Implementation and Monitoring Process

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

Following the distribution of the CHIP report in 2017, the project coordinator followed up with the organizations and coalitions that are taking a lead role for various objectives and developed a matrix with partners’ updates by objective every six months; The community at large will be informed about the interim updates through a presentation at the Power of We Consortium, scheduled for October 2018.

You can find the initial CHIP document and updates for your review at http://hd.ingham.org/Records,DataReporting/Publications.aspx

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

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CHIP project, Ingham County Coordinator
Ingham County Health Department
## Plan Summary: Priority Areas and Objectives

<table>
<thead>
<tr>
<th>Access to Primary Care</th>
<th>II Access to Quality Care</th>
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</thead>
<tbody>
<tr>
<td><strong>1.</strong> By September 30, 2018 the Access to Primary Care Providers workgroup will have defined the scope of the access problem in Ingham County. )</td>
<td><strong>Revised Objective 1</strong>&lt;br&gt;1. By September 30, 2020 Partnering Health Care provider organizations develop and pilot an electronic patient survey which assesses patient satisfaction with quality of care received.</td>
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<tr>
<td></td>
<td><strong>Revised Objective 2</strong>&lt;br&gt;2. By September 30, 2020, Partner providers improve their patient feedback tools by increasing visibility of client satisfaction forms on websites and in the clinics, at checkouts, in multiple languages.</td>
</tr>
<tr>
<td></td>
<td>3. By September 30, 2020 members of the Mid-Michigan Asthma Coalition will recruit providers to agree on a policy to implement evidence based guidelines that will improve the coordination of outreach, education and engagement between physicians, nurses and other clinicians. **&lt;br&gt;&lt;br&gt;4. By September 30, 2020, members of the Mid-Michigan Asthma Coalition will report an increase in the use of evidence based guidelines for asthma management, (e.g. asthma action plan by at least one new school in Ingham County. **&lt;br&gt;&lt;br&gt;5. By September 30, 2020, the Mid-Michigan Asthma Coalition will continue to work on policy and system changes across the sectors leading to at least one such change in one of the sectors. **</td>
</tr>
<tr>
<td>*This objective has been interrupted due to the various policy and measurement issues to be considered. All of the programs provide education to students and residents about loan repayment opportunities. *</td>
<td><strong>Signs Rubric:</strong>&lt;br&gt;Objective completed ✓&lt;br&gt;Objective in progress ❓&lt;br&gt;Waiting for updates or could be revised ❓&lt;br&gt;Objective Interrupted ❗&lt;br&gt;&lt;br&gt;<strong>Mid-Michigan Asthma Coalition no longer exists</strong>&lt;br&gt;<strong>ICHDA staff changes and no current program funding</strong>&lt;br&gt;</td>
</tr>
</tbody>
</table>
## Plan Summary: Priority Areas and Objectives

<table>
<thead>
<tr>
<th>Chronic Disease Prevention</th>
<th>Financial Stability and Economic Mobility</th>
<th>Behavioral and Mental Health Access</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. By 2020 improve by at least 2% the variety of reduced cost fresh fruits and vegetables in neighborhoods known as food deserts in Lansing that have higher concentration of low income Black and Hispanic populations.</td>
<td>1. By December 2019, increase from three to six banks and credit unions in Ingham County offering bank accounts that meet the Bank On account standards promulgated by the national coalition of Cities for Financial Empowerment.</td>
<td>1. By 2020, improve access and availability of Behavioral Health services (MH and SUD) in the tri-county area that will be measured by decreasing numbers of denials to in-patient psychiatric services and increasing numbers of mild to moderate non-emergency cases of clients who are offered Behavioral Health (BH) services.</td>
</tr>
<tr>
<td>2. By September 2018, provide both indoor and outdoor physical activity opportunities within the Sparrow main campus facility.</td>
<td>2.1. By December 2018, pilot a small loan program serving as a viable social enterprise for local lenders and a resource for people in need of emergency, short-term loans that are safe and accessible.</td>
<td>2. By September 30, 2020 increase the use of research based behavioral health interventions</td>
</tr>
<tr>
<td>3. By 2020 Sparrow Health Systems will increase by a 2% participation in their health education, risk identification and management strategies to increase chronic disease prevention opportunities.</td>
<td>2.2. By December 2018, increase from five to 40 Ingham County residents who open an EARN match-savings/Individual Development Account through the Asset Independence Coalition (AIC) each year.</td>
<td>3. By September 30, 2020, enhance and improve the behavioral health screening protocol and practices within primary care and behavioral healthcare settings.</td>
</tr>
<tr>
<td>4. By 2020, the YMCA of Lansing will increase by a 2% participation in their diabetes prevention and management programs.</td>
<td>3.1. By December 2019, engage at least 300 county residents/organizational leaders in dialogue regarding research-based and local connections between exposure to violence and economic mobility.</td>
<td>5. By September 30, 2020 stakeholders will reduce stigma surrounding access to behavioral health services and improve community health and wellness.</td>
</tr>
<tr>
<td>5. By 2020, ICHD will increase by 2% participation in their chronic disease prevention and management programs.</td>
<td>3.2. By December 2019, equipping local law enforcement, justice, education and health practitioners with tools and resources to identify and dismantle racial inequities.</td>
<td></td>
</tr>
<tr>
<td>6. By 2020, Tri-County Regional Planning Commission will create a Land Use and a Regional Non-Motorized Transportation Plan Advisory group to initiate implementation plans that will improve residents’ ability to safely and conveniently travel by foot, bike or other mobility devices for recreation or work purposes in parks and on/off-roads non-motorized facilities.</td>
<td>3.3. By December 2019, increase the number of residents by 100, ranging from ages 16 through 24 who are enrolled in the MY Lansing Mentoring Network.</td>
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</tbody>
</table>

*The number variation under column IV are due to three different goals in this priority area.*
Plan Summary: Partners Tactics Updates

I. Access to Primary Care

Capital Area Physicians Experience (CAPE) Coalition Standing Committee of the Capital Area Health Alliance (CAHA) including Ingham County Health Department (ICHD), Sparrow Health System and McLaren of Greater Lansing.

Define the scope of the access problem in Ingham County.

1) Wait time to obtain appointment

Update: CAPE members reported reduced waiting times to obtain a PCP appointment.

2) Analyze 211 referrals

Update: CAPE requested and analyzed data from 211 on health related referrals in 2017, about calls for assistance in identifying a physician and is working with committee members and 211 to determine if there is information that can be updated or added. Based on the data, physician referrals are second on the 211 total referrals in Ingham County.

3) Analyze no show issues

Update: CAPE members shared their experience that patients not showing for appointments is a problem, both for the patients who do not keep their appointment and for patients seeking appointments. The process for Medicaid patients to get transportation to appointments covered was identified as a policy issue that needs attention. Patient navigators could help with this process, but current requirements are that the patient must arrange the transportation. Even with efforts and activities underway to expand the number of PCPs in the area, there are patient barriers to access. While many providers have decreased the wait time for appointments, no-shows are a continuing problem. No-show patients take up slots that could have gone to someone else. We know that lack of transportation is a big contributor to the problem. Navigators could arrange patient transportation, but Medicaid policy requires that the patient make the arrangements. A policy change allowing the navigators to help in this process would be valuable in getting people seen.

McLaren of Greater Lansing

Update: McLaren conducted an annual medical staff plan and continues to add primary care and mid-level physicians.
Plan Summary: Partners Strategies and Tactics Updates

II. Access to Quality Care

Ingham County Health Department

Updated the measures and tactics since CHIP was done during a transition time at ICHD.

Revised Strategy 1: Partnering health care provider organizations develop and pilot an electronic patient survey which assesses patient satisfaction with quality of care received.

Tactics updated:
- ICHC to revise current patient satisfaction survey (PSS) to include question to assess patient satisfaction with quality of care received. (May-June 2018)
- ICHC to review electronic PSS proposal with ICHC Board of Health. (May 2018)
- ICHC to research and implement an electronic survey administration tool (text-based, web-based) (July/August 2018)
- ICHC to administer revised PSS bi-annually. (July/August 2018)
- ICHC to analyze PSS results and share this information on the ICHC website, with Board of Health and community partners. (September/October 2018)
- Monitor the PSS results for 2 years, review data bi-annually at CQI meetings.
- Monitor the implementation process for 2 years with 6-8 outcome data points.

Measurements updated based on changes in Strategy 1

- Partner providers assess the progress made since the baseline.
- PSS response rates per bi-annum.
- PSS results compiled to assess the perception of quality of care provided over time.

Revised Strategy 2: By September 30, 2020, Partner providers improve their patient feedback tools by increasing visibility of client satisfaction forms on websites and in the clinics, at checkouts, in multiple languages.

Tactics updated

- Gather resources necessary to develop training materials for medical professional student residents/fellows to improve communication with patients. (October 2018)
- Create training module in Health Stream and identify and assign functional roles which should complete it (December 2018)
- Evaluate effectiveness and quality of module in Health stream quarterly and share results with Clinical Standardization/Provider's meetings. (every quarter in 2019)

Measurements updated based on change in Strategy 2

- Number of completed modules in Health Stream by functional area.
- Developed modules in Health Stream

Asthma Care Strategy 1: Develop, implement or monitor guideline that are evidence based for asthma management. Tactic Updates from ICHD. Used guidelines from the Managing Asthma Through Case-Management in Homes (MATCH) program providing asthma care resources to primary care providers.

Asthma Care Strategy 2: Pursue avenues for increasing awareness of evidence based guidelines on asthma management, including the use of Asthma Action Plans at schools.

Tactic Update from ICHD. Lansing School Nurse meeting conducted Nov. 2017 regarding the MATCH program availability with MSU Pediatric Pulmonology support. MATCH Asthma medication adherence and asthma action support were provided to the office staff at eight Ingham County Schools ended in June, 2018.
III. Addressing Chronic Disease

1. Northwest Initiative (NWI) – Evaluation of the pilot season for the Mobile Food Market (MFM)

**Update:** The Mobile Food System was launched in the summer of 2017 and had a total of 13 weekly/bi-weekly stops that were made to low-income housing complexes, and low-income neighborhoods in the Greater Lansing community. In a follow up evaluation, 90% of the participants indicated that because of the MFM they now have increased access to fresh fruits and vegetables and at a much more affordable price compared to before, and the local convenience stores offer produce for sale. They indicated that a typical onion or green pepper would sell for $1.50 and NWI were charging $.50 to $1.00 for a green pepper or onion. Based on these results the MFM proceeded to a new season in June 2018. Assets for this initiative include the truck purchased with the Urban Redevelopment Grant, staff from NWI and local food supplies. The Greater Lansing community has over 20 local farmers markets, one Mobile Farmers Market, and many farms stands.

2. Capital Area Food Council (CAFC) - In 2018 a list of indicators will be determined with partners. Examples may include reports from the Greater Lansing Food Bank on Community Gardens, and on Michigan Farmers Market Association reports on farmers markets.

**Update:** Formed a Data Committee to compile a list of indicators that will be reported on yearly to inform local progress in food access. The committee has also informed the asset mapping process of Healthy! Capital Counties’ Round 2. A number of Indicators are being discussed and policy related questions such as: Are there policies to support water access in rural areas? Does your community prioritize food access and health? A short report will be developed to summarize the 2018 accomplishments. It will be published at https://www.capitalareafoodcouncil.org/about.html

3. Sparrow Health Systems – Established environmental changes and continue wellness education for chronic disease prevention

**Update:** Sparrow continues to offer the Be Well at Sparrow (for Caregivers) and Be Well at Work (for employers) online health management portal, which includes a PHA, Risk Advisor, and online health education workshops. Over 12,000 accounts have been created. Sparrow has completed a request process with facilities for indoor and outdoor improvements for physical activity opportunities.

4. The YMCA of Lansing: Increase by a 2% participation in their diabetes prevention and management programs.

**Update:** Provided two risk assessments and A1C testing to screen and bring awareness to Type II Diabetes, 53 people participated. Provided two diabetes prevention Classes with 15 people in a class. The 2017 numbers will be used as a baseline measure towards a 2% increase. In the process of creating a referral system to the YMCA’s Diabetes Prevention Program; so far one referral source was added.

5. Ingham County Health Department – Chronic Disease unit

A. Screening for heart disease, diabetes and cancer

**Update:** Data for this will be pulled from the EMR for clients who are seen at the Community Health Centers and from the WISEWOMAN database. ICHD will evaluate the increase in screening by comparing numbers from this year with numbers from previous years for both CHC and WISEWOMAN. CHC provides education to clients based on their screening results. Likewise, WISEWOMAN clients are provided with risk reduction counseling based on their screening results. For WISEWOMAN clients who are working on a small step, ICHD will evaluate the increase in understanding by comparing the client’s responses on the WISEWOMAN Health Intake Questions with the WISEWOMAN Follow-Up Questions.
III. Addressing Chronic Disease (continued)

5. **Ingham County Health Department– Chronic Disease unit**
   
   **A. Screening for heart disease, diabetes and cancer**

   **Update:** (Continued)
   The Breast and Cervical Cancer Control Navigation Program has been actively engaged in scheduling joint appointments so that high risk clients receive both their breast and cervical cancer screenings as well as their WISEWOMAN clinical screenings (body mass index, blood pressure, total cholesterol, high density lipoprotein cholesterol, and glucose) at the same appointment. The clinical staff have been informing the clients of their screening results and have been making referrals for needed diagnostics. The BCCNP/WISEWOMAN staff have been following-up with the clients to reiterate their results and to ensure that they are getting needed medical follow-up and diagnostic care. In addition, WISEWOMAN staff have been providing risk reduction counseling and health coaching when a client has been interested in working on a small step.

   **B. Encourage Healthy Lifestyle through coaching and connection with community resources**

   **Update:** Health coaching sessions are documented in the WISEWOMAN database. ICHD measures the impact of health coaching on healthy lifestyle activities by the information provided on the WISEWOMAN Outcome Evaluation Contact Form (e.g. what programs the client participated in, what community resources the client utilized, what changes the client made or noticed). Positive health outcomes are noted by how the respondents answer questions 6 and 8 on the Outcome Evaluation Contact Form (what changes the client made or noticed and on a scale of 0-10, how confident the client is that she can continue the healthy behavior changes she has made). We measure connecting to community resources by documenting the referrals made in the WISEWOMAN database as well as information provided on the WISEWOMAN Outcome Evaluation Contact Form (e.g. what programs the client participated in and what community resources the client utilized).

   WISEWOMAN staff have provided health coaching and have connected clients to community resources to support their health goals. ICHD has established partnerships with community-based organizations and have developed referral mechanisms for our clients.

   **C. Decrease chronic disease disparity:** Provide Navigation services through the Breast and Cervical Cancer Control Navigation Program. We work with clients who, although insured, experience barriers in getting their annual clinical breast exam, mammogram, pelvic exam, and pap/HPV (if eligible) done. The work with underserved clients continues to assist in surpassing barriers in getting these screenings/exams accomplished.

   **Update:** This navigation work is ongoing and includes the work of multiple programs including: Breast and Cervical Cancer Control Navigation Program (BCCNP), WISEWOMAN, Pathways to Care, and Registration and Enrollment.

6. **Tri-County Regional Planning Commission (TCRPC): Access to physical activity through safe walking and biking**

   **Update:** In 2017 TCRPC gathered partners from local planning units of government and public health to participate in the non-motorized plan development. A regional policy and mapping plan were developed to support non-motorized transportation and increase opportunities for physical activity on roads in addition to parks and trails.
Plan Summary: Partners Tactics Updates

IV. Addressing Behavioral and Mental Health Access

Capital Area Community Mental Health Authority:

1. Improve Access to behavioral health services and development of a youth mobile crisis unit
   
   **Update:** Online Behavioral Health Screening Platform is now on CMHA-CEI website as well as NAMI Lansing and will be added to other referral partner websites. 40+ screenings per month are being completed anonymously and provide additional opportunities for individuals and their networks to connect to behavioral health services and CMHA-CEI Access Center. Tracking increase of calls to access center is in progress and the Mobile Crisis to reach the youth has been actively being deployed to the tri-county area.

2. Support implementation of Tri-County crisis intervention training  (CIT)
   
   **Update:** CIT has an established board of directors and is looking to form 501c3 to sustain efforts. The CIT training is being planned and additional training are being offered to existing CIT trained officers.

3. Assist in community mapping to inform future CHIP
   
   **Update:** The H!CC Asset Mapping team has been supplied with all the information needed to develop a resource map for behavioral and mental health access. Initiatives continue to be supported and considered.

4. Continue to explore data and Integrated Care opportunities, grants, and partnerships between primary care, mental health, and substance use disorder provider networks
   
   **Update:** A screening platform has been added to CMHA-CEI website and the National Alliance for Mental Illness (NAMI) Lansing website, and it will be added to other stakeholder websites over the next few months. Screenings have increased along with calls to the access center.

5. Develop a list of behavioral health interventions and support
   
   **Update:** In progress.

6. Provide continuing medical education to behavioral health provider networks and behavioral health education and primary care networks
   
   **Update:** Coordination of Care dinner presentation events were held in February and June of 2018 to more than 180 primary care and behavioral health care clinical staff in the tri-county area attendees. Other integrated care trainings and opportunities continue to be supported by various partners.

7. Screening Brief Intervention Referral to Treatment (SBIRT) in Clinical Practice
   
   **Update:** Project ASSERT continues to be offered within area educators. Ingham Health Plan can provide further details.

8. Develop and begin implementation of a Behavioral Health Promotion Campaign (inclusive of suicide prevention, substance abuse prevention, and wellness activities, events, and opportunities)
   
   **Update:** Lifesavers Coalition continues to meet and gather new members, funding, resources and information to provide suicide prevention preparedness and response resources for our area networks. CMHA-CEI is also developing a stigma reduction campaign for area behavioral health networks and partners called “Stand Up 2 Stigma”.
Plan Summary: Partners Tactics Updates

V. Addressing Financial Security and Economic Mobility

Financial Empowerment Center (FEC) – City of Lansing

1. **Hold meetings with banks and credit unions to explain the Bank On national account standards and ask them to discuss their current standards.**

   **Update:** The updated Bank On National Account Standards (http://joinbankon.org/wp-content/uploads/2017/05/Bank-On-National-Account-Standards-2017-2018-final.pdf) were developed by the Cities for Financial Empowerment Fund and include both core and recommended features. Safe, affordable bank accounts are critical to financial stability, particularly in low-to-moderate income households. The standards help families to bank successfully, by offering products which are safe, affordable, and functional – without hidden fees or confusing language.

   The FEC staff assist in promoting two Bank On approved accounts: a) Dart Bank Bank On Checking Account; b) Flagstar Bank SimplyOne Account; as well as two accounts that are not yet Bank On approved: CASE Credit Union’s Everyday Checking and PNC Bank’s Foundations Checking.

   The FEC staff are currently working with MSUFCU and Fifth Third Bank in their development of Bank On National Account Standards approved accounts. FEC staff met with each financial institution, shared the standards and their value, and they are now working with their development teams to finalize the products.

2. **Offer technical assistance and promotional benefits to banks and credit unions willing to adopt the Bank On national account standards.**

   **Update:** FEC staff promote the four accounts listed above with our Financial Empowerment Center clients (approximately 900 new clients per year). FEC staff also work with the partner financial institutions to assist those who are completely unbanked in order to remove barriers to opening, as well as those who are banked but not in a product that is safe and affordable for them. The Cities for Financial Empowerment Fund provides a Bank On / National Account Standards approved seal for partner institutions to display in their marketing efforts.

   The FEC is looking to work with partners to open branches in unserved and underserved areas. For instance, South Lansing is a banking desert, but there is a payday lender for every 300 people.
### Plan Summary: Partners Tactics Updates

#### V. Addressing Financial Security and Economic Mobility (continued)

<table>
<thead>
<tr>
<th>Capital Area United Way (CAUW)</th>
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<tbody>
<tr>
<td><strong>1.</strong> Host round table discussions with prospective vetting agencies to conduct referrals for short-term loans.</td>
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<tr>
<td><em>Update:</em> The CAUW hosted a small roundtable discussion with identified prospective vetting agencies. Due to proposed changes needed in loan program offered by banks to facilitate access by low-income people, “vetting agencies” will be identified to refer potential clients to CAUW.</td>
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<tr>
<td><em>Initially non-profit partners were going to do the vetting for loan requests, now CAUW will streamline that process and will do the vetting process while non-profits can do the referrals to CAUW.</em></td>
</tr>
<tr>
<td><strong>2.</strong> Identify prospective vetting agencies to conduct referrals for short-term loans.</td>
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<td><em>Update:</em> Non-profit partners make referrals and will not vet applicants; this tactic is no longer valid.</td>
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<tr>
<th>Asset Independent Coalition: (Now part of Capital Area United Way)</th>
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<tr>
<td><strong>1.</strong> Work with Center for Financial Health, Capital Area Housing Partnership, Office of Financial Empowerment and Capital Area Community Services to integrate referrals to EARN into their financial coaching programs.</td>
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<tr>
<td><em>Update:</em> Based upon limited access to the EARN program for typical clients (requires a savings account at a major bank). The Asset Independent Coalition is switching to marketing tax-time savings.</td>
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<tr>
<td><em>The EARN program is limited to big banks while most people CAUW work with are more likely to go to small banks. Therefore, CAUW will focus on savings of tax returns. Instead of promoting EARN to encourage long term saving.</em></td>
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<tr>
<td><strong>2.</strong> Work with Central Michigan 211 to establish a protocol to offer EARN referrals to Ingham County residents who call to schedule an appointment for financial coaching or VITA tax services.</td>
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<tr>
<td><em>Update:</em> As part of the appointment reminder that Central Michigan 2-1-1 sends out (mailer, text, email), VITA clients will be encouraged to bring their Savings Account information rather than the generic – direct deposit information.</td>
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<tr>
<td><em>Rather than having tax returns go in direct deposit into checking accounts, there is a study that says people save more if they have the refund money deposited into their savings account, so when filing taxes the savings account information will be used.</em></td>
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<tr>
<td><strong>3.</strong> Mail <em>EARN</em> educational materials to all VITA appointment-holders in advance of their tax preparation appointment.</td>
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<td><em>Update:</em> Tactic has been initiated and modified.</td>
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Plan Summary: Partners Tactics Updates

Addressing Financial Security and Economic Mobility (continued)

One Love Global

1. Schedule and promote community events, small group dialogues and a community-wide summit to engage residents in conversation about economic mobility and violence.

   **Update:** Funding and staffing is in place to begin planning small group dialogues. The Truth, Racial Healing & Transformation Law Team is planning to host engagement events in four neighborhoods with the highest number of gun violence incidents and arrest rates for Black and Brown residents ages 14-25. The team has also committed to organize at least one community-wide forum and suggests that ongoing engagement in all neighborhoods will be necessary to build trust and a collaborative relationship.

   One Love Global will apply for Roadmaps to Health Team Coaching from County Health Rankings & Roadmaps for coaching regarding public health partnerships to reduce youth, domestic and community violence. Also One Love Global will invite representatives from Cities United to present at the community-wide forum.

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

   **Update:** Funding and staffing are in place to promote high school and post-secondary completion and to begin planning Lansing Opportunity Summer to promote summer and year-round youth employment.

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

   **Update:** MY Lansing My Brother’s Keeper hosted Lansing Opportunity Summer Weekend with a focus on entrepreneurship including a business pitch competition. A prize was sponsored by Leap Inc. There was also a job readiness workshop for youth that included resume and cover letter preparation and a job fair with employers.
Using the CHIP

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

<table>
<thead>
<tr>
<th>Employers</th>
<th>Educators</th>
<th>Faith-based Organizations</th>
<th>Community residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Understand priority health issues that affect your community</td>
<td>• Understand the impact of healthy habits built in childhood</td>
<td>• Invite members of this plan steering committee to present the plan at your congregation.</td>
<td>• Understand how health issues are changing and prioritized in your community.</td>
</tr>
<tr>
<td>• Develop worksite wellness program</td>
<td>• Integrate some of the strategies into the school wellness policies.</td>
<td>• Talk with your members regularly about the importance of practicing healthy lifestyles.</td>
<td>• Use the plan to improve your health and that of people in your circles.</td>
</tr>
<tr>
<td>• Use some of the objectives as discussion topics that may affect the health of your employees</td>
<td>• Collaborate with Ingham County Health Department by sharing your school’s healthy practices that fall under some of the strategies in this plan.</td>
<td>• Identify specific strategies or tactics in the plan that your organization can help advance.</td>
<td>• Use the information to generate leaders’ support.</td>
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<td>• Get involved in future planning activities.</td>
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<thead>
<tr>
<th>Health Care Affiliates</th>
<th>State and Local Public Health Professionals</th>
<th>Community-based Organizations</th>
<th>Government Officials</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Advocate the strategies and tactics in this plan to eliminate barriers to quality health care.</td>
<td>• Use the CHIP to understand and improve the health of Ingham County residents.</td>
<td>• Invite members of this plan’s steering committee to present the plan at your congregation.</td>
<td>• Understand how health issues are changing and prioritized in your community.</td>
</tr>
<tr>
<td>• Offer patients the resources they need to make change relevant to the needs identified in this plan.</td>
<td>• Learn about key priority issues identified by the health improvement planning collaborative.</td>
<td>• Talk with your members regularly about the importance of practicing healthy lifestyles.</td>
<td>• Mobilize leaders in Ingham County and the region to take actions.</td>
</tr>
<tr>
<td>• Get involved in future health planning projects.</td>
<td>• Monitor the implementation of the CHIP by its various leading participants.</td>
<td>• Identify specific strategies or tactics in the plan that your organization can help advance.</td>
<td>• Invest in programs, policy and environmental changes to help residents lead a healthier lifestyle.</td>
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