

State Community Health Assessment Meeting Summary & Findings

Michigan



Prepared for: Michigan Department of Community Health

Prepared by: Cyzman Consulting, LLC

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*Michigan Department
of Community Health*



Rick Snyder, Governor
Olga Dazzo, Director

Abstract

The Michigan Department of Community Health (MDCH) was awarded a Centers for Disease Control and Prevention grant in spring 2011 entitled “Strengthening Public Health Infrastructure for Improved Health Outcomes.” Among the goals of this grant are to conduct a state level community health assessment and to develop a state health improvement plan. The results from the state level community health assessment will help MDCH describe the health status of Michigan residents, identify areas for improvement, determine factors that contribute to health issues, and identify existing assets and resources. One of the first steps was to develop a statewide health data profile. The MDCH prepared a compilation of 46 primary and secondary data indicators that collectively provided an overview of Michigan residents’ health and well-being. State and regional data in comparison to national data were shared to inform and focus eight regional meetings. A diverse group of stakeholders and partners representing a broad range of expertise and experience were invited to attend the meetings and share their perspectives on pressing community health issues for their respective region. This report presents a summary of the process used, an overview of key input received from each region and a synthesis of the findings across all eight regional meetings, including the top ranked leading health issues, problem areas and challenges and the specified most important issue. Smoking, access to healthcare, teen pregnancy and cancer screenings were noted most often by the eight regions as the pressing community health issues trending positively. Issues considered most problematic/challenging in the regions included obesity, access to healthcare, substance abuse and mental health. Obesity was identified as the most important issue by six of the eight regions.

The State Level Community Health Assessment Process

In spring of 2011, the Michigan Department of Community Health (MDCH) was awarded a Centers for Disease Control and Prevention grant entitled “Strengthening Public Health Infrastructure for Improved Health Outcomes.” Among the goals of this grant are to conduct a state level community health assessment and develop a state health improvement plan. The state level community health assessment and related input is one component in the MDCH process to create an agency quality improvement plan, per Figure 1. Other elements to be developed in this process include a state health improvement plan, a public health strategic plan, and a public health quality improvement plan.

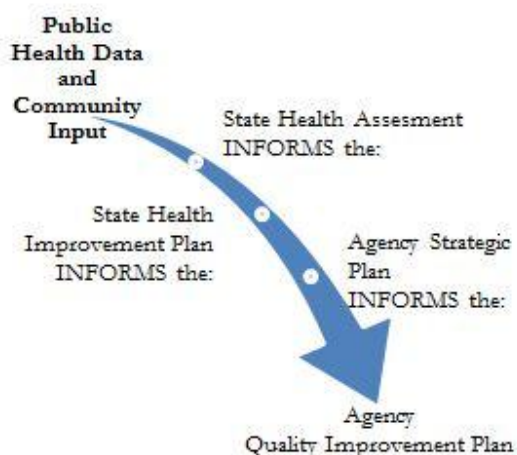


Figure 1

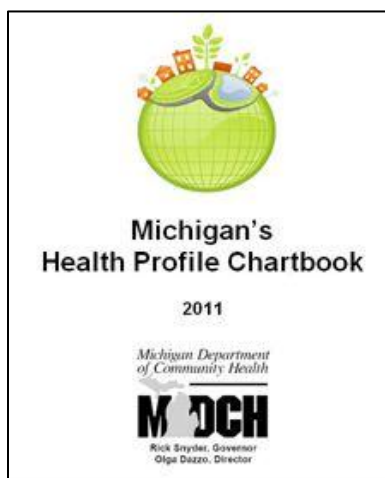
The key components informing the state level community health assessment are:

- Michigan health-related data compiled into the *Michigan's Health Profile Chartbook 2011 and Regional Health Profile Chartbooks*
- Eight regional stakeholder meetings examining regional, state, and national data and providing perspective on pressing community health issues, and subsequent input from regional open comment periods;
- *Community Health Rankings*;
- Local and state representative key informant interviews; and
- Regional reports synthesizing contributions from stakeholder meetings

A highly collaborative process was used to conduct the state level community health assessment. A broad range of expertise and perspective was sought to inform this assessment through regional meetings, public comment and key informant interviews. Data and regional expert input provide the foundation upon which strategies will be determined to improve health status both locally and statewide. All aspects of the state level community health assessment, from the selection of the indicators to the regional meetings, were led by an advisory group comprising representatives from MDCH and some key partners: Michigan Association for Local Public Health, MPRO – Michigan's Quality Improvement Organization, the Michigan Health and Hospital Association and Public Sector Consultants. Local health departments hosted the regional meetings and identified the optimal stakeholders and health system partners to invite to the meeting. On average 100 stakeholders were invited to attend each regional meeting, as was the general public.

Michigan and Regional Health Profiles

The MDCH Health Policy and Planning, Bureau of Disease Control, Prevention and Epidemiology, and Division of Vital Statistics compiled the "***Michigan's Health Profile Chartbook 2011***" and regional complements to provide "snapshots" to serve as a catalyst for identifying pressing community health issues and areas of import for action. The State Level Community Health Assessment Advisory Group selected the specific indicators to be included in the Chartbooks. The advisory group determined that core indicators common to both Mobilizing for Action through Planning and Partnerships (MAPP) and the 2010 Michigan Critical Health Indicators would provide a starting basis for the chartbook development. Additional data elements were included to capture needs identified by the advisory group.



Data presented in the chartbooks and presented at the regional meetings were meant to inform the regional meeting discussion by highlighting data and trends to identify and understand current, emerging, and potential health problems. Collectively, the 46 indicators represented reliable,

comparable, and valid data that describe the health and well-being of Michigan residents. The data included:

- *Demographic:* age, gender, racial/ethnic, education, unemployment, poverty
 - *Access to Care:* workforce (primary care physicians) and access to healthcare
 - *Mortality:* cancer, cardiovascular disease, diabetes, infant mortality, injury
 - *Prevalence:* cardiovascular disease, diabetes, controlled hypertension
 - *Risk Factor:* overweight/obesity, inadequate fruit/vegetable consumption, physical activity, smoking, binge drinking, teen pregnancy, low birth weight and very low birth weight, breast feeding, blood lead levels, oral health, mental health
 - *Clinical Preventive Services:* screenings (breast cancer, cervical cancer, colorectal cancer) and vaccines (influenza and pneumococcal)
 - *Hospitalization:* cardiovascular disease and asthma
 - *Incidence and Trends:* gonorrhea, chlamydia and hospital-induced infections, hepatitis, HIV/AIDS
- Additionally, the leading causes of death and years of potential life lost for selected causes were included indicators.

The Regional Chartbooks provided region-based data, and in many cases compared them to Michigan and, in some cases, national data and goals, such as those developed for *Healthy People 2020*.

Stakeholder and Partner Input

In July and August, 2011, the advisory group held meetings engaging community members in eight Michigan regions (Figure 2). Locations for the regional meetings aligned with Michigan's eight public health preparedness regions. Local health departments in each region facilitated the regional meetings by serving as host sites. Recognizing that all entities within a public health system contribute to the health and wellbeing of the community or state, a broad array of regional stakeholders were invited to examine state and regional data compiled in Chartbooks (described above) and to provide specific input. Figure 3 highlights the experience and expertise of stakeholders invited to attend regional meetings. The 649 community participants represented public health agencies, healthcare providers, public safety agencies, human service and charity organizations, education and youth development organizations, recreation and arts related agencies, economic and philanthropic organizations, and environmental agencies.

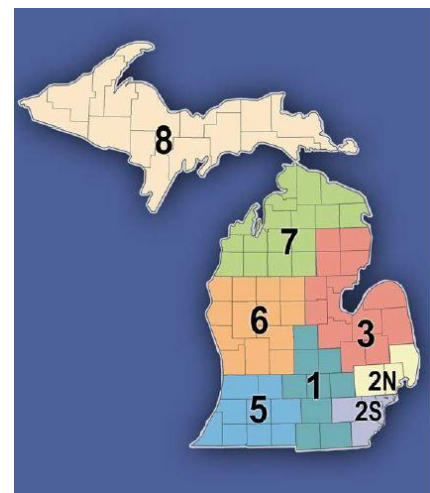


Figure 2

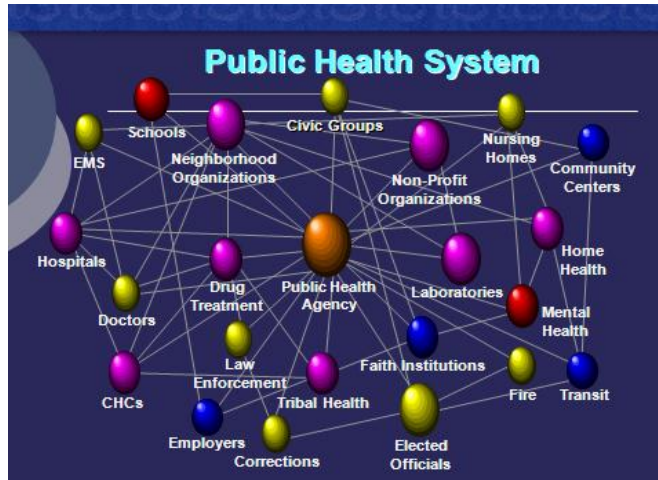


Figure 3

Table 1 provides an overview of the regional meetings, the number of participants and the specific counties represented in the respective meetings.

Table 1: Regional Meetings		
Region	Number of Participants	Counties Represented (in region)
1	83	Clinton, Eaton, Gratiot, Hillsdale, Ingham, Jackson, Lenawee, Livingston and Shiawassee
2 North	92	Oakland, Macomb, and St. Clair
2 South	89	City of Detroit, Monroe, Washtenaw and Wayne
3	56	Alcona, Arenac, Bay, Genesee, Gladwin, Huron, Iosco, Lapeer, Midland, Ogemaw, Oscoda, Saginaw, Sanilac, and Tuscola
5	123	Allegan, Barry, Berrien, Branch, Cass, Calhoun, Kalamazoo, St. Joseph, and Van Buren
6	67	Clare, Ionia, Isabella, Kent, Lake, Mason, Mecosta, Montcalm, Muskegon, Newaygo, Oceana, Osceola, and Ottawa
7	60	Alpena, Antrim, Benzie, Charlevoix, Cheboygan, Crawford, Emmet, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, Montmorency, Otsego, Presque Isle, Roscommon, and Wexford
8	79	Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, and Schoolcraft
	649	TOTAL NUMBER OF PARTICIPANTS

In addition to informing the state planning process, the regional meetings were designed to:

- result in participants' increased awareness and understanding of health status and priorities;
- provide information useful to community assessment efforts;
- disseminate a *Regional Health Profile Chartbook*, providing regional data, and, where possible, comparisons to state data and national targets, such as those found in *Healthy People 2020*;
- serve as a catalyst for community and state discussion and action;
- be a vehicle to share comments between state and community partners; and
- help prepare for national accreditation of Michigan health departments.

Regional participants worked in small groups to respond to questions about their region's leading health issues. Among the questions groups were asked to deliberate included the following:

1. *Leading Health Indicators: Which indicators do you think are moving in the right direction? What is contributing to the region's success in these areas?*
2. *Problem Areas/Challenges: On which indicators do you think the region is not performing well? What are the contributing factors or underlying causes?*
3. *Thinking about the problem areas, what is working well in this region to address these issues?*
4. *What is standing in the way of successfully addressing the problem areas?*

Regional reports were written to provide both a summary of deliberations and the public comment received specifically focusing on issues where improvements had been made and those where opportunities for further progress remain. Further, a synthesis of the discussions on what was working well, including existing assets and resources, and barriers to success were highlighted. All eight regional reports can be found on the MALPH website at www.MAPLH.org, and future accessibility will include the Michigan Department of Community Health website at www.michigan.gov/mdch/.

Public Comment

The general public was encouraged to provide feedback at the regional meetings. Each host health department published a public notice about the meeting, and MDCH released a press release. Public comment was solicited and accepted in two ways: verbal and written. Individuals who were unable to attend an entire regional meeting could provide verbal feedback toward the end of the meeting. In addition, written public comment was accepted during and after the each Regional meeting. Public comment input was integrated into Regional Reports.

Key Informant Interviews

Local health departments in each region identified key informants for interviews to offer greater insight into regional priorities, challenges, efforts, strategies, and leadership. Local public health departments in each of the eight regions were asked to identify three key informants who were both knowledgeable and influential regarding public health issues. Interviewees represented a broad array

of sectors, including health care providers, community and faith-based organizations, education, business, health systems, and local public health. Seven statewide representatives, selected by the advisory group, were also interviewed for a total of 31 key informant interviews.

Regional key informants were asked to identify their region's top one or two most pressing community health issues, as well as contributing factors and barriers to addressing the identified issues. They were also asked what efforts are working well in their region to address those issues, who is involved, and how those efforts could be supported or expanded. Informants were asked if they were aware of other strategies to address those issues that ought to be tried in the region and who should be involved in identifying and leading those efforts. Statewide informants were asked similar questions on a statewide level.

When asked to identify the most pressing community health issues, both regional and state-level interviewees focused on four areas of concern: lack of access to health care, obesity, infant mortality, and substance abuse. Disparities were also mentioned in relation to nearly all issues identified. Key informants also identified a pressing need to inform legislators and decision-makers regarding the health impacts of public policy. The full report summarizing the results of these interviews is found in Appendix A.

Michigan Health Profile: A Snapshot

Michigan is ranked as the eighth most populated state with its population estimated to be 9,883,640 (2010 United States Census) living in 83 counties. Seventy-eight percent of Michigan's citizens live in metropolitan areas. Michigan's population is diverse. [See Table 2.] Of significance is the proportion of Michigan residents 65 years and older (13.8% of the total population). This percentage of older adults in Michigan is higher than the national percentage (12.9%). The proportion of persons living below the poverty level in Michigan has increased from 14.4 percent in 2009 to 16.8 percent in 2010, an increase of 16.7 percent. The elderly and those in lower socio-economic levels are often at increased risk for health issues and disease.

Of further significance is that in 2010, Michigan had the second highest unemployment rate of all states in the nation at 12.5 percent (<http://www.bls.gov/lau/tables.htm>). More recently, the unemployment rate in Michigan for July 2011 was 10.9 percent (versus 9.1% for the U.S.). With the loss of jobs comes the loss of healthcare coverage. In 2010, an estimated 16.6 percent of Michigan adults aged 18–64 years had no health care coverage - an increase of 21 percent from 2008 (www.michigan.gov/brfss). In addition, 14.1 percent of 2010 Michigan adults could not see a doctor in the past year when they needed to due to the cost (www.michigan.gov/brfss). Currently, one out of every six persons living in Michigan is enrolled in Medicaid (1.6 million people). This is a 47 percent increase since 1999.

Table 2
Demographic characteristics of Michigan citizens
Michigan 2010 (US Census estimates)

Demographic Characteristic (2010 Estimate)	Percent of Population
Sex	
Male	49.1%
Female	50.9%
Race	
Black or African American	14.2%
American Indian or Alaska Native	0.6%
Asian	2.4%
White Alone	78.9%
Native Hawaiian or Pacific Islander	<0.1%
Two or more races	2.3%
Ethnicity	
Hispanic or Latino	4.4%
Age Groups (Years)	
<5	6.0%
< 18	23.7%
18 - 64	62.5%
>= 65	13.8%

Table 3 highlights comparisons between Michigan and national data for critical health indicators in 2010. These data helped guide both the regional input and key informant perspective.

Table 3		
Critical Health Indicators: Comparison of Michigan to the United Statesⁱⁱ		
Michigan is Better	Michigan is Worse	Michigan is the Same as US
<ul style="list-style-type: none"> • Injury mortality • Syphilis • HIV/AIDS • Children’s Insurance Coverage • Adult Insurance Coverage • Cholesterol Check • Pediatric Immunizations • High School Completion 	<ul style="list-style-type: none"> • Life Expectancy at Birth • Life Expectancy at Age 65 • Infant Mortality Rate • Self-Reported Health Status • Diabetes • Asthma • Arthritis • Cancer • Gonorrhea 	<ul style="list-style-type: none"> • Chlamydia • Binge Drinking • Obesity • Pap Test • College Completion • Unemployment Rate • Violent Crime Rate • Lead Poisoning • Adult Immunizations • Heart Attack • Stroke • Smoking • Adequate Physical Activity • Adequate Fruit and Vegetable Intake • Health Care Expenditures • Mammogram • Poverty

Community Dialogue: The Results

Key results from the regional health assessment meetings are presented in Table 4. The “top three” most common regional responses related to pressing community health issues, problem areas and challenges and the most important issue identified follow. The numbers corresponding to issues or challenges denote their ranking. The most frequently cited issue or problem area is given a “1.” In some cases, two or more were tied for the same ranking, and the numbers reflect the tie.

Region	Pressing Community Health Issues	Problem Areas/Challenges	Most Important Issue(s)
1	<ol style="list-style-type: none"> 1. Access to healthcare 2. Binge drinking 3. Controlled hypertension 3. Obesity 	<ol style="list-style-type: none"> 1. Access to healthcare 2. Obesity 3. Infant Mortality 3. Smoking 	Obesity
2N	<ol style="list-style-type: none"> 1. Smoking 1. Teen pregnancy 3. Cancer, including screening 	<ol style="list-style-type: none"> 1. Obesity 2. Substance abuse 3. Mental health 	<ul style="list-style-type: none"> • Obesity • Access to care
2S	<ol style="list-style-type: none"> 1. Smoking 2. Cardiovascular disease 3. Cancer, including screening 3. Fruit and vegetable intake 3. Controlled hypertension 3. Infant mortality 3. Sexually transmitted diseases 	<ol style="list-style-type: none"> 1. Access to healthcare 2. Mental health 3. Social determinants of health 3. Obesity 	<ul style="list-style-type: none"> • Health disparities/ health equity • Social determinants of health
3	<ol style="list-style-type: none"> 1. Smoking 2. Mental health 2. Obesity 	<ol style="list-style-type: none"> 1. Obesity 2. Substance abuse 3. Binge drinking 3. Oral health 	Obesity
5	<ol style="list-style-type: none"> 1. Cancer, including screening 2. Access to healthcare 3. Smoking 	<ol style="list-style-type: none"> 1. Access to healthcare 2. Social determinants of health 3. Obesity 	Obesity
6	<ol style="list-style-type: none"> 1. Access to healthcare 2. Immunizations 3. Teen pregnancy 	<ol style="list-style-type: none"> 1. Access to healthcare 2. Obesity 2. Physical activity 	Access to healthcare
7	<ol style="list-style-type: none"> 1. Smoking 2. Breast cancer screening 3. Physical activity 4. Access to healthcare 	<ol style="list-style-type: none"> 1. Mental health 1. Substance abuse (prescription and illicit drug use) 2. Obesity 2. Access to healthcare 2. Smoking 	<ul style="list-style-type: none"> • Obesity • Access to healthcare • Prevalence and management of chronic diseases
8	<ol style="list-style-type: none"> 1. Smoking 2. Binge drinking 3. Teen pregnancy 	<ol style="list-style-type: none"> 1. Physical activity 2. Substance abuse 3. Mental health 	Obesity

Among all eight regions, the community health issue most commonly noted as trending positively was **smoking**, with five regions indicating it as the top issue and another indicating it as the third ranked issue. **Access to healthcare** and **teen pregnancy** were each listed by two regions as the leading issue with two other regions placing it in the top three. **Breast cancer screening** was listed by one region as the leading issue with positive improvement with three other regions ranking it in the top three. Regional reports provide detailed information about factors identified as contributing positively to the improvements. Most often improvement was attributed to state and local policies, ordinances and regulations; collaborations at the state and local level; initiatives and programs; funding; and the leadership of local and state champions. For example, Michigan's Smokefree Air Law, effective May 1, 2010, was a commonly noted state policy that has impacted Michigan's progress toward decreasing tobacco use.

The leading "problem areas/challenges" identified by the regions included **access to healthcare, obesity, substance abuse, and mental health**. Note, for the purposes of this report, "substance abuse" reflects prescription and illicit drug misuse and abuse. Binge drinking and smoking were considered separately.

The most commonly identified contributing factors or underlying causes for the expressed leading problem areas/challenges included:

- Social determinants of health – the environment in which people live and work including housing, health and transportation systems, access to programs, services and healthy food, environmental health policies, and the economy;
- Lack of access to providers and services; and
- Funding for specific services and programs, including insurance and other forms of reimbursement

There was regional variability in the most important health issue. Of the eight regions, six selected **obesity** as the leading issue. **Access to healthcare** was listed by three regions. The most important issues mentioned by at least one region included: **health disparities/health equity, social determinants of**

health and prevalence and management of chronic diseases. Several regions had ties among the participating small groups for the "most important issue."



Among the array of reasons given for **obesity** being the most important issue were:

- Rising rates in Michigan;
- Monumental costs to society, including healthcare costs;
- Broad impact across all ages – from young children to older adults;
- Linkages to many other issues – diabetes, cardiovascular diseases, cancers, hypertension, mental health, arthritis, renal health, and disability; and
- Relationship to numerous underlying issues and factors – economics, nutrition, fruit and vegetable intake, physical activity levels, lack of infrastructure in rural areas, winter climates, and “pay to play” issues.

State Level Community Health Assessment Summary

The compilation and review of state and regional data and comparisons to national data provided a catalyst for discussion and focus for the identification of pressing community health issues and opportunities in the State of Michigan. The thoughtfulness and engagement of more than 649 stakeholders through regional meetings, public comment, and key informant interviews provided broad perspective and expertise in identifying strategic areas for focus going forward.

- **Smoking, access to healthcare, teen pregnancy and cancer screenings** were noted most often by the eight regions as the **pressing community health issues** trending positively.
- Issues considered **most problematic/challenging** in the regions included: **obesity, access to healthcare, substance abuse and mental health**.
- **Obesity** was identified as the **most important issue** by six of the eight regions.

Next Steps

The information gleaned from the state level community health assessment will be used to develop a state health improvement plan, a Public Health Administration strategic plan, and a related quality improvement plan. The ultimate goal of these efforts is to make Michigan a healthier place to live, learn, work, and play.

Michigan’s Health Profile Chartbook 2011, Regional Health Chartbooks, Regional Health Assessment Reports, and this *State Community Health Assessment Report* can be found on the MALPH website at www.malph.org. In the future, these documents will be accessible through the Michigan Department of Community Health’s website at www.michigan.gov/mdch/.

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ⁱ U.S. Department of Health and Human Services. Office of Disease Prevention and Health Promotion. Healthy People 2020. Washington, DC. Available at www.healthypeople.gov.

ⁱⁱ Michigan Department of Community Health. Michigan Critical Health Indicators, 2010. Accessed at http://michigan.gov/documents/mdch/CHI2010_WebFinal-00_340345_7.pdf on 10/16/11.

Michigan's State Health Assessment

Summary of Key Informant Interviews

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Prepared for
Michigan Department of Community Health
Lansing, Michigan

Prepared by
Public Sector Consultants Inc.
Lansing, Michigan
www.pscinc.com

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INTRODUCTION

The Michigan Department of Community Health (MDCH) and partners began a state health assessment and improvement process in June of 2011. Throughout July and August, eight regional meetings were held across the state in order to gather and interpret information from multiple and diverse sources in order to develop an understanding of the health and health needs of communities across the state. In addition to the regional meetings, local public health departments in each region identified three key informants for interviews to offer greater insight into regional priorities, challenges, efforts, strategies, and leadership. Seven representatives of statewide organizations and agencies were also interviewed for a total of 31 key informant interviews.

Local public health departments were asked to identify key informants who are both knowledgeable and influential regarding public health issues in their region. Interviewees represented a broad array of sectors ranging from health care providers, community and faith-based organizations, education, business, health systems, and local public health, among others.

Regional key informants were asked to identify their region's top one or two most pressing community health issues, as well as their contributing factors, and barriers to addressing those issues in the region. They were also asked what efforts are working well in their region to address those issues, who is involved, and how those efforts can be supported or expanded. Finally, informants were asked if they were aware of other strategies to address those issues that ought to be tried in the region and who (organizations or collaboratives) should be involved in identifying and leading those efforts. Statewide informants were asked similar questions on a statewide level.

When asked to identify the most pressing community health issues, both regional and state-level interviewees focused on four areas of concern: lack of access to health care, obesity, infant mortality, and substance abuse. Many interviewees spoke of these issues directly while some mentioned related concerns when asked to identify their region's (or the state's) most pressing health issues. Issues such as poverty, unemployment, cultural and language barriers, stressed safety-nets, and increases in communicable disease are described within the context of the broader issue of limited health care access below. Interviewees also specifically cited issues like cardiovascular disease, diabetes, and chronic disease management, which are included below in conjunction with obesity, overweight, and related chronic disease. Concerns regarding teen pregnancy rates and sexually transmitted diseases are included as contributing factors to infant mortality.

Disparities were also mentioned in relation to nearly all of the issues identified. Racial disparities were specifically mentioned regarding access to health care and infant mortality in Regions 2S, 2N, 3, 5, and 6. Socioeconomic disparities were discussed at the state level and across rural and urban regions in relation to educational access and attainment, health status, and access to available health and human service resources.

ACCESS TO HEALTH CARE

Health care access was identified by informants in each region as either the top or second most pressing community health issue. Three of the seven statewide informants agreed that access is the single most pressing issue. Across the state, several different aspects of access to health care were discussed, and a variety of underlying causes of disparity and contributing factors were

identified. The types of care for which access is limited that were mentioned most often include primary care (all regions), dental care (Regions 1, 3, 8), and mental health care (Regions 3, 6, 7, 8).

Factors contributing to poor health care access

Interviewees cited many reasons for poor access to health care depending on their region. The major and overarching contributing factor, mentioned by state-level and regional interviewees alike, is poverty (or low income). The economic downturn has raised unemployment rates across the state, causing many people to lose health care coverage through their employer. Simultaneously, the costs of health care are rising, making it difficult for employers to continue to cover employee health insurance. Many of the working poor across the state lack employer-sponsored insurance and do not qualify for Medicaid. As a result, many Michigan residents delay seeking needed mental, dental, and primary care. In the northern Lower Peninsula, seasonal employment, low wages, and very few medium to large employers, present unique challenges for people needing comprehensive coverage.

Representatives from nearly all regions stated that lack of transportation is another barrier to seeking care. For example, in Region 5, community clinics and other resources are available, but without a car, there is no way to reach them within counties, and especially between counties. Even when residents have access to a car, gas is prohibitively expensive.

Provider availability is also a barrier to accessing care due to health provider shortage areas (HPSAs) in northern Michigan, limited service hours, and the limited number of providers that accept Medicaid patients. In rural areas in particular, interviewees reported very low numbers of dentists, psychologists, psychiatrists, primary care physicians, and pediatricians. Mental health programs have also received less state funding in recent years, making these providers scarce across the state.

Language and cultural barriers, particularly in southeast Michigan, contribute to the difficulty accessing health care. There is a great need for interpretive services in areas where there are immigrants and/or refugees who do not speak English. In Regions 1, 3, and 5, interviewees reported that many people avoid the health care system since they feel disconnected from it, or there are no established norms in their families to regularly see dentists and primary care providers. For example, one interviewee described how some Medicaid beneficiaries do not know who their primary care provider is or what health plan they have. Another mentioned that the life experiences of patients and their providers are so vastly different, they have difficulty relating to each other.

What's working well to improve access to health care

Interviewees identified a variety of positive local, statewide, and national efforts that are addressing the issue of access to health care.

Cost and Coverage

To address the issue of rising health care costs and decreasing coverage, businesses like Meijer, Kroger, and Wal-Mart offer prescription drugs at low flat rates. This has been critical for many people to be able to afford and easily access medications. For those who are uninsured, Federally Qualified Health Centers (FQHCs) and other free or low-cost clinics are integral in providing access to care, especially in areas of the northern Lower Peninsula and Upper Peninsula where

there are few or no hospitals. Some FQHCs, such as InterCare in southwest Michigan, serve multiple counties with fixed sites, mobile vans, and school-based clinics.

Transportation

Strategies to address transportation issues have been mostly at the grassroots level or initiated by local health plans and health departments. For example, a partnership of the Kent Medical Society and Kent County Health Plan resulted in a number of community outreach initiatives to improve access and transportation. Interviewees noted, however, that transportation funding is beyond the scope of local public health agencies and efforts in Kent and elsewhere have not proved sustainable.

Language and Culture

Some health systems, such as Sparrow Health System in Lansing, along with individual providers have begun to use translation and interpretation services to reduce cultural barriers to access. Community-based organizations, like the Arab Community Center for Economic and Social Services (ACCESS) in Dearborn, use broad networks to provide services and resources to immigrant and refugee populations.

Provider Availability

Provider shortages and limited availability are being addressed through programs aimed at increasing workforce volume, particularly in underserved, rural areas. The National Health Service Corps offers loan forgiveness to future health professionals and The Family Health Center in Kalamazoo is collaborating with Michigan State University's residency program to recruit and house learning and teaching physicians. Blue Cross Blue Shield of Michigan is also providing funding for medical doctors to do their residencies in underserved areas. In the northern Lower Peninsula, "telehealth" has been used successfully for chronic disease management where providers are scarce and distance to care is a barrier. Interviewees agreed that these efforts are positive, but do not suffice.

A promising method of increasing primary care access has been the re-introduction of nurses in schools. In Region 5, two-year nursing schools have rotations in the school systems, and across the state, there is an increasing number of school-based health centers and school nurses thanks to Kellogg and Robert Wood Johnson foundation funding, according to interviewees. School-linked health centers can provide needed medical, behavioral, and dental care for children without coverage.

Free and low-cost options for dental care are available through some clinics and statewide initiatives. Health Delivery Inc. in Saginaw County provides dental and medical care to low-income individuals, and Healthy Kids Dental (a partnership between Delta Dental Plan of Michigan and the Michigan Department of Community Health) exists in most rural counties and is slowly expanding to provide more children on Medicaid with dental care. Universities also have programs for dental students to provide screenings and cleanings for uninsured or underinsured people. These programs are limited, however, and do not provide users with consistent care.

Strategies to improve access to health care

In addition to identifying already successful initiatives, interviewees provided several suggestions for improving access to health care.

Implement Health Reform

The broadest strategy suggested by state-level and regional interviewees alike was to continue implementation of the Affordable Care Act. The legislation will provide nearly universal health insurance coverage for Michigan residents and expand Medicaid eligibility. Interviewees felt that initiatives focused on the Patient-Centered Medical Home (PCMH) and population management models will also encourage more regular primary care visits to prevent delays in seeking care.

Reform Provider Payment

The most common recommended strategy from regional and state-level interviewees is to increase provider reimbursement for Medicaid and Medicare. Higher reimbursement can prevent providers from moving out of areas where their caseloads are largely Medicaid and Medicare patients. Provider payment should promote a more preventive care model, using pay-for-performance, value-based insurance design, and cost-containment strategies. Performance and care outcomes should be measured to determine how much reimbursement providers receive.

Support Translation and Interpretation Services

The federal government offers significant matching funds for translation and interpretation services under the Medicaid and CHIP programs. State government could offer funding or reimbursement, or require these services by law among physicians. One interviewee mentioned that California requires that all providers have translated documents and interpretation services, either in person or over the phone.

Increase and Improve Transportation Options

Interviewees in Regions 3, 6, and 7 suggested increasing public transportation options and coordinating those that already exist. Improvements can be made to public transportation such as punctuality, reliability, and expanded operating hours. This is important in all areas: urban, suburban, and rural.

Strengthen the Safety Net

Many of the suggestions to improve health care access dealt with strengthening the safety net. FQHCs can provide cost-effective preventive care; they should increase in number and capacity, especially in areas where there is a high density of underinsured or uninsured individuals. One participant mentioned that in the Upper Peninsula, safety net staff has dwindled by about 50 percent over the past five or six years due to limited program funding. Interviewees also suggested increasing the health professional workforce in medically underserved areas through greater incentives to learn and practice in areas with health professional shortages, such as Northern Michigan. Local health departments should inform families of resources available to them during encounters for other services. For example, they can use Maternal and Infant Health Program home visits to administer child immunizations.

Improve Communications

Interviewees suggested several ways to simplify and centralize communications among care providers and community organizations to improve quality and access and reduce duplicative efforts. A statewide database of best practices could specify what programs are best for different populations. A similar database could reduce fragmentation by informing grantees working on specific projects about other related projects around the state.

Adoption of information technology should promote easier communication between care providers and third party payers, as well as among health care professionals. Paperwork can be

simplified and streamlined to reduce frustration and inefficiencies. Electronic registries such as the Michigan Care Improvement Registry (MCIR), can be used to monitor the health status of adults, much as it has helped get children immunized and prevented disease and hospitalizations.

Communications from programs and organizations to consumers can also be improved by sending more persistent and consistent messages. New social media and technologies should be used, as well as traditional methods of reaching community members. This is especially important for linking low-income families to the health care system.

Reduce Disparities in Care

Interviewees suggested several ways to reduce racial and socioeconomic disparities in care. The state could make it easier for more minorities to enter health care professions and train current providers and staff to develop better patient-provider relationships, respect, and cultural understanding. Data on disparities should be measured and communicated to care providers to promote ownership of the problem. For socioeconomically disadvantaged individuals who are unable to take off time from work to seek care, providers in all care settings ought to offer evening hours on a more regular basis.

OBESITY, OVERWEIGHT, AND RELATED CHRONIC DISEASE

Three of the seven state-level informants and interviewees from almost all regions agreed that obesity is a significant community health issue in the state. Some raised the broad issue of obesity, while others specifically mentioned obesity among children and the increasing prevalence of Type II diabetes mellitus and conditions such as cardiovascular disease and diabetes for which obesity is a risk factor.

Contributing factors to obesity, overweight, and related chronic disease

Lifestyle factors such as unhealthy diets and sedentary lifestyles were the major underlying causes identified by interviewees for obesity and overweight, which are risk factors for diabetes, cardiovascular disease, cancer, and premature death. High smoking rates were also mentioned in Regions 3, 5, and 7 as a contributing factor to cardiovascular disease and cancer.

Interviewees described a variety of reasons for unhealthy diets. Across the state, there are both urban and rural “food deserts,” where there is limited access to fresh fruits and vegetables. An abundance of inexpensive, calorie-dense, and processed foods is widely available and heavily marketed in schools, convenience stores, workplaces, and even health care settings. Vending machines are also very prevalent and promote unhealthy and frequent snacking. Interviewees noted that it is becoming increasingly challenging for families to find time to prepare meals at home, and many do not know how to prepare healthy, well-balanced meals. Large portion sizes at restaurants also contribute to overeating. Although food assistance programs exist for low-income individuals, they are often used to purchase processed and unhealthy foods, according to interviewees.

Across the state, the reasons given for sedentary lifestyles included unsafe and poorly designed environments for daily physical activity or play, increases in screen time (computer, television, videogames), and sedentary job requirements. As one interviewee pointed out, a lot of “our time is spent at work—often at a desk—and we likely drive a car to and from our workplace.” Interviewees also noted that kids are more dependent upon cars to get to school than in the past when they might have walked, biked, or walked to a bus stop.

A final factor contributing to obesity and overweight as cited by interviewees is cultural norms. These conditions and contributing behaviors are considered “the new normal” and are socially accepted. Several interviewees also suggested that people are “lazy” and fail to take personal responsibility for their own health.

Interviewees also suggested that a reason for the increasing levels of chronic disease is the demographic shift happening nationwide, particularly in Michigan. Because the Baby Boomers are aging while so many younger people are leaving the state, there are a greater proportion of older adults developing diseases for which age is a risk factor. This phenomenon is particularly evident in Region 3, which attracts many retirees.

What’s working well to reduce obesity, overweight, and related chronic disease

Interviewees were hopeful about the state-level and national attention that obesity and overweight have received thanks to Governor Snyder and the First Lady, Michelle Obama. Although most agreed that there is still not an appropriate sense of urgency about this issue, interviewees described many efforts across the state focusing on improving diets, increasing physical activity, or both. They noted a growing awareness of the need to create more farmers’ markets, opportunities for daily physical activity, and shifting cultural norms. Local health departments and nonprofit organizations across the state are receiving grant funding to engage in obesity initiatives. Some schools in Region 2N have adopted a culture of health and established health and well-being as core values.

Healthy Food

The following organizations, initiatives, and programs were described by interviewees as working to grow more food locally, expand farmer’s markets, urban gardening, and hoop houses; educate people about healthy foods and meal preparation; make fruits and vegetables more affordable and accessible; put healthy foods in schools, workplaces, and health care settings while removing unhealthy, competitive foods and vending machines; and advocate for policy change.

- Achieve Marquette
- Fair Food Network’s Double-Up Food Bucks Program
- Faith-based organizations
- Gleaners Food Bank
- Good Food Battle Creek
- Head Start partnership with the National Kidney Foundation
- Healthy Oakland Partnership
- Project Healthy Schools
- YMCA: Healthier Communities Initiatives

Healthy Environments

Interviewees mentioned the following organizations, initiatives, and programs as working to encourage more physical activity among children; make changes to the built environment to increase walkability and bike ability; and develop opportunities, standards, and policies for physical activity in communities, schools, and workplaces.

- Building Healthy Communities Grants (MDCH)

- Calhoun County Challenge to lose 100,000 pounds
- Complete Streets Policies
- Girls on the Run
- Iron Heritage Trail in the Upper Peninsula
- Michigan Land Use Institute
- MI-Vibe in Midland County
- Rails to Trails in Region 7
- Safe Routes to School
- We Can! Healthy Berrien: Ways to Enhance Children’s Activity and Nutrition

Worksite Wellness

Worksite wellness programs were also identified as having demonstrated a considerable return on investment among medium to large employers. Blue Cross Blue Shield of Michigan has successfully managed worksite wellness programs for many employers, primarily focused on smoking cessation and weight management.

Strategies to reduce obesity, overweight, and related chronic disease

The overarching strategy suggested by state and regional interviewees is to change people’s nutritional and leisure time habits, while modifying environments to promote integrated physical activity. According to interviewees, we need to shift from a one-on-one education model to policy changes at the state and local levels related to the environmental and broader social issues. Healthy choices and behaviors should be the defaults in health-promoting environments versus health-hindering environments.

Interviewees generally agreed that obesity prevention requires a long-term perspective and should use evidence-based programs with measureable, positive outcomes. Incentives, supports, and champions within communities and workplaces should help people make lifestyle changes, even in adverse environments. Media will play a large role in developing consistent and frequent messages to shape social norms, just as it did for smoking.

Make Healthy Food the Easy Choice

Several state and local policies were suggested by interviewees to make healthy foods more affordable and accessible. Food systems can be localized by an increase in hoop houses for year-round growing and farmer’s markets to support local farmers. State policies could encourage farming of fruits and vegetables, since the federal government currently subsidizes grains and meats instead. The Double-Up Food Bucks Program, which matches food assistance dollars with tokens specifically designated for Michigan-grown fruits and vegetables, should also be expanded across the state to encourage greater consumption of healthy, local foods. Increasing the ratio of grocery stores with fresh produce to convenience stores in urban and rural areas of the state is important, according to interviewees.

Schools were identified as a critical piece in improving food environments. Individual schools, districts, or the state can develop policies to take soft drinks out of the schools; eliminate vending machines with pop or unhealthy snacks; eliminate fried foods at lunch time and require whole grains; and offer home economics classes to teach how to prepare a well-balanced meal including fruits and vegetables. Connecticut and Pennsylvania are examples of states that have adopted standards for competitive foods, or foods sold separate from the USDA school meals program, so

that schools that meet standards get financial support from the federal government. Growing Power, based in Milwaukee, is a nonprofit that has been successful in working with city schools to supply them with produce. They are teaching students how to compost, where food comes from, and what healthy options are available to them. One interviewee suggested making a publicly available inventory of school-based policies, such as standards for meals served at schools, meals brought onto campus, vending, and physical activity.

Policies and Environments to Promote Physical Activity

Interviewees suggested that communities, schools, businesses, and workplaces take steps to encourage more physical activity in daily activities. Since many people cannot afford the time or money required to have a gym membership, there is an opportunity to make infrastructural changes. For example, more public structures could be built or used to support health (such as skate parks, schools staying open at night for walking, wider sidewalks, and bike lanes). Complete Streets and Safe Routes to School should be expanded and supported to provide more opportunities for non-motorized transportation, which can have positive health and environmental impacts while allowing people to save money otherwise spent on gas.

Growing attention has been given to the idea that “place matters” when it comes to obesity, overweight, and chronic illness, meaning that where we live, work, and play affects our health and health behaviors. Interviewees described how developers and city planners have a role in shaping building and community design, the location of housing developments, and the distance people live from their daily needs and community resources. Local and state policies ought to emphasize a sense of place, interviewees claimed. One example of a place-based policy is that buildings should be designed with well-lit and inviting stairs, encouraging their use instead of elevators.

As with nutrition, schools were mentioned by interviewees as key players regarding physical activity promotion. Individual schools, districts, or the state can develop standards for the amount of recess time and physical education requirements, and could make team sports more affordable and available to everyone. A specific program suggested to increase physical activity in gym classes is the CATCH program, or Coordinated Approach to Child Health. CATCH modifies traditional games, like dodge ball, to have more opportunities to stay in the game and increase overall activity levels.

Increase Screening for Chronic Disease Risks

Opportunities to receive screening for hypertension, cholesterol, and blood glucose levels should be made more widely available and on a regular basis. Schools, workplaces, and even malls could be used across the state to inform people of their health status in these regards. One representative suggested that funding be restored to the state’s Breast and Cervical Cancer Control Screening Program that provides mammograms and cervical cancer screenings for low-income women 40 and older.

INFANT MORTALITY

Five of the eight regions across Michigan and one statewide informant identified infant mortality as one of the most pressing community health issues. Interviewees, particularly those in southeast Michigan, noted the disproportional rate of infant mortality among African Americans.

Contributing factors to infant mortality

Interviewees stated that high rates of teen pregnancy (Regions 1, 5), sexually transmitted diseases (STDs) (Region 5), and poor maternal health contribute to infant mortality. Most of these factors, according to interviewees, stem from social issues. Poverty, racism, lack of transportation, low wages, cultural avoidance of the health care system, and a lack of parenting and life skills education are all social issues that contribute to high infant mortality rates. One interviewee noted that over one-half of births in Michigan are to low-income women.

There are also issues related to health care systems such as insufficient STD prevention, screening, and treatment, little or no prenatal care, and a lack of obstetric units and providers in nearby hospitals, especially in the mid-to-northern Lower Peninsula. These circumstances often result in pre-term births.

What's working well to reduce infant mortality

Interviewees identified several activities that they believe will successfully contribute to lowering infant mortality rates. In relation to teen pregnancies and STD prevention, school-linked clinics in some areas provide teenagers with access to information on STDs and contraception, among other health issues. Programs like Girls on the Run are working to strengthen young girls' self-esteem and avoid pregnancy at an early age.

In Regions 2N, 5, and 6, interviewees stated that the Nurse-Family Partnership (NFP) has been working very well to follow families from conception until children are two years of age. The NFP has suffered funding cuts over recent years, even though it is one of the few interventions that have shown positive results. A successful family planning program mentioned is Plan First!; other efforts that were viewed positively by interviewees include WIC (specifically the peer lactation counselors), Head Start, and the Healthy Mothers Healthy Babies Coalition.

Regarding the social issues that interviewees felt are largely responsible for high rates of infant mortality, the Wayne County Place Matters Team is working to address the social determinants of health.

Strategies to reduce infant mortality

Interviewees identified a few strategies that they believe will successfully contribute to reducing infant mortality rates. Some suggested a model such as that used by Illinois to bring down infant mortality rates in that state over the past decade. Illinois' rates dropped by more than 20 percent through the use of an integrated care delivery model by the Illinois Department of Human Services WIC and Family Case Management programs.¹ Further implementation of perinatal regionalization plans was also suggested to increase access to obstetric care. To expand upon what already works in the state, the Nurse-Family Partnership program should be extended across the state and have state funding restored. Placing more nurses in schools should also help improve the health of young women before conception, as well as promote conversations about STD prevention and treatment among both sexes. Targeted social media was identified as one other strategy to reach expectant mothers to offer messages and resources during and after pregnancy.

¹ <http://www.dhs.state.il.us/page.aspx?item=41742> (accessed 10-21-11).

SUBSTANCE ABUSE

Interviewees from several regions cited substance abuse as one of the top community health issues. Substance abuse includes binge drinking, prescription drug abuse, and tobacco use.

Contributing factors to substance abuse

The underlying causes for binge drinking and prescription drug abuse described by interviewees include mental illness or poor mental health and availability of alcohol and prescription drugs. Across the state, unemployment is a contributing factor to poor mental health, including depression, stress, and anxiety. Social acceptance of risk behaviors, including tobacco use, was also identified as a contributing factor to substance abuse.

What's working well to reduce substance abuse

Interviewees did not identify many activities aimed at reducing substance abuse, although some modest efforts were noted. There is a growing number of prescription drop-off locations for old, unused, or unneeded medications to help reduce prescription drug abuse. Severely mental ill individuals are able to receive care coordination and support from Community Mental Health Service Programs, though limited funding prohibits them from serving people with less severe mental illnesses. Finally, Michigan's Smoke-Free Air Law was mentioned across all regions as a positive step towards reducing smoking and second-hand smoke exposure. Delta County has gone one step further to regulate smoking has enacted laws for smoke-free beaches and ice-arenas.

Strategies to reduce substance abuse

Interviewees suggested a handful of strategies to reduce substance abuse, mainly emphasizing and expanding policies or programs that already work. First, hours of sale for alcohol should be reduced, as opposed to the recent approval of additional hours for the sale and purchase of alcohol. Funding for community mental health should be increased. To reduce tobacco use, the state should increase taxes on tobacco products and prohibit smoking in more public places.

SUPPORTING WHAT WORKS

While there are several current efforts across the state designed to address the specific issues described above, interviewees also identified overarching strategies that can help to ameliorate a broad spectrum of community health issues.

- Engage the public and listen to consumer voices.
- Provide strong state leadership and local champions.
- Seek buy-in from a broad range of stakeholders.
- Build on existing partnerships, collaborations, and coalitions.
- Offer incentives and supports rather than punitive measures.
- Encourage collaboration among state-level departments.
- Provide sustainable and focused public and private funding.

Key Players

When interviewees offered descriptions of successful efforts, they identified many key players, whom they suggested should be involved in any future efforts to address community health issues. They also identified organizations that may not presently be engaged, but should be involved in any efforts moving forward. It is clear that interviewees recognize how community health issues can be affected by a broad range of stakeholders. In many counties, multi-body collaboratives, health councils, coalitions, and alliances already exist, according to interviewees.

Interviewees recognized the following types of organizations in current efforts to address community health issues.

Health Care	<ul style="list-style-type: none"> • Area hospitals • Community Mental Health Service Programs • Free health clinics and FQHCs • Health plans (BCBSM, Priority Health, etc.) • Health providers (including dentists, pediatricians, psychologists, psychiatrists, physicians, nurses, and allied health professionals) • Health systems • Local health departments • Third party payers
Community Organizations	<ul style="list-style-type: none"> • Area Agencies on Aging • Churches and faith-based groups • Civil rights organizations • Community coalitions and collaboratives • Foundations • Human service agencies • Minority organizations (Arab-Americans, Hispanics, Chaldeans, African-Americans) • MSU-Extension • Senior services • United Way • Universities • YMCA
Schools	<ul style="list-style-type: none"> • Individual schools • Intermediate school districts
Government	<ul style="list-style-type: none"> • Department of Community Health • Department of Human Services • Department of Education • Department of Transportation • Michigan State Housing Development Authority • Local government
Transportation	<ul style="list-style-type: none"> • Private transportation agencies • Public transit agencies
Community Design	<ul style="list-style-type: none"> • City and county planners • City managers • Real estate developers • Parks and recreation departments
Businesses	<ul style="list-style-type: none"> • Chambers of Commerce • Employers • Farmers markets • Grocery stores • Local restaurants • Media and news sources

Collaborations	<ul style="list-style-type: none"> • Calhoun County Pathways to Health • Great Start Collaboratives • Greater Detroit Area Health Council • Greater Flint Health Coalition • Michigan Health Information Alliance • North Central Council • Power of We • Regional Health Alliance in Battle-Creek • Senior Health Partners • Together We Can Initiative • Traverse Bay Poverty Reduction Initiative • Washtenaw County Integrated Health Services • Washtenaw Health Initiative
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In almost all regions, interviewees suggested there are certain key players missing or that could have a greater representation on community health coalitions than at present.

- **Policy and decision makers:** County commissioners and policy makers at the municipal, county, and state levels were mentioned as key players that need more involvement in coalitions and community health issues in Regions 2N, 3, 6, 7, 8.
- **Schools:** Schools, school districts, and universities were identified as entities that could be more in tune to community health initiatives and planning in Regions 2S, 2N, 3, and 7.
- **Private Sector:** Interviewees in Regions 2S, 3, and 7 and interviewees at the state level suggested the business community and chambers of commerce play a more active role to have a better understanding of insurance and health care since they are purchasers of insurance and some offer wellness programs. Businesses and corporations need a greater understanding of their role in helping a community to better health. Regions 6 and 7 suggested that major third-party payers specifically be more involved.
- **Health care providers:** Dentists, hospitals, and providers could be more involved and have a sustained presence, according to in Regions 1, 3, and 7, respectively.
- **Community members:** Faith-based communities and community organizing initiatives need to be stronger in Regions 2N, 5, 6, 7, 8.
- **Media:** Media also can be more involved by attending and reporting on local health department meetings and forums, or developing and promoting community-wide competitions, according to an interviewee in Region 3.

Lead Entities Moving Forward

Interviewees were asked who should be involved in identifying strategies and leading efforts in the region and across the state. Across all regions, the predominant response was local public health departments. Local health departments were described as natural community leaders that already have developed relationships with key players and have a big-picture perspective. Local health departments currently have a unique opportunity to partner with hospitals, given new rules for hospitals to conduct community health needs assessments every three years. This should help develop a closer working-relationship with the Michigan Health and Hospital Association and local public health to determine priorities and identify local strategies to address community health issues.

Several stakeholders suggested the state health department ought to be responsible for leadership and guidance, but should partner with local health departments to coordinate activities in their own communities. The state and localities ought to come together regularly to develop planning-

partnerships. State-level and regional interviewees reported that they believe state-level departments operate in silos and the MDCH should work more closely with other state departments, such as Human Services, Education, and Transportation.

State-level informants identified the following key players as organizations doing great work in Michigan that should be involved in statewide planning efforts.

- Center for Healthcare Research and Transformation
- Center for Michigan
- Citizens Research Council
- Early Childhood Investment Corporation
- Health insurance carriers
- Michigan Association of Charter School Boards
- Michigan Association of Public School Academies
- Michigan Association of School Administrators
- Michigan Consumers for Healthcare
- Michigan Health Insurance Access Advisory Council
- Michigan League for Human Services
- Michigan Public Health Institute
- Michigan State University-Extension
- Universities

CONCLUSION

In light of the many efforts currently working in the state to address access to health care, obesity, infant mortality, and substance abuse, both statewide and regional stakeholders felt that there is disheartening ignorance on the part of legislators and decision makers regarding the health impacts of public policy. The constant gridlock in Congress makes it difficult for people to have hope in this depressed economy. Until political will around economic and social issues such as poverty, unemployment, and disparities begin to change, regional and state-level informants believe these health issues will continue to fester. Multi-level, multi-disciplinary involvement should foster more community engagement and understanding of public policy impacts. Certainly this statewide needs assessment process was viewed favorably by many interviewees and they believe it will help prioritize strategies across the state for the development of the health improvement plan.