Public Health - Dayton & Montgomery County is committed to making measurable improvements in the health of this community. As part of an ongoing community health improvement process, community partners from various organizations worked together to develop Montgomery County’s Community Health Improvement Plan (CHIP). Health priorities selected by partners for the CHIP are based on data presented in the 2014 Community Health Assessment. The Community Health Assessment summarized the health status of the 534,325 residents who call Montgomery County home, and included data on overall health, behavioral health risks, health outcomes, the built environment and access to medical and dental care. A review of the data shows little improvement from our first health assessment conducted in 2010.

Despite the significant resources aimed at promoting health and wellness, too many of our citizens continue to use tobacco products, are overweight or obese, eat unhealthy foods, and lack access to affordable, healthy foods. Too many babies are born too small and die before their first birthday, and our drug overdose deaths continue to increase.

Disparities in health continue among races in Montgomery County. Blacks experience a disproportionate burden of disease and premature death compared to Whites.

These trends are unacceptable and require an urgent call to action. The 2016-2019 CHIP provides the framework for mobilizing community action through partnerships to improve the health of all Montgomery County residents, particularly our most vulnerable citizens. Three data-driven health priorities are identified: chronic disease prevention, birth outcomes and behavioral health.

Our community shares ownership of these complex public health problems and will need diverse community engagement to show improvement. Better alignment of our efforts and resources across sectors will be essential to meeting the goals established for each health priority. By working together, we can improve the health of the citizens we serve and achieve our vision of Montgomery County as a healthy, safe and thriving community!

Together, we begin moving the needle today.

Jeffrey A. Cooper, M.S.
Montgomery County Health Commissioner
A Community Health Assessment (CHA) completed by Public Health - Dayton & Montgomery County (PHDMC) in 2014 presented an evaluation of the health issues and health status of the County’s population. In an effort to improve the health of Montgomery County, PHDMC solicited support from community stakeholders in the development of a Community Health Improvement Plan (CHIP). The CHIP is a long-term plan that identifies health priorities, goals, objectives, and action steps that can be used by community organizations to guide them in the development of projects, programs, and policies that are aimed at improving the health of Montgomery County’s residents.

Over 35 community organizations participated in the CHIP development process, and representatives from these organizations served as members of the Steering Committee, Stakeholder Group, and Workgroups. The small Steering Committee oversaw the development of the CHIP. The Stakeholder Group, which represented a larger, more diverse group of organizational representatives, used data collected in the CHA to select the three health priorities:

**Birth Outcomes, Chronic Disease Prevention, and Behavioral Health**

Additionally, the Stakeholders were also responsible for developing a vision for the health of Montgomery County. Once the health priorities were selected, an on-line survey was deployed in the community to solicit residents’ input on possible actions that could be taken to address the priorities. Workgroups for each priority area met frequently to create action plans that detailed specific goals, objectives, and measures that will be used to address these priorities and track progress.

The Workgroups and the Stakeholder Group were asked to consider several overarching principles as they selected the health priorities and created action plans. These principles included the concepts of Collective Impact and Systems-Level Thinking; the tiers of the Health Impact Pyramid; and priority alignment with other county, state, and national health improvement initiatives.

Implementation of the CHIP will begin in mid-2016. On an annual basis, PHDMC will publish a report outlining the progress made accomplishing the goals outlined in the action plans. Revisions to the plan may occur based on the annual review. The CHIP is slated to be implemented over a four year period (2016-2019). Following the next CHA in 2019, the Community Health Improvement Planning process will begin again.
VISION STATEMENT

MONTGOMERY COUNTY: A HEALTHY, SAFE, AND THRIVING COMMUNITY!

We believe that all residents of Montgomery County should have:

▶ equal access to resources that promote a healthy lifestyle
▶ an environment that promotes health and wellness
▶ social support and community connections
▶ knowledge about healthy choices and behaviors
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## PRIORITIES

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In 2014, Public Health - Dayton & Montgomery County (PHDMC) completed a Community Health Assessment (CHA) that provided a comprehensive evaluation of the health status and issues that exist among the County’s population. In order to address the major health issues identified in the CHA, PHDMC engaged a wide-range of community stakeholders to first assist in selecting health priorities for Montgomery County and then work together to create a plan of action to address these problems. The Community Health Improvement Plan (CHIP) is comprehensive and long-term and details goals, objectives, and action steps that will be used by organizations as they implement projects, programs, and policies.
TOOLS FOR UNDERSTANDING THIS REPORT

This report begins with a brief description of the process used to engage the community and stakeholders in the development of the CHIP. Following the summary of the process, there is a section for each identified priority. This document lists the goals and key measures selected for each health priority accompanied by data that supports its significance. A more detailed action plan that includes objectives, action steps, assets and resources, and evidence-based strategies for each priority is available upon request. This report concludes with a discussion of the next steps relative to implementation, ongoing monitoring, and evaluation of the CHIP. A list of key terms and acronyms can be found in the Appendix.

Each health priority has been paired with an icon that will be used to represent the priority throughout this report. These icons will also be used in the community as strategies are implemented to help highlight efforts being made to address the priorities.
HOW WAS THE PLAN DEVELOPED?

Public Health - Dayton & Montgomery County was responsible for providing oversight for the CHIP development process. PHDMC contracted with The Ohio State University’s (OSU) College of Public Health Center for Public Health Practice to serve as lead facilitator. In that role, OSU designed the overall CHIP development process, as well as organized and led CHIP project meetings.

More than 35 community organizations representing hospitals and healthcare providers, insurance companies, city and county government, law enforcement, fire and EMS, not-for-profits, civic groups, foundations, universities, and local businesses participated in the development of the CHIP.

COMMUNITY & PARTNER ENGAGEMENT

A Steering Committee comprised of representatives from five organizations within Montgomery County oversaw the development process of the CHIP and served as the primary decision-making body.

The Stakeholder Group, which represented a broader collection of community organizations, developed a vision for the health of Montgomery County and identified the health priorities.

An on-line survey was developed and deployed community-wide to allow residents to provide input pertaining to possible actions that could be taken to address the selected priority areas. The survey also asked residents to share information regarding resources that are currently in place in their communities that address the priorities.

Workgroups created action plans for each priority area. The Workgroups were comprised of members of the Stakeholder Group, members of active priority-related coalitions, and other critical community partners.
COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP) TIMELINE

July 2015
- CHIP Planning Begins
- First Steering Committee Meeting

August 2015
- First Stakeholder Meeting
- Vision Statement Developed

September 2015
- Second Steering Committee Meeting
- Community Survey Released

October 2015
- Priorities Selected
- First Workgroup Meetings

November 2015
- Continued Development of Action Plans

December 2015
- Final Drafts of Action Plans Completed

January 2016
- Steering Committee final review of CHIP
- Input from CHIP Executive Advisory Council and Board of Health

February 2016
- CHIP report finalized
The Health Impact Pyramid and the concepts of Collective Impact and Systems-Level Thinking were introduced to both the Stakeholder Group and Workgroups as overarching principles to consider throughout the planning process. Alignment with other health improvement initiatives at the county, state, and national levels was also considered throughout the planning process.

**GUIDING PRINCIPLES**

**Common Agenda**
All participants have a shared vision for change including a common understanding of the problem and a joint approach to solving it through agreed upon actions.

**Shared Measurements**
Collecting data and measuring results consistently across all participants ensures efforts remain aligned and participants hold each other accountable.

**Mutually Reinforcing Activities**
Participant activities must be differentiated while still being coordinated through a mutually reinforcing plan of action.

**Continuous Communication**
Consistent and open communication is needed across the many players to build trust, assure mutual objectives, and create common motivation.

**Backbone Support**
Creating and managing a collective impact requires a separate organization(s) with staff and a specific set of skills to serve as the backbone for the entire initiative and coordinate participating organizations and agencies.

Source: Hanleybrown, Kania & Kramer, 2012

**THE FIVE CONDITIONS OF COLLECTIVE IMPACT**

**Collective Impact**
“Organizations from different sectors agree to solve a specific problem using a common agenda, aligning their efforts, and using common measures of success (Kania & Kramer, 2011).”
The Health Impact Pyramid describes the effectiveness of different types of public health interventions. Interventions focusing on socioeconomic factors, at the base of the pyramid, have the greatest potential to improve health. Although interventions at the higher levels have less of an impact on health, the likelihood of long-term success is maximized when strategies are implemented at all intervention levels (Frieden, 2010).
GUIDING PRINCIPLES

SYSTEMS-LEVEL THINKING

A Systems-Level Thinking approach to community health improvement places the focus on the systems that impact health, not solely on individuals. Interventions implemented at the systems-level are intended to affect change in organizations, policies and laws. As part of this CHIP process, five cross-cutting themes were introduced to help the Stakeholders and Workgroups approach the process of selecting priorities, goals, and objectives at the systems-level.

5 CROSS-CUTTING THEMES:

- Infrastructure
- Policy
- Evidence-Based Practice
- Relationships/Partnerships
- Health Disparities/Health Equity

ADDRESSING HEALTH DISPARITIES AND HEALTH EQUITY

WHAT ARE HEALTH DISPARITIES?

Health disparities are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.

HOW CAN HEALTH EQUITY BE ACHIEVED?

Every person must have full and equal access to opportunities that enable them to lead healthy lives. Everyone must be treated equally and avoidable health inequities and health disparities should be eliminated.

PRIORITY ALIGNMENT WITH OTHER HEALTH IMPROVEMENT INITIATIVES

In order to have the greatest impact on health, it was important that the priorities selected for the CHIP align with county, state, and national health priorities. The figure illustrates priority alignment with Montgomery County’s health and safety strategic planning priorities, the Ohio Department of Health (ODH) State Health Improvement Plan (SHIP), and at the national level, Healthy People 2020 topics and the National Prevention Strategy.
After an extensive review of the data from the CHA, Stakeholders discussed possible health priorities for the County. Three priorities were selected through a facilitated process using a set of criteria established by the Steering Committee: Birth Outcomes, Chronic Disease Prevention, and Behavioral Health. Once priorities were agreed upon, Stakeholders were asked to identify existing community assets and resources that supported each of the chosen priorities.

Armed with the data from the CHA, a list of community assets and resources, and the community responses from the on-line survey, the Workgroups created action plans for the priority areas. An action plan acts as a blueprint for addressing these priorities. The action plans include goals, objectives, a timeline, action steps, and lead organizations. The lead organizations are responsible for implementing these plans.

Complete Action Plans for each priority are available by request.
Infant Mortality is the key long-term indicator for birth outcomes as well as for overall community health and well-being. Key influences on infant mortality (deaths of children less than 1 year of age) include: preterm birth (< 37 weeks), low birth weight (< than 5lbs, 8oz), pre- and post-natal maternal tobacco use, and late or no prenatal care.

Healthy moms = Healthy babies

**Goal 1**
- Reduce preterm births.

**Key Measure**
- Decrease the percent of preterm births by 10%.

**Goal 2**
- Reduce substance misuse in pregnant women and mothers of infants.

**Key Measures**
- Decrease the percent of mothers smoking in the third trimester by 10%.
- Decrease the number of infants admitted to the NICU for drug dependency by 10%.
- Increase the number of healthcare practices using evidence-based screening methods to identify pregnant women using alcohol by 10%.

**Goal 3**
- Reduce the infant mortality racial disparity in zip codes 45402, 45405, 45406, 45414, 45415, 45416, 45417, and 45426.*

*These target areas were identified by the Montgomery County Infant Mortality Coalition. These zip codes were selected based on the following criteria: a Black IMR greater than 7.5 and 100 or more Black births. Eighty-one percent of Black infant deaths occurred in these zip codes.

**Key Measure**
- Decrease the Black infant mortality rate in the target areas by 10%.
1. 14% of babies were born prematurely in Montgomery County in 2013.

2. Preterm births are the leading cause of long-term neurological disability in children. Other problems include:
   - Breathing problems
   - Cerebral palsy
   - Vision problems
   - Feeding difficulties
   - Developmental delays
   - Hearing impairment

3. In Montgomery County, 13% of women smoked during the last trimester of their pregnancy.

4. Pregnant women who smoke are almost 2 times more likely to have a preterm birth than those who do not smoke.

5. Fetal Alcohol Spectrum Disorders (FASDs) are a group of conditions that can occur in a person whose mother drank alcohol during pregnancy.
   - Almost 60% of Ohio mothers reported drinking 3 months before pregnancy; 7% during the last 3 months of pregnancy.
   - FASDs are 100% preventable.

6. Black infant mortality in Montgomery County is more than 3 times higher than White infant mortality.

7. Prematurity is the top cause of death among Black babies.

8. 70% of Black infant deaths occur within the first 4 weeks of life.
Obesity, poor nutrition, lack of exercise, and tobacco use are risk factors for chronic diseases such as heart disease, cancer, and diabetes. By increasing the number of Montgomery County residents who lead healthy lifestyles, the prevalence of these diseases will decrease. Regardless of the neighborhood or community in which they live, all residents should have access to safe recreational facilities and healthy food options. New policies and programs emphasizing chronic disease prevention can “make the healthy choice, the easy choice”.

| Goal 1 | • Increase access to safe physical activity opportunities in zip codes 45402 & 45406 (West Dayton), 45417 (Jefferson Township), and 45416 & 45426 (Trotwood).*  
  *These zip codes are identified as priority areas for the Creating Healthy Communities and the Communities Preventing Chronic Disease programs. These are both grant-funded programs within PHDMC.  
  
**Key Measures**  
• Increase the number of existing parks and recreation facilities in the targeted areas that are safe (objective) by 10%.  
• Increase the percent of residents that perceive that the existing parks and recreation facilities in the targeted areas are safe (subjective) by 10%.  

| Goal 2 | • Increase access to healthy foods.  
  
**Key Measure**  
• Decrease the number of census tracts in Montgomery County that are considered to be food deserts by 10%.  

| Goal 3 | • Decrease tobacco use.  
  
**Key Measure**  
• Reduce cigarette smoking by adults by 10%.  

| Goal 4 | • Increase physical activity and healthy eating in children.  
  
**Key Measures**  
• Increase the percent of children who eat a healthy, balanced diet by 10%.  
• Increase the percent of children who participate in one or more hours of physical activity by 3%.  

---
Why is This Important?

Risk factors for many chronic diseases can begin early in life, but evidence shows that making dietary and lifestyle changes may prevent disease progression and premature death.

1. Seven of the top ten causes of death in Montgomery County are due to a chronic disease.
   - 52% of deaths are due to heart disease, cancer, diabetes, or stroke.
   - Heart disease is the leading cause of death in Montgomery County.
   - Black men have the highest heart disease death rate; more than 1.5 times higher than the overall rate for Montgomery County.
   - Diabetes is the 3rd leading cause of death for Blacks and the 7th leading cause of death for Whites.

2. 19% of Montgomery County census tracts are food deserts.
   - 66% of Montgomery County's food deserts are located within the City of Dayton.

<table>
<thead>
<tr>
<th>Montgomery County, Ohio - 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Access to Food</strong></td>
</tr>
<tr>
<td>Population, low access to store</td>
</tr>
<tr>
<td>Population, low income &amp; low access to store</td>
</tr>
<tr>
<td>Children, low access to store</td>
</tr>
<tr>
<td>Households, no car &amp; low access to store</td>
</tr>
</tbody>
</table>
Integration of partners - mental health, primary care, public health, and substance abuse - is critical to meet the behavioral health needs and ultimately the overall health of Montgomery County residents. Primary care providers need to screen for behavioral health issues so that residents receive the behavioral health services they need at the right time. Information must be shared among partners to ensure care is coordinated.

**Goal 1**
- Ensure access to needed behavioral health services at the right amount, at the right time, for the right person, and in the appropriate setting.

**Key Measures**
- Decrease average appointment wait time for clients with referrals for behavioral health services by 10%.
- Increase the number of mental health and substance abuse treatment and prevention programs by 10%.

**Goal 2**
- Increase integration of physical and behavioral healthcare services.

**Key Measure**
- Increase the number of primary care providers who screen for behavioral health disorders by 10%.

**Goal 3**
- Enhance care coordination and information sharing across behavioral health and other system partners.

**Key Measure**
- Implement cross-system coordination protocols. (number of practices to be determined)
Why is This Important?

1. Montgomery County residents reported an average of 4.2 poor mental health days a month.
   - On average, residents reported being depressed 4 days a month and feeling anxious 6.5 days a month.
   - An estimated 8 out of 100 residents (7.8%) had a major depressive episode in the last year.
2. In the United States:
   - Nearly 60% of adults with a mental illness did not receive mental health services in the previous year.
   - Blacks used mental health services at about half the rate of Whites.
   - Approximately 10.2 million adults have both mental health and addiction disorders.
3. 13% of Montgomery County residents report binge drinking.
4. Accidental drug overdose deaths increased 16.8% from 2013 to 2014.
   - Since 2010, the number of overdose deaths in Montgomery County has doubled.
5. Beginning at the end of 2013, illicit fentanyl has substantially contributed to the increase in accidental drug overdose deaths in Montgomery County.
1. Community Health Improvement Plan implementation will begin in mid-2016.

Within each action plan, a lead agency has been identified for each objective. These agencies are responsible for continued planning and implementation. While keeping in mind the concept of Collective Impact, the tiers of the Health Impact Pyramid, and Systems-Level Thinking, agencies will put into practice evidence-based strategies that will show improvements in the community’s health.

2. Conduct an Annual Review of the Community Health Improvement Plan.

Yearly, PHDMC will create an annual report outlining the progress made in implementing the CHIP. Based on that progress, revisions to objectives, responsible organizations, targets, and time-frames may be needed.

3. A Community Health Improvement Plan is a Long-Term Plan.

The current CHIP reflects goals and objectives slated to be implemented over a four year period (2016-2019). By the end of 2019, PHDMC will complete the next Community Health Assessment, and after which, Montgomery County will begin the Community Health Improvement Planning process again.
ACKNOWLEDGEMENTS

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Montgomery County Sheriff’s Department

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Carol Smerz
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Trish Tingler
NOVA Behavioral Health
DATA SOURCES & RESOURCES

Guiding Principles

Birth Outcomes
Ohio Birth Certificates, Ohio Department of Health.
Ohio Death Certificates, Ohio Department of Health.

Chronic Disease Prevention
Ohio Death Certificates, Ohio Department of Health.

Behavioral Health
National Alliance on Mental Illness (NAMI), Mental Health by the Numbers. Retrieved from https://www.nami.org/Learn-More/Mental-Health-By-the-Numbers

Additional Resources
PHDMC Community Health Assessment. Retrieved from http://www.phdmc.org/resources/cha
## Target Areas - Demographics

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<th>45405</th>
<th>45406</th>
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<tr>
<td>White</td>
<td>73.9%</td>
<td>23.4%</td>
<td>29.4%</td>
<td>12.3%</td>
<td>81.6%</td>
<td>65.2%</td>
<td>26.6%</td>
<td>16.7%</td>
<td>21.5%</td>
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<tr>
<td>Black or African American</td>
<td>20.9%</td>
<td>72.8%</td>
<td>65.4%</td>
<td>84.0%</td>
<td>14.4%</td>
<td>30.1%</td>
<td>69.8%</td>
<td>79.9%</td>
<td>74.8%</td>
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<td>Other Race</td>
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<td>1.9%</td>
<td>2.1%</td>
<td>1.0%</td>
<td>0.8%</td>
<td>1.1%</td>
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<tr>
<td>Two or More Races</td>
<td>2.4%</td>
<td>2.5%</td>
<td>3.2%</td>
<td>2.7%</td>
<td>2.1%</td>
<td>2.5%</td>
<td>2.7%</td>
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### Economic Characteristics (2010-2014)

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<th>45416</th>
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<tbody>
<tr>
<td>Poverty - All People</td>
<td>18.5%</td>
<td>47.7%</td>
<td>37.7%</td>
<td>29.8%</td>
<td>19.6%</td>
<td>12.4%</td>
<td>29.1%</td>
<td>41.1%</td>
<td>20.0%</td>
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<td>Average household income</td>
<td>$58,890</td>
<td>$31,531</td>
<td>$34,599</td>
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<td>$54,476</td>
<td>$64,137</td>
<td>$54,135</td>
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### Educational Attainment (2010-2014)

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<th>45415</th>
<th>45416</th>
<th>45417</th>
<th>45426</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than a high school diploma</td>
<td>11.4%</td>
<td>23.6%</td>
<td>17.9%</td>
<td>13.9%</td>
<td>12.9%</td>
<td>8.9%</td>
<td>19.4%</td>
<td>20.4%</td>
<td>12.5%</td>
</tr>
<tr>
<td>High school graduate</td>
<td>29.3%</td>
<td>29.7%</td>
<td>30.1%</td>
<td>32.4%</td>
<td>32.2%</td>
<td>27.8%</td>
<td>34.9%</td>
<td>33.4%</td>
<td>33.0%</td>
</tr>
<tr>
<td>More than a high school diploma</td>
<td>59.3%</td>
<td>46.8%</td>
<td>53.7%</td>
<td>53.7%</td>
<td>54.9%</td>
<td>63.4%</td>
<td>45.6%</td>
<td>46.1%</td>
<td>54.5%</td>
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</table>

### Infant Mortality Rate (IMR) (2011-2013)

<table>
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<th>45406</th>
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<tr>
<td>All Races</td>
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<td>9.3</td>
<td>21.3</td>
<td>15.1</td>
<td>18.4</td>
<td>13.7</td>
<td>15.3</td>
<td>12.1</td>
<td>14.4</td>
</tr>
<tr>
<td>Black IMR</td>
<td>16.9</td>
<td>12.3</td>
<td>25.2</td>
<td>16.8</td>
<td>29.4</td>
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<tr>
<td>White IMR</td>
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<td>0.0</td>
<td>13.7</td>
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KEY TERMS

Behavioral Health Integration - Coordination of mental health, substance abuse, and primary care services

Chronic Disease - A disease that persists for 3 months or more and generally cannot be prevented by vaccines or cured by medication, nor do they just disappear.

Collective Impact - Organizations from different sectors agree to solve a specific problem using a common agenda, aligning their efforts, and using common measures of success

Food Desert - Urban neighborhoods and rural towns without ready access to fresh, healthy, and affordable food

Health Disparities - Differences in health outcomes among groups of people

Health Equity - Attainment of the highest level of health for all people

Health Impact Pyramid - 5-tier pyramid that describes the impact of different types of public health interventions and provides a framework to improve health

Infant Mortality Rate - The number of infant deaths (less than 1 year of age) for every 1,000 live births

Low Birth Weight - A baby weighing less that 2500g or 5 pounds, 8 ounces at birth

Preterm - A birth occurring before 37 weeks of pregnancy

Social Determinants of Health - Conditions (social, economic, and physical) in the places where people live, learn, work, and play that affect a wide range of health risks and outcomes

Systems-Level Thinking - A focus on the systems that impact health, not solely on individuals

ACRONYMS

ADAMHS - Alcohol, Drug Addition & Mental Health Services
CDC - Centers for Disease Control and Prevention
CHA - Community Health Assessment
CHIP - Community Health Improvement Plan
GDAHA - Greater Dayton Area Hospital Association
EMS - Emergency Medical Services
HP2020 - Healthy People 2020
IMR - Infant Mortality Rate
LBW - Low Birth Weight
NICU - Neonatal Intensive Care Unit
ODH - Ohio Department of Health
OSU - Ohio State University
PHDMC - Public Health - Dayton & Montgomery County
SHIP - State Health Improvement Plan
“The power of community to create health is far greater than any physician, clinic or hospital.”

Mark Hyman
Montgomery County
A healthy, safe, and thriving community!