2025-2027 Community Health Improvement Plan

CLINTON * EATON * INGHAM

Healthy!CapitalCounties℠
a community approach to better health

Get Involved in the CHIP

Healthy! Capital Counties is always seeking new partners in the Tri-County area to join our stakeholders. We invite participation from individuals and organizations across all areas of the Capital Area. We encourage stakeholders to share this plan, along with any actions being taken to achieve its goals, with the Healthy! Capital Counties core team (contact information can be found on page 3). This report is updated twice, once a year after publication and then again 6 months later. Any updates to this report can be found on **https://www.healthycapitalcounties.org/.**

Stakeholders receive monthly email communications regarding current CHA/CHIP projects, are invited to quarterly large-group stakeholder meetings, and are invited to join Priority workgroups. Stakeholders are encouraged to get as involved as they are able to - whether that is through only receiving email updates or joining a workgroup and creating a CHIP activity. Stakeholders can help Healthy! Capital Counties to decide CHA directives, vote on priorities, and initiate CHIP activities. If you would like to join as a stakeholder, please email Kara Trimbach Shirley at **kshirley@ingham.org.**

Acknowledgements

This report could not be possible without the dedication and hard work of the organizations, community coalitions, residents, and agencies that contributed to our Community Health Improvement Plan (CHIP) goals, objectives, strategies, and activities. We sincerely thank our partners for their consistent time and work that they have invested in our Clinton, Eaton, and Ingham County CHIP. These dedicated partnerships continue to strengthen Capital Region efforts towards improved community health outcomes, and much of the continued success with this CHIP can only be attributed to these entities. A complete list of stakeholders can be found at the end of the report.

We also acknowledge the hard work and dedication of the members of the Healthy! Capital Counties collaborative (Eaton Rapids Medical Center, McLaren Greater Lansing, University of Michigan Health - Sparrow, Barry-Eaton District Health Department, Ingham County Health Department, and Mid-Michigan District Health Department). Healthy! Capital Counties has served as the regional Community Health Profile and Health Needs Assessment since 2012. This cycle marks only the second time the collaborative has worked on a truly region-based CHIP. We look forward to continuing this collaborative, Tri-County approach to improving our community's health.

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Introduction

The Capital Region, made up of Clinton, Eaton, and Ingham Counties, completes the Community Health Assessment (CHA) every three years to inform the Community Health Improvement Plan (CHIP). The 2025 CHIP is the fifth in a continuous series of CHAs that Healthy! Capital Counties has undertaken since its inception in 2012. This cycle also marks the second time the CHIP has been developed regionally through the collaborative. The partners at Healthy! Capital Counties are excited to announce a modified CHIP approach designed to weave community health and well-being into the fabric of our entire community.

The 2025 CHIP is designed to address the needs and gaps identified in the 2024 CHA, with a focus on integrating health equity, policy, social well-being, and collaborative, long-term community action. The COVID-19 pandemic helped to pave the way for an era of closer partnership between health departments and many community organizations, demonstrated in regional initiatives and coordinated responses to health threats and evolving policies. This closer relationship between community organizations helped Healthy! Capital Counties decide to continue the regional approach to the CHIP with the goal of making a larger impact together than each county could make separately.

The 2024-2027 CHA/CHIP cycle chose three priorities: Access to Care, Behavioral Health, and Housing. Each of these three priorities were chosen in the previous CHA/CHIP cycle, marking a continuous community need. Healthy! Capital Counties partners continue to deeply consider the social determinants of health (SDOH), like housing and food access, when deciding the priorities for the Tri-County region. The partners involved with the CHA/CHIP continue to grow and expand as more organizations see the need for community collaboration to improve the root cause of health outcomes and inequities. For the 2025-2027 CHIP, **23 community partners** committed to **73 activities** designed to advance the health of the Capital Region.

CHIP Priorities for 2025-2027 are:

Access to Care
Behavioral Health
Housing

Vision

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

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

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

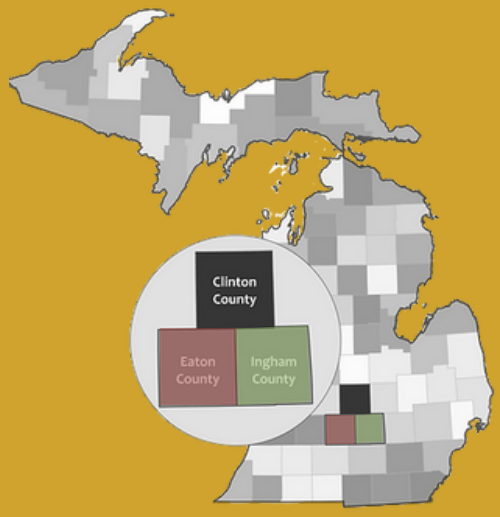
with minimal barriers and adequate resources to reach their full potential

Purpose

The purpose of this CHIP is to address the priorities identified in the 2024 Tri-County CHA and create actionable steps to improve our Capital Area region through collaborative efforts of community partners. Within this plan, goals, objectives, strategies, and activities are created and implemented to improve the health and well-being of the entire community. The CHIP is developed and executed through rigorous and continuous collaboration with a diverse group of community organizations. Healthy! Capital Counties will coordinate and lead priority group meetings and help to facilitate the implementation of the 2025-2027 CHIP.

Geographic Area

The Capital Area, made up of Clinton, Eaton, and Ingham counties, is connected by shared economic, social, and geographic ties, with Lansing and East Lansing serving as the regional hub. While Lansing functions as Michigan's capital and a major urban center, the surrounding area includes a mix of community types including college towns, older suburbs, rural farmland, and small outlying villages. Health services are provided through both large hospital systems and smaller local providers, reflecting the area's urban–rural mix. Healthy! Capital Counties serves residents across all three counties, with attention to regional patterns as well as the unique needs of individual communities.



Tri-County Capital Area

Geography	Total Population	Median Age	Total Households	Median Household Income	Live Births	Deaths
Clinton	79,419	41.8	31,314	$85,928	765	741
Eaton	109,000	41.2	45,115	$78,025	1,097	1,234
Ingham	282,015	33.3	116,566	$64,354	2,772	2,530
Tri-County	470,434	36.6	192,995	$71,050	4,634	4,505
Source:	**2023 ACS 5-year Estimates, Table S0101**	**2023 ACS 5-year Estimates, Table S0101**	**2023 ACS 5-year Estimates, Table S2503**	**2023 ACS 5-year Estimates, Table S2503**	**2023 MDHHS Vital Statistics 5-year averages**	**2023 MDHHS Vital Statistics 5-year averages**

Geography	White/ Non-Hispanic		Black/ African American		Asian		Additional Races*		Hispanic/ Latino	
	%	Change from 2022 Cycle	%	Change from 2022 Cycle	%	Change from 2022 Cycle	%	Change from 2022 Cycle	%	Change from 2022 Cycle
Clinton	89.6%	-2.6	1.7%	-0.2%	1.4%	0.0%	7.3%	2.8%	5.1%	0.5%
Eaton	82.5%	-3.2%	7.0%	0.0%	2.2%	-0.2%	8.2%	3.4%	6.2%	0.7%
Ingham	70.4%	-3.3%	11.8%	0.0%	6.3%	-0.4%	11.6%	3.7%	8.7%	0.7%
Tri-County	76.5%	-3.1%	9.0%	-0.1%	4.5%	-0.3%	10.1%	3.5%	7.5%	0.6%
Source	2023 ACS 5-Year Estimate Table	2023 ACS 5-Year Estimate Table	2023 ACS 5-Year Estimate Table	2023 ACS 5-Year Estimate Table	2023 ACS 5-Year Estimate Table	2023 ACS 5-Year Estimate Table	2023 ACS 5-Year Estimate Table	2023 ACS 5-Year Estimate Table	2023 ACS 5-Year Estimate Table	2023 ACS 5-Year Estimate Table

*Additional races includes American Indian/Native American, Native Hawaiian/Pacific Islander, Multiracial, and other races.

Race and Ethnicity were measured as separate variables; therefore the sum of percentages of race and ethnicity variables may not add up to 100%. Race variables may contain individuals who identify as Hispanic or Latino. Arab ethnicity is not available in ACS data tables.

About the Plan

Description of the CHIP

The Community Health Improvement Plan (CHIP) is a strategic, community-driven, and measurable work plan that guides health departments, partners, and residents in improving the health of the population. This plan begins with the Community Health Assessment (CHA), where data are collected from qualitative and quantitative sources and analyzed to identify both community strengths and areas for improvement. The CHIP then utilizes these findings to inform a collaborative effort among a wide range of organizations, schools, businesses, healthcare systems, and institutions to address priority health issues and enhance the well-being of the entire community. This plan is critical for developing policies and defining actions, and its success is rooted in the understanding that we are more effective when we work together than as individual entities.

Healthy! Capital Counties is a partnership between the health departments and hospital systems serving the Tri-County area in which the City of Lansing lies. Since 2012, Mid-Michigan District Health Department (representing Clinton County), Barry-Eaton District Health Department (representing Eaton County), and the Ingham County Health Department have worked together to conduct the regional CHA and CHIP. The Healthy! Capital Counties team works alongside the Tri-County area's hospital systems - Eaton Rapids Medical Center, McLaren Greater Lansing, and University of Michigan Health-Sparrow - and several community organizations that act in the public health field including the Community Mental Health Authority of Clinton, Eaton, and Ingham Counties, area libraries, and other dedicated stakeholders committed to improving the social determinants of health.

About the Plan

How CHA was conducted

The CHA is a year-long data collection and analysis project that culminates in a report (that can be found at **healthycapitalcounties.org**). The 2024 CHA was informed by data from both primary and secondary sources. Surveys and focus groups provided personal insights from community members, while a wide range of health indicators were collected from sources like the Behavioral Risk Factor Surveillance System and the Michigan Profile for Health Youth. Epidemiologists and health analyst staff across the three counties' health departments worked to ensure applicable measures were analyzed to inform a comprehensive understanding of health and wellbeing in the Tri-County area.

Selecting priority areas

H!CC adopted a new approach to priority area selection this cycle to ensure equitable decision-making. All findings from the focus groups, surveys, and secondary data were first presented to the steering committee, which collaboratively discussed each potential priority area. This method aimed to mitigate potential biases and ensure a comprehensive selection process. The steering committee employed Strategy Grids and consensus-building to determine priority areas, with unresolved issues to be voted on by the larger stakeholder group. Ultimately, the steering committee unanimously selected two priority areas: Access to Care and Behavioral Health, both of which were also prioritized in the previous cycle. The steering committee was unable to reach a consensus on the final two possible priority areas: Housing and Food Access. This was then brought to the larger stakeholder group at the Data Party for a final vote, where Housing was selected.

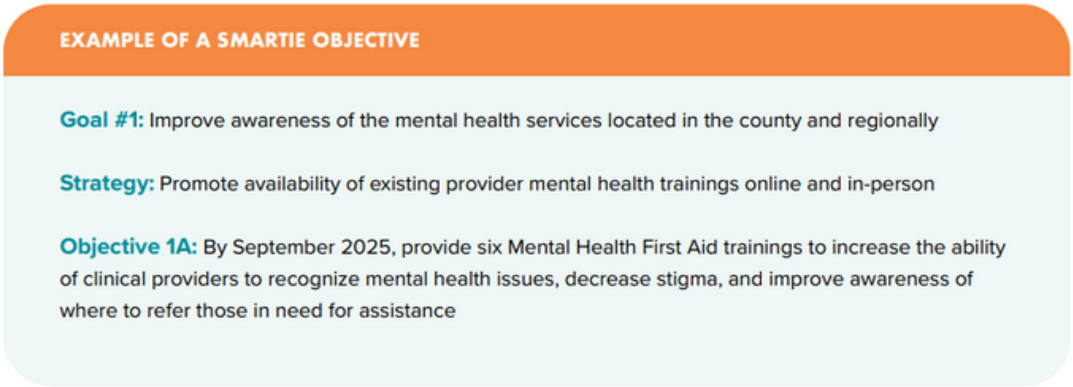
About the Plan

How goals were selected

After the Data Party, a hybrid CHIP Priority Workshop was held for stakeholders to give an overview of the CHIP process and to choose which priority area(s) individual stakeholders wanted to work on. Stakeholders were divided into breakout rooms to brainstorm 1-3 goals for each priority area. This discussion was led by a H!CC lead with a facilitation guide to help structure the conversation, answer questions, and promote collaboration. Goals were chosen within the priority groups by consensus. Additional goals were added to priority areas, if needed, based on the activities submitted after the CHIP Priority Workshop and were shared out at Priority Group meetings to establish a consensus.

Activity worksheet description

Organizations were asked to design SMARTIE objectives pursuant to the goals selected during and after the CHIP Priority Workshop. An example of this can be found in the image below. These objectives were defined as Specific, Measurable, Ambitious, Realistic, Time-bound, Inclusive, and Equitable, and they serve to ensure the team is able to effectively measure our impact on the health priorities most salient to Tri-County residents. Organizations then described the activities or interventions they will use - complete with measurements informing their success - to achieve those objectives.



About the Plan

Health Equity, Social Justice, and Social Determinants of Health

What consists of a healthy community? A truly healthy community is one that recognizes and integrates physical health with mental health and social factors, all of which play a crucial role in the well-being of individuals and the community as a whole.

For a healthy community to thrive, health equity must exist. Health equity means everyone has a fair and just opportunity to attain their highest level of health. This requires the equitable distribution of resources and opportunities necessary to achieve well-being and improve the quality of life. H!CC strives to promote equitable values in our work especially as it relates to the community. The CHIP is an example of how our counties collaborate to address health inequities in our communities.

There are several factors that may lead to poor health outcomes and health inequities such as income, neighborhood, education level, access to resources, safety, and social connection. These non-medical factors are called social determinants of health (SDOH), which influence the overall health and well-being of individuals, communities, and jurisdictions.

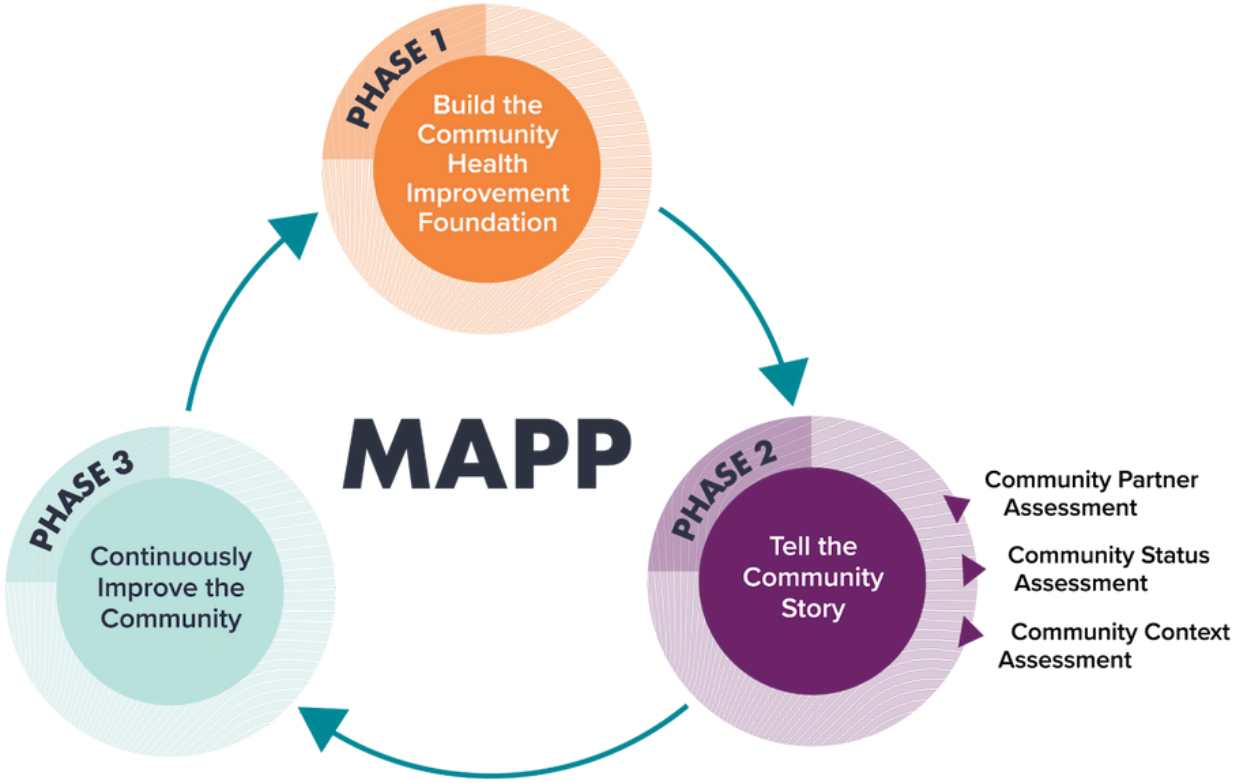
An important aspect of achieving health equity is to address the root causes of health inequities, which are systemic issues. Poverty, discrimination, and power imbalances often stem from systems that impose their values on marginalized communities. These issues can lead to high-level forms of oppression at the structural and institutional level. Understanding systemic issues that lead to oppression is necessary for improving health outcomes in the community.

It is important for the community to work together to address health inequities, social determinants of health, and systemic issues to ensure our communities are healthy and thriving. This CHIP will not only address these issues but also aim to work towards a goal to address health inequities of the entire Tri-County area.

MAPP 2.0 Framework

Healthy! Capital Counties follows the Mobilizing for Action through Planning and Partnership (MAPP) framework when conducting the CHA and CHIP. MAPP was developed by the National Association of County and City Officials (NACCHO). An update to the MAPP framework was made in 2023 and coined MAPP 2.0. The goal of the MAPP 2.0 framework is to achieve health equity by identifying urgent health issues in a community and aligning community resources.

MAPP 2.0 provides a framework that is amenable to Public Health Accreditation Board (PHAB) standards, which set a number of minimum criteria for the nature, content, and performance of a CHA by a local health department. MAPP 2.0 assists with providing structure for communities to address priority health issues by simplifying the ongoing and continuous process into three phases. As the figure below suggests, MAPP 2.0 serves as H!CC's "community road map to health."



CHIP Priority Workshop

On January 15, 2025, Healthy! Capital Counties hosted a CHIP Priority Workshop at the Ingham County Health Department. The goal of the CHIP Priority Workshop was to have an initial meeting of all Priority groups (Access to Care, Behavioral Health, and Housing) and to create Goals for each group. The session began with a presentation from Healthy! Capital Counties staff providing an overview of the CHA findings, a refresher on the purpose and process of the CHIP, and a highlight of current grant opportunities that could support future CHIP strategies. An AmeriCorps member introduced community resilience as a cross-cutting theme and discussed how it could be integrated throughout the CHIP process as part of H!CC's goal of exploring root causes and structural and institutional barriers to health.

Following a short lunch break, participants moved into priority-specific breakout rooms, each focused on one of the health priorities identified from the CHA. The primary purpose of these sessions was to initiate the development of 1–2 broad goal statements per priority area and begin identifying 2–4 measurable objectives that would guide action planning. Participants also engaged in brainstorming activities to surface potential strategies, programs, or partnerships that could support objective implementation.

The workshop concluded with a brief report-out and discussion of next steps, including timelines for completing the CHIP and establishing workgroups for strategy development.

As a follow-up to the workshop, a second CHIP stakeholder meeting was held virtually on May 21, 2025. During this session, attendees reconvened in priority-specific breakout groups to review submitted activities and develop overarching strategies aligned with each goal. Afterward, each workgroup began meeting independently on a recurring basis, with meeting frequency determined by each individual group.

CHIP Mini-Grants

Ingham County Health Department, in collaboration with Healthy! Capital Counties, launched a mini-grant opportunity to support the implementation of CHIP activities in Ingham County. This grant aimed to address key health priorities - Access to Care, Behavioral Health, and Housing - through community-driven projects and to increase participation within the CHIP. A total of $45,000 was available, with a maximum award of $15,000 per organization, for projects running from May 2025 through the end of this CHIP cycle in September 2027. This was the first time that a CHIP Mini-Grant was offered for CHIP stakeholders and their activities.

The CHIP Mini-Grant process was designed to be fair and transparent, making the application process accessible for every organization, from the smallest community groups to large, experienced entities. The grant Request for Proposal (RFP) clearly outlined all grading information, detailing the evaluation process, criteria, and scoring scale. Two virtual opportunities were provided for feedback and questions, consisting of a webinar that explained the grant RFP and an open Q&A session. The RFP included the application questions along with the link to the actual application, which was completed through Alchemer.

The CHIP Mini-Grants funded six projects, totaling the full $45,000. These funded projects included activities in Access to Care and Housing with projects funded from May 1, 2025 through September 30, 2027.

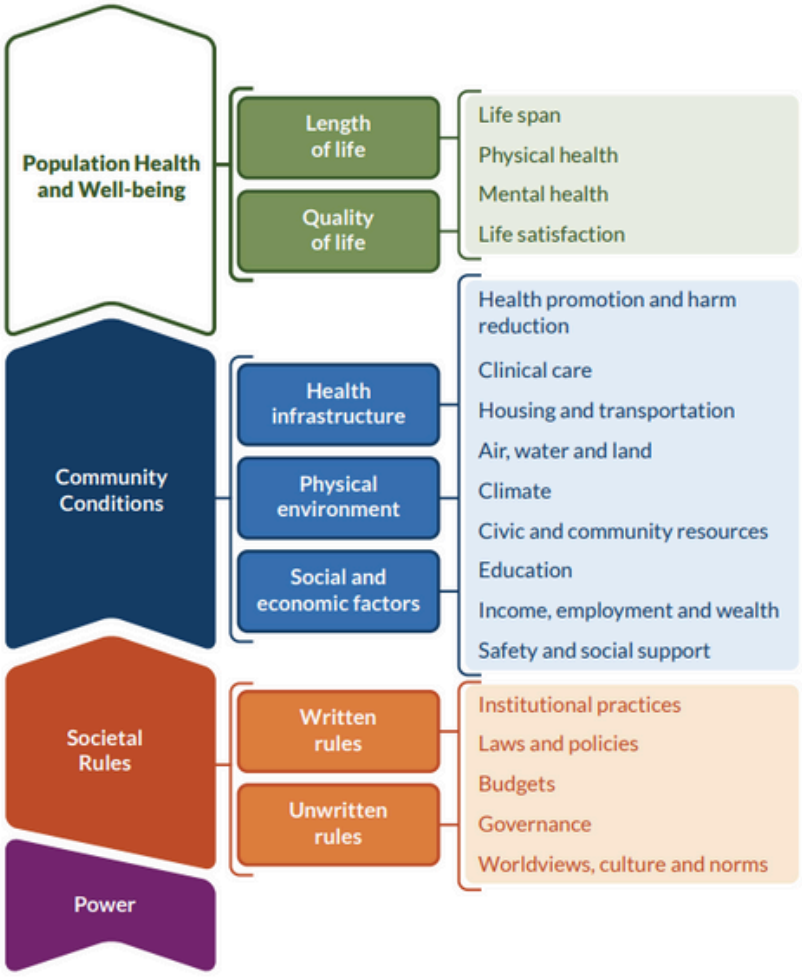
Funded projects include:

- Increasing access to healthcare and health education in the Eastside of Lansing
- Gathering and distributing emergency supplies to people who are unhoused (2 organizations were funded)
- Providing support for low-income and refugee families
- Helping to stock personal care items at local schools
- Increasing access to maternal healthcare resources with a primary focus on Black mothers

Policy Priorities

Healthy! Capital Counties acknowledges that many aspects of health are directly related not just to personal choices, but to outstanding factors including local, state, and federal laws and policies. For this reason, the CHIP includes policy recommendations on the three priority areas of Access to Care, Behavioral Health, and Housing.

In alignment with the CHA priorities, the CHIP includes policy priority areas and recommendations that focus on those three priority areas.



University of Wisconsin Population Health Institute Model of Health © 2025

The CHIP policy priorities provide recommendations, education, and health advocacy to policies and legislation that promote quality access to care, specifically policies that expand Medicaid, reduce barriers to receiving care, and promote preventative services that reduce emergency services.

For housing, the CHIP policy priority is focused on legislation that reduces the barriers to accessing affordable and safe housing, expansion on all types of housing including rental housing, permanent housing, and short-term shelter housing.

For behavioral health, the CHIP policy priority advocates for policies that promote harm reduction services, improve access to mental healthcare services, and address youth mental health.

Health In All Policies

Healthy! Capital Counties utilizes a Health in All Policies (HiAP) framework to improve health outcomes and ensure that policies, procedures, or initiatives are firmly rooted in health equity. The core principle of the HiAP approach is to ensure that all policies have a neutral or beneficial impact on the SDOH for affected communities. This approach is critical to upholding diverse community voices in the decision-making process and ensures both accountability and sustainability.

The Michigan Department of Health and Human Services (MDHHS) uses a HiAP approach with key elements including 1) cross-sector collaboration; 2) applying a health equity lens; 3) identifying shared goals and co-benefits for multiple partners; and 4) promotion of structural change and sustainability. Healthy! Capital Counties embrace these key elements throughout the CHA and CHIP. Strategies for utilizing these elements are implemented through authentic community engagement to raise voices and ensure meaningful listening, maintaining an open feedback loop for CHA/CHIP stakeholders, and actively identifying ways to engage with community-identified concerns.

In 2020, Ingham County passed resolution #20-022 “To Address and Reduce Implicit Bias in All County Decision-Making by Developing And integrating an Equity Review Process And Health in All Policies Approach”, recognizing the need for a Health in All Policies policy to ensure equity in decision-making processes across all aspects of Ingham County. Following the resolution, a HiAP Taskforce was established to create the policy and procedure that will ensure all new and revised county policies adhere to a HiAP approach.

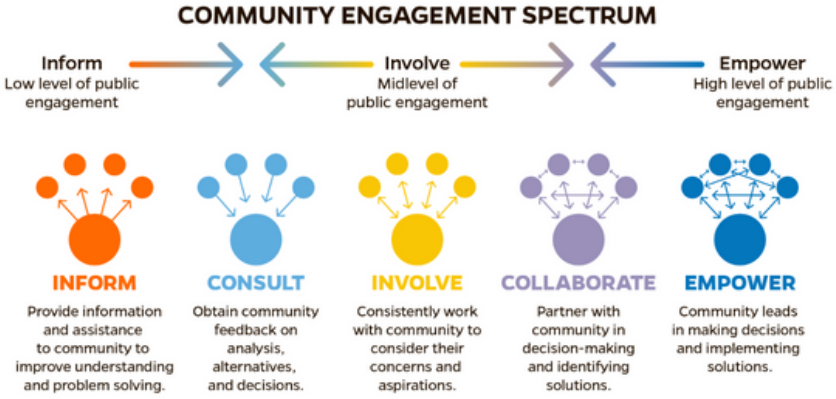
The Region 7 SDOH Hubs - a Tri-County initiative funded and supported by MDHHS - uses a HiAP framework for grant writing and selection processes. Grant applicants are required to complete a HiAP Checklist that evaluates how their proposed project meets a HiAP standard by addressing the four key elements of the framework.

Health Equity Council

The Ingham County Health Department received grant funding in 2022 to establish a Regional Health Equity Council (HEC). This initiative was sponsored by the Michigan Department of Health and Human Services (MDHHS) Office of Equity and Minority Health in partnership with the Michigan Public Health Institute, and it was one of eleven Regional Health Equity Councils formed across the state. The original intent for the HEC was to provide backbone organizations (the Ingham County Health Department and the Capital Area Health Alliance) with funding to locally address COVID-19 disparities within Black, Indigenous, and People of Color (BIPOC) communities who were disproportionately impacted by the pandemic.

Community members representing the region joined this initiative to serve on the HEC. This established a group of people from the community committed to centering equitable decisions, uplifting consensus building, and practicing facilitative leadership. The HEC went on to re-grant dollars to over twenty community-based organizations, both large and small, that were doing critical work to address disparities in BIPOC communities. A key step taken in the project's first year was to establish compensation for council members' time, a practice that continues today. Like many public health entities, funding for this council was taken back in 2025. The Ingham HEC secured an alternative funding stream that allowed it to remain in place and continue its work. Today, the HEC ensures that Black, Brown, and Indigenous representation is uplifted and honored through community-led engagement, having expanded its focus to other specific issues such as the SDOH Hubs, the CHIP/CHA process, and facilitating essential community dialogues.

Healthy! Capital Counties, in partnership with the HEC, has plans to work more closely together with the council in the 2027-2030 CHA/CHIP cycle. This may include having a paid Health Equity Council member sit on our steering committee, obtaining feedback and advice from the council, and utilizing their expertise within the community. Healthy! Capital Counties will continue to improve its community engagement by enhancing how it interacts, listens, and collaborates with the local community.



CHIP Terminology

Community Health Assessment (CHA): A process that engages with community members, hospital systems, and partners to systematically collect and analyze qualitative and quantitative health-related data from a variety of sources within a specific community. The findings of the CHA are presented in the form of a community health profile and inform the prioritization of health problems, guide community decision-making, and support the development and implementation of CHIPs. This process is repeated every 3-5 years to ensure availability of recent data.

Community Health Improvement Plan (CHIP): An action-oriented plan outlining the prioritized community health issues (based on the CHA findings and community member, provider, and partner input) and how these issues will be addressed - including strategies and measures to ultimately improve the health of a community over the course of 3-5 years. The CHIP is developed through the community health improvement process.

Evidence-Based: Strategies that are backed by research and scientific findings and recommended by trusted sources.

Lead Role: The partner on a specific strategy for one of the priority areas, that will be the primary contact for monitoring of tactics and implementation of that strategy. They may collaborate on data collection, the priorities and the plan, but each partner has flexibility to tackle the priorities and implement actions for which they are best suited.

Priority Area: One of a few community health and/or public health system needs or assets identified during a data analysis process, as the targets/subjects of a CHIP. Determination of the region's strategic priority areas are based on a combination of factors.

Goals: Broad or long-term outcomes that set the direction for addressing priority issues and measuring progress. Goals should be specific, easy to understand and direct. Each priority area has at least one goal.

Strategies: Strategies are activities that organizations will perform to achieve the desired outcome and are community-wide efforts that help address the root cause of the priority issue. A goal may have one or multiple strategies.

Objectives: Specific steps that lead to the successful completion of a goal and implementation of a strategy. Each strategy has at least one objective.

Activity: Concrete tasks that fulfill the objective**.** Each objective has at least one activity.

Performance Indicator: The direct results of an activity and how it will be measured.

Priority Areas

01. Access to Care

GOAL: Promote Health Through Better Access to Quality Health Care

02. Behavioral Health

GOAL: Ensure Mental Health and Substance Use Services are Accessible, Available, and Appropriate for All

GOAL: Improve and Expand Mental Health and Substance Use Supports to Ensure a Healthy and Effective Workforce

03. Housing

GOAL: Increase Housing Education and Knowledge

GOAL: Build and Strengthen Community Support to Address Housing Related Factors that Influence Health and Well-being

Access to Care

GOAL: Promote Health Through Better Access to Quality Health Care

Access to care has consistently emerged as a critical need and a legacy priority area in every CHA conducted by H!CC since its first CHA in 2012. This ongoing designation is strongly supported by recent data on healthcare access.

Access to care is significantly influenced by the availability of healthcare providers within a community. The Primary Care Provider (PCP) ratio, which measures the population per one provider, serves as a key indicator, with higher ratios suggesting fewer PCPs relative to the population. Across the Tri-County area, Clinton and Eaton Counties consistently exhibit notably higher PCP ratios compared to Ingham County. For instance, in 2019, Clinton County reported 3,316 residents per PCP, and Eaton County had 2,689, in stark contrast to Ingham County's 952. By 2021, while Clinton County saw a slight improvement to 3,309 and Eaton County's ratio worsened to 3,026, Ingham County's ratio continued to be significantly lower at 866 (United States Health Resources & Services Administration [HRSA], Bureau of Health Workforce, 2025). This consistently lower ratio in Ingham County highlights a more robust primary care infrastructure compared to its neighbors during these years.

Despite the variations in PCP ratios, the rates of uninsured adults highlight significant disparities in access to health insurance. Among adults aged 19-64 years old, Clinton County consistently reported the lowest percentage without health insurance, decreasing from 3.7% to 3.4% between 2021 and 2023. Eaton County followed with rates decreasing from 4.4% to 4.2% during the same period. Ingham County's rate of uninsured adults remained higher during this same period, increasing from 4.8% to 4.9% (ACS, 2025, Table S2701). Uninsured adults face significant barriers to obtaining necessary services, including timely preventive and screening services, prescription drugs, and specialty services. Consequently, they are less likely to receive appropriate care for acute and chronic diseases, leading to worse clinical outcomes, greater declines in health status over time, and increased mortality compared to adults with continuous coverage (Institute of Medicine, 2002).

Furthermore, the percentage of adults without a primary care provider demonstrates a gap in foundational access to care, regardless of the PCP ratio. In 2019 and 2022, Ingham County had a higher proportion of adults reporting that they do not have a primary care provider compared to Clinton and Eaton Counties. In 2019, 24.0% of Ingham County adults were without a PCP, compared to 14.0% in Clinton County and 19.0% in Eaton County. By 2022, while all counties saw improvements, Ingham County's rate remained the highest at 13.0%, significantly more than Clinton County's 5.0% and Eaton County's 9.0% (Healthy! Capital Counties & Public Sector Consultants, 2023).

The indicators examined in the CHA reveal a significant and persistent need for enhanced access to care across the Tri-County region. These data highlight distinct challenges, ranging from issues with healthcare provider availability in some areas to more pronounced barriers concerning health insurance coverage and direct patient access in others. Addressing these critical disparities will be essential for fostering improved health outcomes and ensuring equitable access to services throughout the entire region, affirming access to care as a vital and ongoing shared priority.

STRATEGY #1: Expand access to primary, preventative, maternal, and other specialty care through community-based, mobile, and co-located services

Objective 1
By September 2027, provide health care services to at least 4,500 encounters through new or expanded community based, mobile or co-located programs

Action Plan			
Program Activities	**Person/Group Responsible**	**Timeline**	**Performance Indicator**
Expand hypertension management using Ahva RPM with FDA approved monitors, AI support and virtual nurse check-ins	Health Numeric	July 2025-December 2026	Enroll 500 hypertensive patients by December 2026

Action Plan			
Program Activities	**Person/Group Responsible**	**Timeline**	**Performance Indicator**
Deploy Ahva RPM for pregnant/post-partum clients with Blood Pressure devices, AI support, nurse check-ins, and health education	Health Numeric	July 2025-December 2026	Provide blood pressure devices and RPM support to at least 200 patients
Hire primary care providers who accept all insurance types	McLaren Greater Lansing	March 2025-January 2026	The time it takes for a new patient to get an appointment with a PCP
Open South Lansing clinic for underinsured/insured patients	McLaren Greater Lansing	2026	The number of patients who are seen in the clinic
Launch mobile health clinic to serve patients where they live/work	McLaren Greater Lansing	2026	Number of patients cared for by the mobile clinic
Expand access to breastfeeding services	Mid-Michigan Health Department	July 2025-September 2027	Increase the number of clients utilizing breastfeeding services by 20%
Partner with maternal health providers (lactation, doulas, WIC, etc.)	North Star Birthing Services	January - May 2026	Link Community Baby Shower attendees to over 10 local care providers for resources to support their birthing journey
Secure 2026 community baby shower venue	North Star Birthing Services	April-May 2025	Host the 4th Community Baby Shower in Ingham County serving 40 families

Action Plan			
Program Activities	**Person/Group Responsible**	**Timeline**	**Performance Indicator**
Set up baby shower registration system	North Star Birthing Services	Jan - April 2026	Ongoing number of attendees registered
Purchase baby shower items for families	North Star Birthing Services	December 2025 - April 2026	Items secured to assist 40 families with essential items for care of newborn baby
Expand access to specialty care in Clinton County by adjusting provider panels and extending office hours	University of Michigan Health - Sparrow	June 2025-June 2027	Number of additional patients served
Expand services in Eaton County (oncology, OB/GYN, immunizations, pediatrics, and mental health)	University of Michigan Health - Sparrow	June 2025 - June 2027	Number of providers added
Improve care access for uninsured and underinsured in Lansing via emergency department-based insurance enrollment, PCP connection, and maternal-infant health services	University of Michigan Health - Sparrow	June 2025 - June 2027	Number of patients enrolled in health insurance or with a PCP
Provide outreach to low-income primarily minority employed persons with vaccinations and preventative services through the mobile bus unit	Ingham County Health Department	March 2025 - September 2027	Number of outreach events completed
Opening a new ED and medical services building in Grand Ledge with CATA transport system	McLaren Greater Lansing	Opening October	Traffic to this site
Americorps member placed for access-related capacity-building projects	Ingham County Health Department	October 2025 - September 2026	Member completes required hours for their slot type at host site

Action Plan			
Program Activities	**Person/Group Responsible**	**Timeline**	**Performance Indicator**
Americorps members placed for direct service projects improving access	Ingham County Health Department	October 2025 - September 2026	Member completes required hours for their slot type at host site
Expand Relationships with community partners to increase awareness of Ingham Community Health Center's services	Ingham County Community Health Centers	August 2025 - September 2027	Complete 5 scheduled meet and greets with new or previously unengaged partner community organizations and distribution of 250 brochures
Collaborate with Punks with Lunch to promote mobile health services	Barry-Eaton District Health Department	July 2025 - September 2027	Number of mobile health services promoted
Identify two partnerships a year with Ingham County mobile health Unit	Barry-Eaton District Health Department	July 2025 - September 2027	Number of partnerships identified with Ingham County mobile unit annually
Analyze data to identify areas in the community with limited access to healthcare once per year	Barry-Eaton District Health Department	July 2025- September 2027	Number of geographic areas identified and mapped as having limited access

STRATEGY #2: Increase enrollment in and retention of health insurance coverage through personalized navigation, outreach, and advocacy

Objective 2

By September 2027, provide health insurance coverage through personalized navigation, outreach, and advocacy

Action Plan			
Program Activities	**Person/Group Responsible**	**Timeline**	**Performance Indicator**
Attend events to promote Allen Neighborhood Center services and assist with coverage	Allen Neighborhood Center	April 2025 - September 2027	Number of community events attended and number of neighbors talked to about access to care
Enroll clients in Medicaid and other public benefit programs as MI Bridges partner	Allen Neighborhood Center	April 2025 - September 2027	Number of neighbors enrolled in Medicaid
Enroll clients in Ingham Health Plan as gap or alternative coverage	Allen Neighborhood Center & Ingham Health Plan	April 2025 - September 2027	Number of neighbors enrolled in Ingham Health Plan
Refer clients to trained staff for Medicare and Marketplace enrollment	Allen Neighborhood Center & BeneGuides	April 2025 - September 2027	Number of neighbors referred to BeneGuides or Medicare and Healthcare Marketplace
Expand Health coverage enrollment and retention through outreach, systems and staff certification	Community Mental Health - Clinton, Ingham, Eaton Counties	January 2025 - December 2027	Health Coverage Eligibility Counselors will maintain certification in HealthCare Marketplace and Medicare and complete 500 health coverage applications per year
Health and Resource Navigation - Navigators assist with Medicaid, IHP, and Marketplace applications	Ingham County Health Department	May 2025 - September 2025	Number of residents assisted with Medicaid applications and number of individuals assisted with improving access to and coordination of Medicaid services

Action Plan			
Program Activities	**Person/Group Responsible**	**Timeline**	**Performance Indicator**
Train staff on navigation and utilization of the MI Bridges Platform including account set-up, benefit applications, document uploads, and troubleshooting common user issues	Barry-Eaton District Health Department	June 2025 - September 2027	Number of staff trained on MI Bridges navigation
Promote Medicaid enrollment by participating in community events focused on outreach and access to coverage	Barry-Eaton District Health Department	July 2025 - September 2027	Number of community events attended annually to promote Medicaid enrollment

STRATEGY #3: Improve connection, coordination, and continuity of care by addressing logistical, technological, and communication barriers

Objective 3

By September 2027, support at least 1,500 encounters in overcoming barriers related to care coordination

Action Plan			
Program Activities	**Person/Group Responsible**	**Timeline**	**Performance Indicator**
Assist neighbors in choosing a primary care physician	Allen Neighborhood Center	April 2025 – September 2027	Assist 125 neighbors in choosing a primary care physician.
Schedule medical appointments for neighbors	Allen Neighborhood Center	April 2025 – September 2027	Schedule 100 medical appointments for neighbors
Utilize a Health in All Policies framework in all SDOH Hub grant writing and evaluations	Region 7 SDOH Hub	May 2025- September 2027	Two Health In All Policy evaluations for all grant awarded projects completed

Action Plan			
Program Activities	**Person/Group Responsible**	**Timeline**	**Performance Indicator**
Bridge the communication gaps between neighbors and healthcare providers, case workers, etc. through direct communication	Allen Neighborhood Center	April 2025 – September 2027	Assist 125 neighbors communicate with their health care team
Assist neighbors legally affirm their gender via a legal name and/or gender marker change	Allen Neighborhood Center, Trans-ilience Research Lab, & MSU Triangle Bar Association	April 2025 – September 2027	75 neighbors will receive assistance in legally affirming their gender
Connect individuals we serve to Primary Care Physicians in the community.	Community Mental Health - Clinton, Ingham, Eaton Counties	January 2025- December 2027	Increase the percentage of individuals with an identified PCP to 91%
Increase the awareness and identification of physical health needs of those we serve.	Community Mental Health - Clinton, Ingham, Eaton Counties	January 2025- December 2027	Establish a baseline number of physical health related treatment plan goals, then a standard of improvement. Establish a regular training about this in every clinical department
Develop text messaging reminders and other targeted interventions to decrease the percentage of no-show appointments	Ingham Community Health Centers	August 2025 – September 2027	Decrease the no-show rates of all Ingham Community Health Center appointments from 30% to 25% by September 30, 2027
Translate materials and forms into Spanish and other needed languages	Barry-Eaton District Health Department	July 2025- September 2027	Number of materials translated into languages other than English
Educate the community about transportation barriers and promote awareness of Medicaid transportation benefits and local resources	Barry-Eaton District Health Department	July 2027 - September 2027	Number of community members and stakeholders reached through transportation education efforts

STRATEGY #4: Integrate social determinants of health into care delivery through screening, resource linkage, and essential item distribution

Objective 4

By September 2027, launch the incorporation of SDOH into the services of at least 5 organizations, through either needs screening or the provision of relevant supplies

Action Plan			
Program Activities	**Person/Group Responsible**	**Timeline**	**Performance Indicator**
Identify and address SDOH needs through the implementation of a standardized SDOH screening tool	Community Mental Health - Clinton, Ingham, Eaton Counties	January 2025-December 2027	Establish a baseline number of SDOH screenings and establish a standard of improvement
Standardize staff training and workflows to screen for common care barriers, maintain a shared resource list, and track patient referrals to address SDOH	Eaton Rapids Medical Center	June 2025 - June 2027	Percentage of discharges with documentation of a barrier screening question, and if applicable, referral or support provided
Ensure consistent, equitable access to necessary health and hygiene supplies in the Care Closet	Lansing School District, Office of School Culture	September 2025 – May 2027	Fulfillment of 10,000 care package orders filled from September 2025 to May 2026
Address health disparities by providing personal hygiene items necessary to mitigate the risk of infection and/or communicable disease among students	Lansing School District, Office of School Culture	September 2025 – May 2027	Track the number of clinic student visits for personal hygiene concerns

Action Plan			
Program Activities	**Person/Group Responsible**	**Timeline**	**Performance Indicator**
Implement a continuous improvement process to identify and reduce the root causes of transportation barriers at the Specialty Care Center, tracking intervention impact on readmission rates.	University of Michigan Health - Sparrow (Specialty)	June 2025 - June 2027	Number of patients served
Opened an expanded food pantry that now can include fresh foods (due to new equipment) and personal hygiene products.	McLaren Greater Lansing	Opened June 2025	Numbers of families helped vs. 2024
Develop and launch an integrated SDOH resource guide accessible digitally via the AhvaHarmony platform	Health Numeric	October 2025 - June 2026 (Compilation); July 2026 (Launch)	Launch of Digital SDOH Resource Guide; At least 750 resource guide interactions within the first year
Conduct process mapping and collaborate with hospital systems to improve clinician best practices for overdose prevention.	Barry-Eaton District Health Department	October 2025 - December 2027	Process mapping completed; number of partners engaged
Improve access to community resources that address SDOH needs by actively promoting and increasing awareness and utilization of the 211-resource line.	Barry-Eaton District Health Department	October 2025 - September 2027	Number of programs referring to 211
Participate in community information exchange discussions to strengthen cross-sector coordination	Barry-Eaton District Health Department	July 2025 - September 2027	Number of conversation or groups participated in that discuss community information exchange

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Behavioral Health

GOAL #1: Ensure Mental Health and Substance Use Services are Accessible, Available, and Appropriate for All

GOAL #2: Improve and Expand Mental Health and Substance Use Supports to Ensure a Healthy and Effective Workforce

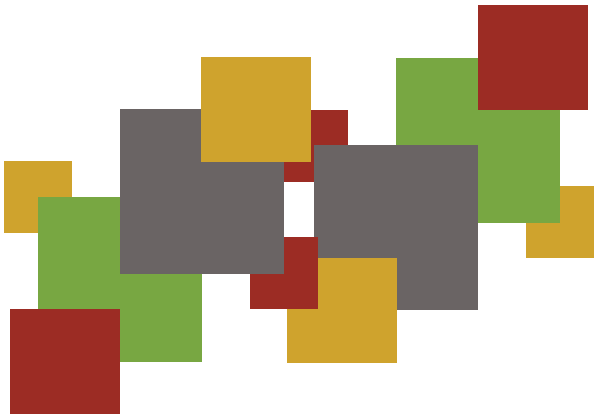
Behavioral Health was chosen as a priority area for the 2025-2027 CHIP in response to the widespread prevalence of mental health and substance use challenges across Clinton, Eaton, and Ingham counties. As behavioral and mental health are often connected, a comprehensive approach is crucial for enhancing the community's health and well-being. Improving health outcomes, increasing quality of life, and promoting well-being for residents requires a coordinated approach that addresses both physical and mental health. This effort is essential for understanding and mitigation of substance use, which may be connected to underlying mental health challenges.

Data has shown that there have been many improvements in recent years regarding substance use in the Tri-County Area. Opioid-related death rates went down in Michigan, Eaton, and Ingham Counties between 2021 and 2022 (MiTracking, 2022). This decline shows that efforts to provide help to those struggling with substance disorder might be working. It is important to continue and expand upon those efforts to reduce opioid use and overdoses. In addition to a decrease in opioid-related deaths, there had been a decrease in binge drinking among adolescents and adults and a decrease in cannabis use among adolescents. Adult cannabis use has decreased in Eaton and Clinton Counties, but increased in Ingham County (Capital Area BFRS, 2014-2022). However, the 5-year age-adjusted rate due to suicide for Tri-County Area has increased in Clinton and Ingham Counties and only slightly decreased in Eaton County. The rate has been consistently higher in Eaton County than in Clinton County, Ingham County, or the state of Michigan over the last 3 years (Vital Statistics, 2016-2022).

There have also been improvements in regards to mental health outcomes in the Tri-County area. The percentage of adults who reported experiencing poor mental health in the past 30 days decreased from 2017-2019 to 2020-2022 (Capital Area BRFS, 2014-2022). In 2023-2024 fewer high school students in Clinton, Eaton, and Ingham counties reported symptoms of depression in the past year compared to the previous two years (MiPHY, 2022).

While there has been an overall improvement in behavioral health outcomes in recent years in the Tri-County area, there is still room for improvement when it comes to behavioral health treatment and services. Focus group participants from the Tri-County area have stated that there are not many recovery options for women and that transgender and non-binary individuals are often pushed away from receiving recovery services. Residents have also mentioned a stigma surrounding mental health and how biases will affect their treatment. Behavioral Health stakeholders in the Tri-County area have discussed the lack of a single platform that pulls the available resources together, as well as burnout among the behavioral health workforce.

Community organizations in the Tri-County area will continue their efforts on improving behavioral health outcomes by expanding upon what has already been done and creating new ways to ensure happier and healthier communities.



GOAL #1: Ensure Mental Health and Substance Use Services are Accessible, Available, and Appropriate for All

STRATEGY #1: Increase access to and awareness of behavioral health services

Objective 1

By September 2027, engage with 5 health organizations across the Tri-County area to explore and understand the applications of utilizing AI and/or technology in improving access to mental or behavioral health services

Program Activities	Person/Group Responsible	Timeline	Performance Indicator
Implement Ahva Harmony, an integrated AI-driven platform providing real-time location-based directory of mental health and substance use resources, autonomous scheduling, immediate crisis intervention and culturally responsive connections to faith-based community providers	Health Numeric	Development: July 2025- December 2025 Implementation: January 2026 - September 2027	Launch platform. Achieve at least 500 active platform users by June 2026. Reduce teletherapy waiting lists by at least 30% within one year
Develop and launch a media campaign to increase public understanding of harm reduction and awareness of local services in Barry-Eaton jurisdiction	Barry-Eaton District Health Department	September 2025 - September 2027	Number of views and interactions on media posts
Add Behavioral Health data and education into school newsletter.	Barry-Eaton District Health Department	September 2025 - September 2027	Number of newsletters distributed with Behavioral Health education or data
Present data and information on local Behavioral Health gaps to community coalitions and partners	Barry-Eaton District Health Department	September 2025 - September 2027	Number of presentations or coalition meetings attended

Program Activities	Person/Group Responsible	Timeline	Performance Indicator
Increase Behavioral Health visits and number of patients served through Behavioral Health providers	Ingham Community Health Centers	September 2025 - September 2027	1) Establish a baseline number of patients receiving BH Services 2) Establish a standard of improvement 3) Increase patients served by 10%

STRATEGY #2: Expand and strengthen crisis response and stabilization services

Objective 2

By September 2027, increase the availability of crisis stabilization services and expand harm reduction efforts by establishing or improving at least 2 new or existing programs that address immediate crisis response and/or ongoing harm reduction needs across the Tri-County area

Program Activities	Person/Group Responsible	Timeline	Performance Indicator
Development/Implementation of the Crisis Care Center including the addition of the Crisis Stabilization Units	Community Mental Health - Clinton, Ingham, Eaton Counties	January 2025 - June 2026	1. Renovation of space to meet all program needs for the Crisis Care Center 2. Complete Certification process for the Adult and Child Crisis Stabilization Units 3. Hiring Staff for the CSU 4. Open CSU Services
Partner with a local syringe services program provider to establish mobile SSP access in Eaton County	Barry-Eaton District Health Department	September 2025 - September 2027	Number of syringes provided
Establish partnerships with local businesses to distribute Narcan	Barry-Eaton District Health Department	September 2025 - September 2027	Number of businesses participating
Establish a harm reduction program in Clinton County	Mid-Michigan District Health Department	July 2025- September 2027	Establishment of a harm reduction program and number of clients utilizing harm reduction program

STRATEGY #3: Promote suicide prevention and build community capacity

Objective 3
By September 2027, train at least 300 participants in mental health awareness or response by supporting their completion of at least one recognized mental health training

Program Activities	Person/Group Responsible	Timeline	Performance Indicator
Implementation of Zero Suicide within the organization	Community Mental Health - Clinton, Ingham, Eaton Counties	January 2025 - December 2027	1. Update current Zero suicide action plan and time frame to drive planning activity, workgroups, and rollout of enhanced Zero suicide training, care pathways, and protocol.
Continue to provide Mental Health First Aid training and Question, Persuade, Refer Suicide Prevention training to our area networks, professionals, and community members	Community Mental Health - Clinton, Ingham, Eaton Counties	October 2025 - September 2027	1. Monitor and track total MHFA and QPR trainings per fiscal year and total numbers trained

GOAL #2: Improve and Expand Mental Health and Substance Use Supports to Ensure a Healthy and Effective Workforce

STRATEGY #1: Strengthen behavioral health workforce recruitment and retention

Objective 4
By September 2027, improve the capacity and quality of the behavioral health workforce in the Tri-County area by reducing the time required to fill critical clinical positions and increasing staff completion of cultural competence or trauma-informed care training

Program Activities	Person/Group Responsible	Timeline	Performance Indicator
Recruit "hard to fill positions" within a 6-month time frame of posting a position, including Mental Health Therapists and Psychiatrists	Community Mental Health - Clinton, Ingham, Eaton Counties	January 2025 - December 2027	HR will recruit new agency management allies for taking interns, which will include different departments, then will track interns until their commitment is over and recruit to positions, taking the time to check-in with them halfway through their internship
Increase cultural competence and/or trauma informed care approaches for all staff	Ingham Community Health Centers	October 2025 - September 2027	Develop a plan to establish means to assess current cultural competencies and/or knowledge of trauma informed care to create baseline, then explore training opportunities and implementation of trainings for HC Staff

Note: The CHIP will be reviewed and updated as needed every 6 months to reflect updated data and changes to organizational goals. To join us, contact Kara Trimbach Shirley at kshirley@ingham.org.

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Behavioral Health

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Housing

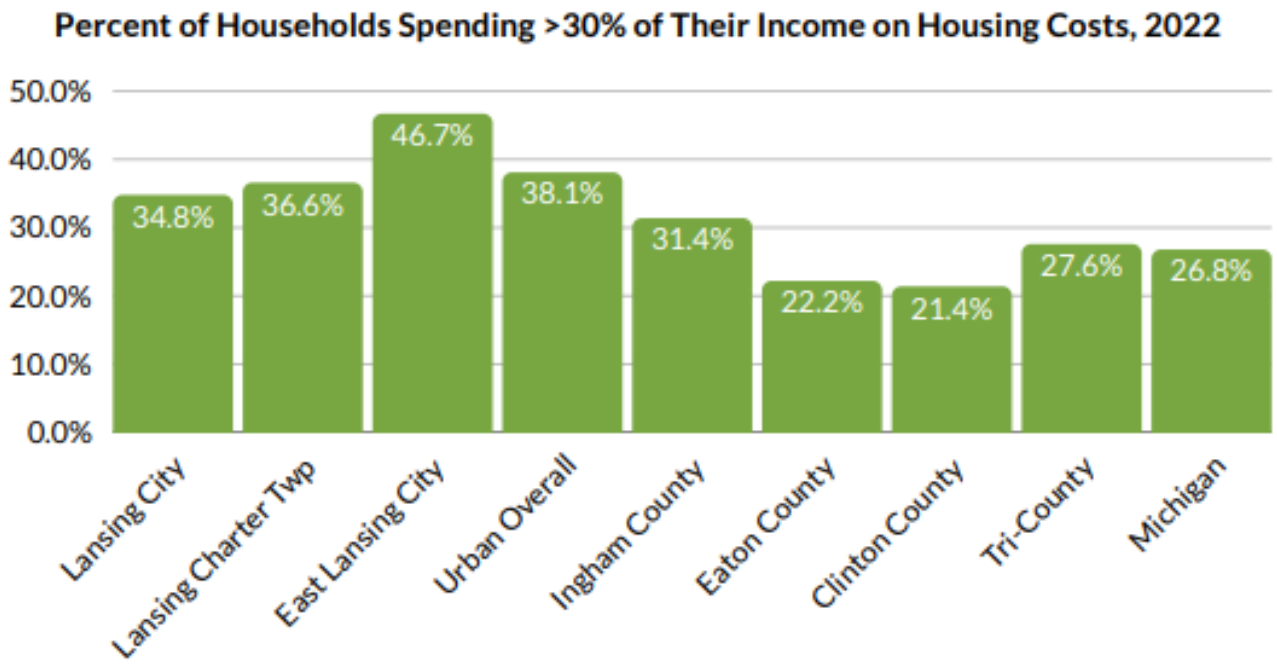
GOAL #1: Increase Housing Education and Knowledge

GOAL #2: Build and Strengthen Community Support to Address Housing-Related Factors that Influence Health and Well-Being

Recent data from 2022 revealed a significant challenge for the Tri-County area: over one quarter of households were considered housing burdened (American Community Survey, 2025). A household is housing burdened when more than 30% of its income goes toward housing costs, including rent, mortgage payments, utilities, and other necessary housing expenses. This financial strain can result in households struggling to afford critical essentials such as food, healthcare, and transportation (Cromwell, 2024). The impact of this burden varies across the region, with urban centers like the Cities of East Lansing and Lansing experiencing higher rates compared to more rural areas such as Eaton and Clinton County (American Community Survey, 2025). When households face ongoing financial pressure, they often have fewer resources to put toward home maintenance and repairs, which can create additional health risks.

Beyond affordability, the age and condition of the housing stock present their own set of health concerns for Tri-County residents. Encouragingly, the region has seen a steady decrease in the percentage of children under six with elevated blood lead levels (EBLL), from 5.1% in 2019 to 3.9% in 2022 (Childhood Lead Poisoning, 2023). While EBLL rates are decreasing, any level of lead exposure remains a concern, as there is no safe blood lead level for children. Lead can cause damage to children's kidneys, blood, and brains. One significant source of childhood lead exposure is lead-based paint, which was commonly used in homes built before 1978. As this paint deteriorates in older homes, it creates lead-contaminated dust and soil that children may ingest through normal hand-to-mouth behavior. Because the Tri-County housing stock is older than that of many other Michigan communities, more homes are likely to contain lead-based paint. By prioritizing housing rehabilitation and upkeep, particularly in homes more than 50 years old, community members can further reduce lead exposure and promote safer, healthier environments.

Housing is a fundamental SDOH because its affordability, quality, and stability directly impact the ability to afford other essentials, avoid environmental hazards, and maintain their overall well-being. The issues of housing burden and lead exposure in older homes, for example, are not isolated concerns - they are deeply interconnected challenges that reveal the crucial link between where we live and our health. Addressing housing through targeted strategies defined in the CHIP confirms the Tri-County area's dedication to a comprehensive, action-oriented approach that will improve the health and stability of residents.



Just over one quarter of households in the state of Michigan, and in the tri-county area, spend more than 30 percent of their income on housing.

GOAL #1: Increase Housing Education and Knowledge

STRATEGY #1: Expand access to housing resources through integrated navigation and outreach

Objective 1
Host collaborative housing outreach to at least five community events to improve housing stability and resource awareness for vulnerable populations by September 2027

Action Plan

Activity	Person/Group Responsible	Timeline	Performance Indicator
Partner with local housing resource agency to attend the Community Baby Shower and share housing resources with families in attendance	North Star Birthing Services	March-May 2026	Families in attendance will report increased knowledge of housing resources in the post event survey
Integrate a location-based housing resource directory into the AhvaHarmony platform, featuring real-time listings of shelters, rental assistance programs, transitional housing, and legal aid resources, including AI-powered navigation and referral tools for at-risk patients identified through screenings	Health Numeric	August 2025 – March 2026 (Develop); April 2026 – Ongoing (Implement)	Launch platform and at least 250 referrals to housing support services within the first year
Expand outreach of Ingham County Housing Resource Guides (Emergency Rooms, hospitals, healthcare organizations, schools)	Ingham County Health Department	May 2025 - September 2026	Distribution of 10,000 housing resource guides

STRATEGY #2: Enhance housing stability through financial empowerment and education

Objective 2
By September 2027, improve housing stability and foster equitable housing practices by providing financial empowerment and housing support to at least 200 individuals

Action Plan			
Activity	**Person/Group Responsible**	**Timeline**	**Performance Indicator**
Provide a multi-level financial literacy program for resettled refugees and low-income families that includes an introduction course for refugees, a housing assistance workshop including community advocacy, and one-on-one financial literacy program for long-term success and self-sufficiency	Catholic Charities of Ingham, Eaton, and Clinton Counties and the Office of Global Michigan	April 2025 - September 2027	Tracking the number of people participating in the financial literacy program and those receiving housing assistance support

GOAL #2: Build and Strengthen Community Support to Address Housing-Related Factors that Influence Health and Well-Being

STRATEGY #3: Strengthen housing infrastructure through organizational collaboration

Objective 3
By September 2027, expand and strengthen the Regional Housing Partnership by actively engaging at least three new Tri-County organizations or key stakeholders in collaborative efforts to address regional housing problems

Action Plan			
Program Activities	**Person/Group Responsible**	**Timeline**	**Performance Indicator**
Within the Regional Housing Partnership, expand the reach of the 3E (Engagement, Education, Empowerment) workgroup to support other housing organizations through accessibility, coordination of services, and creation of materials	Ingham County Health Department	May 2025 - September 2027	Completion of 3E key performance indicators

STRATEGY #4: Increase availability of supportive housing and emergency shelter options through advocacy, education, and partnerships

Objective 4

By September 2027, collaboratively improve essential support systems and expand access to vital housing and critical services for at least 300 individuals who are unhoused or housing insecure

Action Plan			
Program Activities	**Person/Group Responsible**	**Timeline**	**Performance Indicator**
McLaren will be assisting and collaborating with the Medical Respite Care Facility, helping to create and start this work	McLaren Greater Lansing	May 2025 - September 2027	Number of connections made to find stable housing for discharged patients
Distribute critical survival supplies (tents, sleeping bags, warm clothing, blankets, and hand warmers) to unhoused individuals living in Ingham County, as part of comprehensive harm reduction and mutual aid outreach	Punks With Lunch	May 2025 - May 2026	Number of individuals served; number of survival items distributed; recipient feedback collected at outreach

Action Plan (continued)			
Program Activities	**Person/Group Responsible**	**Timeline**	**Performance Indicator**
Expand access to resources including backpacks, tents, and other supplies for Category 1, 2, and 4 unhoused individuals based on individual need, with a focus on individuals living in encampments	Ingham County Health Department	July 2025-July 2027	Completion of a minimum of 5 visits to encampments/ homeless outreach events to distribute resources
Begin the creation of a Tri-County Collaborative Medical Respite/Recuperative Shelter (TC MR/RS) that would allow unhoused or housing insecure people to recover for medical purposes	Michigan State University College of Human Medicine, Ingham County Health Department, Community Mental Health	May 2025 - December 2025	Collaborative group created with a completed TC MR/RS workplan
Gather data on demographics and existing services, convene multi-sector community partners, and conduct focus groups with unhoused older adults to inform TC MR/RS program design	Michigan State University College of Human Medicine, Ingham County Health Department, Community Mental Health	Dec 2025 - July 2026	Completion of a needs assessment for a Medical Respite / Recuperative Shelter
Secure diverse funding sources, identify staffing requirements, determine facility needs, and develop a comprehensive business plan	Michigan State University College of Human Medicine, Ingham County Health Department, Community Mental Health	January 2026 - December 2026	Grant(s) or funding secured and completed with a plan for opening of medical respite care facility

Note: The CHIP will be reviewed and updated as needed every 6 months to reflect updated data and changes to organizational goals. To join us, contact Kara Trimbach Shirley at kshirley@ingham.org.

Sources

Housing

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Using the Plan

Creating a healthier Capital Area is a shared responsibility that requires the collaboration of everyone, from residents and government agencies to community organizations. Everyone can contribute to creating a healthier community by staying informed about local issues, making healthier decisions for themselves, and prioritizing policies that address the social determinants of health. This collaborative work is essential for contributing to a healthier and more equitable future for all.

Residents

- Talk to people about health and the community when the opportunity arises
- Learn from the CHA and use the CHIP to reflect upon and improve your health as you are able
- Get involved in future CHA/CHIP activities by joining the email list by emailing one of our core staff (page 2)

Employers

- Understand health issues that affect our community
- Update the Strategic Plan using CHA and CHIP data
- Consider the CHIP priorities when selecting employee benefit plans
- Incorporate priorities into corporate giving (if applicable)

Educators

- Understand health issues that affect our community
- Recognize that some healthy habits can be established in childhood
- Develop or review school wellness program

Faith-Based and Community-Based Organizations

- Understand health issues that affect our community
- Incorporate priorities into service activities
- Talk with members about health, including SDOH and root causes
- Invite CHIP staff or stakeholders to speak to members

Healthcare Affiliates

- Consider adding your organization to the plan
- Update the Strategic Plan using CHA and CHIP data
- Offer patients resources to address not only health care needs, but also behavioral health and SDOH needs
- Address the root causes of healthcare needs

Government Officials

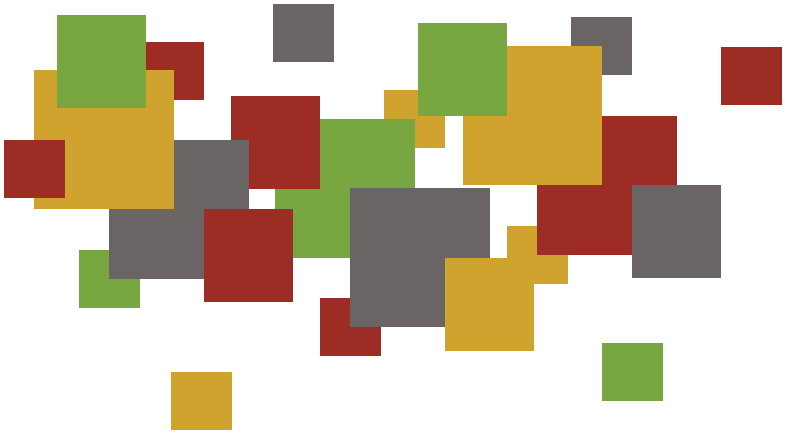
- Talk to people about health and the community when the opportunity arises
- Understand health issues, including SDOH and root causes, that affect our community
- Review the policy-related approaches
- Invite steering committee members to speak with you and your staff about this plan

Conclusion

Healthy! Capital Counties is proud to announce the scope of work for the 2025-2027 CHIP, which involves 73 activities being undertaken by 23 partner organizations. This will be the second time that the three counties of Clinton, Eaton, and Ingham come together to complete the CHIP with plans to continue this collaborative effort. The Tri-County community has shown their dedication to improving health from all aspects, but especially within Access to Care, Behavioral Health, and Housing.

Improving health, both on an individual and community level, is a multifaceted endeavor that extends beyond personal decisions. It is significantly influenced by a variety of factors, including structural and institutional barriers, systemic racism, poverty, housing, and education. Impacting these root causes of health and the social determinants of health can have a direct effect on more traditional health outcomes, such as heart disease, cancer, and depression. Healthy! Capital Counties is committed to improving all aspects of health, recognizing that lasting change requires a comprehensive approach rather than addressing a single aspect of health.

Healthy! Capital Counties invites participation from all organizations, people, and sectors across the entire Capital Area. Please share this plan, and any actions that are being taken to achieve the goals within the plan, with core staff and others in the community. Join us and stay informed by signing up for our email list by emailing Kara Shirley at kshirley@ingham.org.



Community Stakeholders Organizations

The following community organizations are actively involved in the 2025-2027 CHIP, either by submitting an activity or partnering with another organization to complete one. While many other organizations contribute to the CHIP, this list specifically highlights those with submitted activities.

Allen Neighborhood Center
Barry-Eaton District Health Department
BeneGuides
Catholic Charities IEC
Community Mental Health of Clinton, Eaton, and Ingham Counties
Eaton Rapids Medical Center
Health Equity Council
Health Numeric
Ingham County Community Health Centers
Ingham County Health Department
Ingham County Health Department - Pathways to Care
Ingham Health Plan
Lansing School District
McLaren Greater Lansing Hospital
Michigan State University - College of Human Medicine
Mid-Michigan District Health Department
MSU Triangle Bar Association
North Star Birthing Services
Office of Global Michigan
Punks with Lunch
Region 7 Social Determinants of Health Hub
Trans-ilience Research Lab
University of Michigan Health - Sparrow

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