSOT	(989) 743-2355	
Memorial Healthcare	(989) 723-5211	
National Eye Care Project (Age 65 & older)	(800) 222-3937	https://www.aao.org/eyecare-america
Respite Volunteers of Shiawassee County	(989) 725-1127	http://www.respitevolunteers.org/
Sparrow Health System	(989) 725-8710	
YMCA	(989) 725-8136	www.shiawasseeymca.org
Dental		
Senior Dental Program	(800) 589-2632	
Vision		
Vision and Hearing Screening	(989) 743-2355	http://health.shiawassee.net/Personal-Health/Vision-Screening-Program/
Mental Health		
Catholic Charities	(989) 723-8239	https://www.catholiccharitiesflint.org/contact-us/
Crisis Line	(989) 723-6791	
Memorial Healthcare Crisis Services	(989) 725-8101	www.memorialhealthcare.org
Parent Helpline	(800) 942-4357	
REACH (Family)	(810) 233-8700	www.reach-traverseplace.org/
Shiawassee Community Mental Health	(989) 723-6791	https://shiabewell.org/
Substance Use		
Narcotics Anonymous	(800) 338-1188	

Alcoholics Anonymous	(989) 723-5711	www.shiacoaa.org/index1.html
Catholic Charities	(989) 723-8239	www.catholiccharitiesflint.org/shiawassee/
Education		
Children		
Head Start	(989) 723-5849	http://www.sresd.org/District/Department/11-early-childhood/1327-Preschool-Programs.html
Great Start Readiness Program	(989) 725-2581	http://www.sresd.org/District/Department/11-early-childhood/1327-Preschool-Programs.html
Adults		
TIP (Low Income College Tuition Program) – Michigan Department of Health and Human Services	(888) 447-2687	
Shiawassee Regional Education Service District	(989) 743-3471	http://sresd.org/
Perry/Morrice Alternative/Adult Education	(517) 625-6116	
Community Education Owosso	(989) 729-5682	www.owosso.k12.mi.us
Community Education Durand	(989) 288-8704	
Community Education Corunna	(989) 743-6338	https://www.corunna.k12.mi.us/domain/57
Child & Family Services		
Big Brothers Big Sisters		www.bbbsmcr.org
WIC	(989) 743-2355	www.michigan.gov/mdhh
Looking Glass Community Services	(517) 651-6846	
Head Start	(989) 723-8151	www.cacsheadstart.org
Housing		
C.A.C.S.	(989) 723-3115	www.cacs-inc.org/
USDA Home Loan	(877) 432-5626	https://www.fedhomeloan.org/usda-home-loan-information-resources/
Habitat for Humanity	(989) 720-0381	https://www.sshfh.org/
USDA Rural Development	(810) 230-8766	
MI State Housing Development Authority (MSHDA)	(517) 695-8783	www.michigan.gov/mshda
Shiawassee County Housing Rehab	(231) 225-2619	
The Salvation Army	(989) 725-7485	http://www.salarmyowosso.org/

Clothing		
Baby Pantry	(989) 723-5877	http://cap-council.org/babypantry/
St. Vincent de Paul	(989) 723-4277	
Goodwill Family Store	(989) 723-9737	www.goodwill.org/
Food		
Baby Pantry	(989) 723-5877	
Bancroft Food Pantry	(989) 634-5724	
C.A.C.S.	(989) 723-3115	www.cacs-inc.org/
Shiawassee Hunger Network	(989) 723-8239	
MSU Extension	(989) 743-2251	https://www.canr.msu.edu/shiawassee/
Greater Lansing Food Bank	(517) 853-7800	www.greaterlansingfoodbank.org
Transportation		
American Red Cross	(989) 743-6118	www.redcross.org/
C.A.C.S.	(989) 723-3115	www.cacs-inc.org/
Shiawassee Regional Education Service District	(989) 725-8341	http://www.sresd.org/District/Department/7-Transportation
Shiawassee County MDHHS	(989) 725-3200	www.michigan.gov/mdhhs
SATA	(989) 729-2687	
Job Placement		
Career Alliance	(810) 233-5627	
Capitol Area Center for Independent Living	(989) 723-2556 ext. 162	www.cacil.org/
CACS - Senior Aides	(989) 723-3115	www.cacs-inc.org/
Human Investment & Development	(989) 723-1322	
Michigan Rehabilitation Services	(989) 725-7517 or 725-0040	
Michigan Works	(989) 729-6663	www.camw.org/
Mott College Employment Center	(989) 729-6663	
Shiawassee Rehabilitation Program	(989) 723-8205	
SVRC Industries	(989) 729-1942 or (989) 723-8205	
Unemployment Benefits	(989) 729-6663	

Veterans Employment Services	(989) 729-7685	
Disability Services		
The Arc Shiawassee	(989) 723-7377	https://arcmi.org/find-your-local-arc/shiawassee-county/
Special Olympics	(989) 498-0137	http://somi.org/area22/index.html
Capital Area Center for Independent Living	(517) 999-2760	www.cacil.org/
Shiawassee Regional Education Service District	(989) 743-3471	
Respite Volunteers of Shiawassee County	(989) 725-1127	http://www.respitevolunteers.org/
Michigan Rehabilitation Services		www.michigan.gov/mdhhs/0,5885,7-339-73971_25392---,00.html
National Alliance on Mental Illness	(517) 881-1796	https://www.namishiawassee.org/
Shiawassee Health and Wellness	(989) 723-6791	Shiawassee Health and Wellness
Emergency Services		
American Red Cross	(989) 743-6118	www.redcross.org/
Ambulance	911	
Shiawassee County Sheriff's Office	(989) 743-3411	http://web.shiawasseechamber.org/Government/Shiawassee-County-Sheriff%27s-Office-421
Fire	911	
Police	911	
Poison Control Center	(800) 222-1222	www.aapcc.org/
Community Resources		
Parks		
Geeck Road	(989) 743-2220	www.shiawassee.net/departments/county-parks
Henderson Park	(989) 743-2220	
Kerby Park	(989) 743-2220	
Lytle Road Park	(989) 743-2220	
Shiatown Park	(989) 743-2220	
Libraries		
Shiawassee District Library – Owosso	(989) 725-5134	www.sdl.lib.mi.us/

Durand Memorial	(989) 288-3743	http://sdl.lib.mi.us/
Services for Senior Citizens		
Shiawassee Council on Aging	(989) 723-8875	www.shiawasseecoa.org/
Respite Volunteers of Shiawassee	(989) 725-1127	http://www.respitevolunteers.org/
Memorial Healthcare - Home Health and Hospice	(989) 725-2299	https://www.memorialhealthcare.org/owosso-campus/
Alzheimer's Association	(989) 839-9910	http://www.kintera.org/site/c.frKOIVPGIuE/b.551423/k.CB68/Home.htm

MONTCALM COUNTY RESOURCES

Health		
Medical		
Spectrum Health Hospice	(616) 391-4250	/www.spectrumhealth.org/patient-care/hospice
Sparrow Health System	(517) 364-1000	www.sparrow.org/
Metro Health Hospital	(616) 252-7200	metrohealth.net/
Mercy Health St. Mary's	(616) 685-5000	www.mercyhealth.com
Sheridan Community Hospital	(989) 291-3261	www.sheridanhospital.com
Spectrum Health		www.spectrumhealth.org/
Mid-Michigan District Health Department	(989)-328-2200	www.mmdhd.org/
Dental		
Ferris State University	(231) 591-2260	www.ferris.edu
Grand Rapids Community College Dental Hygiene Clinic	(616) 234-4237	www.grcc.edu/dentalprograms/dentalclinic
Lansing Community College Dental Clinic	(517) 483-1458	www.lcc.edu/services/community-campus-resources/dental-clinic.html
Montcalm Area Community-Based Dental Center- Sidney	(989) 328-2200	www.mmdhd.org/dental-care/
Mental Health		
Montcalm Care Network	(989) 831-7520	http://montcalmcare.net/
Pine Rest Christian Mental Health Services	(800) 678-5500	www.pinerest.org/
Education		
Children		
Carson City-Crystal Area Schools	(989) 584-3138	www.carsoncity.k12.mi.us
Central Montcalm Public Schools	(989) 831-2000	www.central-montcalm.org
Greenville Public Schools	(616) 754-3686	www.greenville.k12.mi.us
Lakeview Community Schools	(989) 352-7221	www.lakeviewschools.net
Montabella Community Schools	(989) 427-5148	www.montabella.com
Tri-County Area Schools	(616) 636-5454	www.tricountyschools.com
Vestaburg Community Schools	(989) 268-5353	www.vcs-k12.net

Adults		
Central Montcalm Adult Education	(989) 831-2402	
Child & Family Services		
Big Brothers Big Sisters	(616) 225-1515	https://midmichiganbbbs.org/gratiot-montcalm-counties/
Michigan Department of Health and Human Services	(989) 831-8400	www.michigan.gov
EightCap Inc	(616) 754-9315	https://www.8cap.org/
Great Start Collaborative	(616) 225-6146	http://www.greatstartmontcalm.org/wp/
Great Start to Quality – Western Region Resource Center	(877) 614-7328	https://greatstarttoquality.org/western-resource-center
Great Start Readiness Program	(616) 225-6278	
MIChild/Healthy Kids	(888) 988-6300	www.michigan.gov/michild
Mid-Michigan District Health Department	(989) 831-5237	www.mmdhd.org/
Mid-Michigan Migrant Education	(989) 831-2000	http://central-montcalm.org/our-district/departments/elmigrant/
Montcalm Area Intermediate School District	(616) 225-4700	www.maisd.com
Montcalm County Great Start Collaborative	(616) 225-6166	www.greatstartmontcalm.org
Montcalm County Great Start Parent Coalition	(616) 225-6166	www.greatstartmontcalm.org/wp/parent-corner/parent-coalition/
Special Olympics Michigan	(616) 794-1783	www.somi.org
Housing		
Michigan Department of Health and Human Services	(989) 831-8400	www.michigan.gov
EightCAP, Inc. Community Service	(616) 754-9315	www.8cap.org
Greenville Housing Commission (HUD)	(616) 754-7179	http://greenvillemi.org/housing
Habitat for Humanity	(616) 754-5772	www.habitat.org
MI State Housing Development Authority (MSHDA)	(517) 373-8370	www.michigan.gov/mshda
Montcalm County Housing Commission (HUD)	(231) 937-4241	https://www.montcohsgcomm.org/
Salvation Army	(989) 463-2864	https://centralusa.salvationarmy.org/Alma/who-we-are/
USDA Rural Development	(616) 942-4111	www.rd.usda.gov
Clothing		
Alpha Family Center of Greenville	(616) 225-2265	www.alphafamilyservices.org/

Baby Pantries		http://www.greatstartmontcalm.org/wp/resources/baby-pantries/
Crystal Clothing Closet	(989) 235-4208	
East Montcalm Baby Pantry	(989) 268-5551	
Food		
EightCAP, Inc. Community Services for Referrals	(800) 221-2033	www.8cap.org
Montcalm County Food Pantries		www.liveunitedm-i.org/sites/liveunitedm-i.org/files/Montcalm-Ionia%20Counties%20Pantry%20List.pdf
Transportation		
Greenville Transit	(616) 754-9331	http://greenvillemi.org/transit/
Job Placement		
Goodwill Industries (for people with disabilities)	(616) 794-9845	www.goodwill.org
Michigan Works Service Center	(989) 772-5304	www.michiganworks.org
Telamon Corporation	(517) 323-7002	www.telamon.org
Disability Services		
Department of Human Services (State Disability)	(989) 831-8400	www.michigan.gov
Children's Special Health Care /Mid-Michigan District Health Department	(989) 831-3643	www.michigan.gov/mdhhs/0,5885,7-339-71547_35698---,00.html
Special Olympics Michigan	(989) 774-3911	www.somi.org
Emergency Services		
Ambulance	911	
American Red Cross	(800) 482-2411	www.redcross.org/
Burn Center	(616) 774-3940	www.spectrumhealth.org
Fire	911	
Michigan State Police	(989) 352-8444	www.michigan.gov/msp
Montcalm County Sheriff's Department	(989) 831-7590	www.montcalm.org/government/sheriff/index.php
Poison Control Center	(800) 222-1222	
Police	911	
Community Resources		
Parks		

Artman Park	989-831-7300	www.montcalm.us/community/community_m_-_z/recreation
Krampe Park	989-831-7300	
McCarthy Park	989-831-7300	
Schmeid Park	989-831-7300	
Ford Lincoln Park	989-831-7300	
The Carl Paepke Flat River Nature Park	989-831-7300	

Libraries

Carson City Public Library	(989) 584-3680	www.carsoncity.michlibrary.org
Crystal Community Library	(989) 584-3680	www.crystal.michlibrary.org
Flat River Community Library	(616) 754-6359	www.flatriverlibrary.org
Home Township Library	(989) 427-5241	www.edmore.llcoop.org
Montcalm Community College Library	(989) 328-2111	www.montcalm.edu/library
Reynolds Township Library	(231) 937-5575	www.tchrtl.michlibrary.org
Richland Township Library	(989) 268-5044	www.richlandtownshiplibrary.com
Seville Township Library	(989) 833-7776	www.seville.michlibrary.org
Tamarack Public Library	(989) 352-6274	http://tamaracklibrary.org/
White Pine Library	(989) 831-4327	www.whitepinelibrary.org

Services for Senior Citizens

EightCAP, Inc. Foster Grandparent & Senior Companion Program	(616) 754-9315	www.8cap.org
Elder Law	(866) 400-9164	www.elderlawofmi.org
Montcalm County Commission on Aging	(989) 831-7476	www.montcalm.org/departments_services/health_and_human_services/commission_on_aging.php

GRATIOT COUNTY RESOURCES

Health		
Medical		
Mid-Michigan District Health Department	(989) 875-3681	www.mmdhd.org/
Mid-Michigan Home Care and Hospice	(989) 839-1773	www.midmichigan.org/
Sparrow Medical Group Ithaca	(989) 875-4166	www.sparrow.org/
Dental		
Lansing Community College Dental Hygiene Clinic	(517) 483-1458	www.lcc.edu/services/community-campus-resources/dental-clinic.html
University Of Michigan Dental School	(734) 763-6933	www.dent.umich.edu/
Vision		
Lions Club	(989) 436-3162	www.lionsclubs.org/
Mental Health		
ASCC Therapy Solutions	(989) 779-9449	www.asccts.com/
Pine Rest Mental Health Services	(800) 678-5500	www.pinerest.org/
Substance Use		
ASCC Therapy Solutions	(989) 779-9449	www.asccts.com/
The Recovery Village Addiction and Alcohol Hotline	(844) 244-3171	www.therecoveryvillage.com/alcohol-abuse/alcohol-hotline/#gref
Education		
Children		
Alma Public Schools	(989) 463-3111	www.almaschools.net
Ashley Community Schools	(989) 847-4000	www.ashleyschools.net/
Beal City Public Schools	(989) 644-3901	www.bealcityschools.net/
Breckenridge Community Schools	(989) 842-3182	www.breckhuskies.org/
Fulton Schools	(989) 236-7300	www.fultonpirates.net
Mt. Pleasant Public School District	(989) 775-2300	www.mtpleasantschools.net
Shepherd Public School District	(989) 828-5520	www.shepherdschools.net

St. Louis Public Schools	(989) 681-2500	www.stlouisschools.net

Adults		
EightCAP, Inc.	(989) 463-5693	www.8cap.org
Fulton Alternative Education	(989) 236-5404	www.fultonpirates.net/Domain/34
Mid-Michigan Literacy Council	(989) 462-0130	
Mid-Michigan Migrant & ELL Program	(616) 794-4753	
Michigan State University Extension Office	(989) 875-5233	www.canr.msu.edu/gratiot/
Child & Family Services		
Boys and Girls Town National Hotline	(989) 463-3434	https://midmichiganbbbs.org/gratiot-montcalm-counties/
Family Support Network/CSHCS	(800) 359-3722	
Pregnancy Services of Gratiot County	(989) 466-2295	www.pregnancyservicesgratiot.com/
EightCAP, Inc. Head Start	(989) 463-5693	www.8cap.org
Women's Aid Service	(989) 463-6324	www.womensaidservice.org/
Housing		
Alma Housing Commission	(989) 463-4200	www.ci.alma.mi.us/1/307/alma_housing_commission.asp
EightCAP, Inc.	(989) 463-5693	www.8cap.org
Gratiot Emergency Housing Corporation	(989) 466-0709	https://gratiotemergencyhousingcorporation.com/
Salvation Army	(989) 463-2864	www.salvationarmyusa.org/
St. Louis Housing Commission	(989) 681-5100	www.stlouismi.com/1/stlouis/housing_commission.asp
USDA Rural Development	(800) 944-8119	www.rd.usda.gov
Clothing		
American Red Cross-Mid Michigan Chapter	(517) 484-7461	www.redcross.org/
Food		
American Red Cross-Mid Michigan Chapter	(517) 484-7461	www.redcross.org/
Greater Lansing Food Bank	(517) 853-7800	www.greaterlansingfoodbank.org
Gratiot County Human Services Department	(989) 875-5181	www.michigan.gov/mdhhs/
St. Vincent De Paul	(989) 828-5720	http://stvincentdp.com/

Transportation		
Alma Transportation Center	(989) 463-4444	
Job Placement		
Michigan Works Service Center	(989) 772-5304	http://www.michiganworks.org/agencies/county/Gratiot
Disability Services		
Project Find	(989) 875-5101	www.giresd.net/
Emergency Services		
EightCAP, Inc.	(989) 463-5693	www.8cap.org/
Emergency Housing Commission	(989) 466-0709	https://gratiotemergencyhousingcorporation.com/
Ambulance	911	
Fire	911	
Police	911	
Gratiot County Sheriff's Department	989-875-5211	http://www.gratiotmi.com/Law-Justice/Sheriffs-Office
Community Resources		
Parks		
Hubscher Park	989-875-5278	www.gratiotmi.com/Departments/Parks/Hubscher-Park
Luneack Park		www.gratiotmi.com/Departments/Parks/Luneack-Park
Pompeii Park		www.gratiotmi.com/Departments/Parks/Pompeii-Park
Reed Park	989-875-5278	www.gratiotmi.com/Departments/Parks/Reed-Park
Libraries		
Alma Public Library	(989) 463-3966	www.youseemore.com/alma/default.asp
Ithaca City Library	(989) 875-4184	www.ithacalibrary.michlibrary.org/
Seville Township Library	(989) 833-7776	www.seville.michlibrary.org
Services for Senior Citizens		
Gratiot County Commission on Aging	(989) 875-5246	www.gratiotmi.com/departments/commission-on-aging

IONIA COUNTY RESOURCES

Health		
Medical		
Ambulatory Care Clinic	(616) 522-9110	
Ionia Area Hospice	(616) 527-0681	http://ioniahospice.org
Ionia County Health Department	(616) 527-5341	www.ioniacounty.org/health/health-department/
Montcalm Area Health Center	(616) 225-9650	www.cherryhealth.org
Sparrow Ionia Hospital	(616) 523-1400	www.sparrow.org/sparrowionia
Spectrum Health Integrated Care Campus at Ionia	(616) 775-7500	www.spectrumhealth.org/locations/spectrum-health-integrated-care-campus-at-ionia
Dental		
Ferris State University Dental Hygiene Clinic	(231) 591-2260	www.ferris.edu
Grand Rapids Community College Dental Hygiene Clinic	(616) 234-4237	www.grcc.edu/dentalprograms/dentalclinic
Lansing Community College Dental Hygiene Clinic	(517) 483-1458	www.lcc.edu/services/community-campus-resources/dental-clinic.html
University Of Michigan Dental School	(734) 763-6933	www.dent.umich.edu/
Vision		
Saranac Lions Club	(616) 901-5473	www.lionsclubs.org/
Mental Health		
River's Edge Drop-in Center	(616) 522-9773	
The Right Door for Hope, Recovery and Wellness- Ionia Office	(616) 527-1790	www.rightdoor.org/
The Right Door for Hope, Recovery and Wellness -Belding Office	(616) 527-1790	www.rightdoor.org/
The Right Door for Hope, Recovery and Wellness - Portland Office	(616) 647-2128	www.rightdoor.org/
Montcalm Care Network	(989) 831-7520	www.mcbh.org/
Pine Rest	(800) 678-5500	www.pinerest.org/
Substance Use		
Journeys Counseling Center	(616) 523-9033	www.journeyshouseofhealing.com/
Two Rivers Counseling	(517) 647-4747	www.tworiverscounselingpc.com/

Education		
Children		
Belding Areas School District	(616) 794-4700	www.bas-k12.org/
Berlin Township School District	(616) 527-4900	
Easton Township School District	(616) 527-4900	
Ionia Public Schools	(616) 527-9280	www.ioniaschools.org/
Ionia Township School District	(616) 527-4900	
Lakewood Public Schools	(616) 374-8043	www.lakewoodps.org/
Saranac Community Schools	(616) 642-1400	www.saranac.k12.mi.us/
Adults		
Belding Community Education	(616) 794-4646	www.bas-k12.org/community-education/
Great Start Quality Central Resource Center	(877) 614-7328	http://greatstarttoquality.org/
Heartlands Institute of Technology	(616) 527-6540	www.ioniaisd.org/cte/
Ionia County Literacy Council	(616) 389-8529	www.ioniacountyliteracycouncil.org
Mid-Michigan Migrant Education & ELL Program	(616) 794-4753	www.bas-k12.org/mmmep/
Portland Alternative and Community Education	(517) 647-2987	www.portlandk12.org/5/Home
Child & Family Services		
Adoptive Family Support Network	(616) 458-7945	https://dabsj.org/what-we-do/adoption/post-adoption-support
Early On	(616) 527-4900	www.ioniaisd.org/earlychildhood/early-on/
EightCAP, Inc.	(866) 754-9315	www.8cap.org/
Enrich	(616) 522-1126	www.enrichioniami.org/
Friend Of the Court	(877) 543-2660	https://ioniacounty.org/courts/foc/
Ionia County Health Department	(616) 527-5341	https://ioniacounty.org/health/health-department/
Department of Community Health	(800) 642-3195	www.healthcare4mi.com/MISelfService/resources/portal/index.html
Planned Parenthood	(800) 230-PLAN	www.plannedparenthood.org
Women's Resource Center	(616) 458-5443	www.grwrc.org/
Housing		

Habitat For Humanity	(616) 523-6899	www.ioniahabitat.org/
Housing Assessment and Resource Agency (HARA)	(866) 754-9315 ext. 3335	
Michigan State Housing Development Authority	(517) 373-8370	www.michigan.gov/mshda
Saranac Housing Commission	(616) 642-9832	www.saranachousingcommission.org/
USDA Rural Development	(517) 324-5190	www.rd.usda.gov
Clothing		
EightCAP, INC	(866) 754-9315	www.8cap.org
Goodwill Retail Outlet Store	(616) 532-4200	www.goodwillgr.org/
Manna's Market	(269) 331-1943	www.mannasmarket.org/
Mel Trotter Ministries	(616) 454-8249	www.meltrotter.org
Seventh Day Adventist Church	(616) 527-6465	
Food		
Manna's Market	(269) 331-1943	www.mannasmarket.org/
Portland Area Service Group	(517) 647-4004	
Transportation		
Belding Dial-A-Ride	(616) 794-3278	
Dial-A-Ride	(616) 527-4000	www.ci.ionia.mi.us/dial-a-ride.php
Job Placement		
Manpower	(616) 527-6688	www.manpower.com/
West Michigan Works! Service Center	(616) 389-8525	www.michworks.org/
Disability Services		
Children’s Special Health Care Services	(616) 527-5341	https://ioniacounty.org/health/cshcs/
Special Olympics Michigan	(800) 644-6404	www.somi.org/
Emergency Services		
American Red Cross	(800) 733-2767	www.redcrossggr.org/
Michigan State Police	(989) 352-8444	http://michigan.gov/msp
Ambulance	911	

Police	911	
Fire	911	
Department of Human Services	(616) 527-5200	www.michigan.gov/mdhhs
Lakewood Community Council	(616) 374-3117	

Community Resources		
Libraries		
Alvah N. Belding Memorial Library	(616) 794-1450	www.belding.michlibrary.org
Clarksville Area Library	(616) 693-1001	www.clarksville.michlibrary.org/
Dolly Parton Imagination Library	(865) 428-9606	www.imaginationlibrary.com/
Hubbardston Library	(989) 981-6106	
Ionia Community Library	(616) 527-3680	www.ioniacommunitylibrary.org
Lake Odessa Community Library	(616) 374-4591	www.lakeodessalibrary.org/
Portland District Library	(517) 647-6981	www.pdl.michlibrary.org/
Services for Senior Citizens		
Ionia County Commission on Aging	(616) 527-5365	https://ioniacounty.org/health/commission-on-aging/
Grandparents Raising Grandchildren		http://raisingyourgrandchildren.com/Index.htm

Appendix B: Focus Group Discussion Guides

Sparrow Carson Hospital, Sparrow Ionia Hospital, and Sparrow Specialty Hospital Focus Group Discussion Guide

1. **What is your vision for a healthy community?**
    a. In an ideal situation, what types of programs or services would be available to improve the health of people living in this community?
    b. What features should these programs/services have?

2. **Where is this community now in terms of its health needs?**
    a. What are the community's greatest health-related strengths and assets?
    b. What are this community's most critical health needs?
    c. What are the factors causing the health needs in this community?
        i. How do social or economic conditions influence health in the community?
        ii. What resources are available to address the factors causing the health needs in this community?
    d. How would you describe the community's attitudes about health?
        i. What affects community members' attitudes toward health?
    e. To what extent are existing resources and services adequate and/or easily accessible?

3. **What else does the community need to be healthy?**
    a. Which types of programs/services do you think are absolutely essential to this community?
    b. What can be done to improve access to programs and services?
    c. What do you think the role of a hospital or health system, like Sparrow Hospital Name, should be in addressing these health needs?
        i. …either on its own or in collaboration with other programs or organizations?

4. **Is there anything else we should know about the health needs of this community?**

Sparrow Clinton Hospital Focus Group Discussion Guide

1. **Prevention/Early Detection of Signs & Symptoms**
    a. Thinking about the last time you visited the emergency department, what signs and symptoms were you experiencing?
        i. What do you think lead to your symptoms becoming worse?
    b. What factors did you consider when you chose to visit the emergency department versus another type of medical provider (i.e. primary care, urgent care)?
    c. {Hand out the patient education guide}: Were you given something like this to help you identify signs and symptoms you should watch for?
        i. If not, to what extent would this guide have been helpful to you in deciding where to go for medical care?
        ii. If yes, to what extent did the guide help you identify appropriate steps to take given your signs and symptoms at the time?
        iii. If you were experiencing signs and symptoms in the yellow zone, what would you do next?

2. **Access to Care**
    a. What barriers exist to receiving preventative care and staying out of the hospital?
        i. Probe: For example, hours at primary care provider's office, transportation, issues with insurance?
        ii. What can be done to reduce these barriers or make it easier to receive primary care services?

iii. Did you experience any delays in your care?
    1. If so, what were the delays and how did they affect you?

b. To what extent are the primary care services in this community adequate and/or easily accessible?
    i. What types of services do you need that are not available?

3. Supports and Services Needed to Manage their Condition and Stay Out of the Hospital *("Support" refers to clinical, psychological, emotional, financial or other needs.)*

a. Before you were discharged from the hospital, what services were offered to you?
    i. At discharge, what questions did you still have about your follow-up care or the treatment provided to you?
        1. Did you receive discharge instructions? How/were they explained to you?
        2. To what extent were the discharge instructions clear and easy to understand?
    ii. Did someone help you schedule an appointment with your primary care provider before you left the hospital?
        1. Did you attend this appointment? Why or why not?
    iii. Did your primary care provider's office call you within 48 hours of discharge to follow-up with you?
        1. To what extent were your questions answered and needs addressed?
    iv. To what extent were these services helpful to you?

b. Which programs and services are most helpful to you in staying out of the hospital?
    i. Why are they the most helpful?

c. What types of services or programs to help you stay out of the hospital are missing/not available in Clinton County?
    i. Why are these services or programs important to have?

4. Conclusion

a. Is there anything else we should know about how Sparrow Clinton Hospital can help you manage your symptoms and stay out of the hospital?

Appendix C: Key Informant Interview Questions

Key Informant Interview Questions

1. Could you please tell me a little about yourself and your role in working to improve the health of the community?
    a. What is your vision for a healthy community?

2. What are this community's most critical health needs?
    a. To what degree are the healthcare services or programs that promote healthy lifestyles in this community adequate and/or accessible?
        i. To what extent are needed primary and/or specialty care services available and/or accessible? *{Sparrow Carson Hospital and Sparrow Ionia Hospital only}*
    b. What can be done to improve access to programs and services?

3. What are the factors causing the health needs in this community?
    a. How do social or economic conditions influence health in the community?

4. What do you see as the community's assets and resources?
    a. Which types of programs/services do you think are absolutely essential to this community?
    b. What resources are available to address the factors causing the health needs in this community?

5. What do you think the role of a hospital or health system, like Hospital Name, should be in addressing these health needs?
    a. …either on its own or in collaboration with other programs/organizations?
    b. (If the participant is a medical provider…): To what extent have you heard about the PATH program for diabetes management? Do you refer people to this program? Why or why not? *{Sparrow Carson Hospital and Sparrow Ionia Hospital only}*

6. Is there anything else you would like to tell me about the health needs of this community?