“Alone, we can do so little; together, we can do so much.”

Helen Keller
In 2016, with contributions of over 35 organizations throughout the county, Public Health - Dayton & Montgomery County identified Birth Outcomes, Chronic Disease Prevention, and Behavioral Health as the major issues the community would focus on for the duration of the 2016-2019 Community Health Improvement Plan (CHIP). Since implementation of the CHIP, our community has increased services for women and infants, improved care coordination of behavioral health services, and developed a food equity plan to increase community food security. While these are noteworthy successes, the data presented in the 2019 Community Health Assessment clearly demonstrate that there is still a great deal of work needed to show measurable improvements in the overall health of Montgomery County residents. This is more than evident as the data revealed obvious health disparities due to race; Black residents have a lower life expectancy, live in communities with limited access to healthy foods, and experience higher rates of infant deaths.

As community organizations came together to select the health priorities for the 2020-2022 CHIP, there was a clear consensus that the major health issues in Montgomery County remain the same. It is important to understand that if we want to see meaningful and long-lasting improvements in maternal and infant health, chronic disease prevention, and behavioral health, the work of the CHIP must focus on improving the conditions of the environments where we are born, live, learn, work, play, and age that have an impact on our quality of life – the social determinants of health. As we sharpen our focus, we must also go beyond addressing individual needs through new programs, but aim at making changes to policies, systems, and the environment in which we live.

Finally, we will be most successful in creating meaningful change through collaboration among organizations. Over the past few years, we have laid a solid foundation as organizations throughout Montgomery County now share a common vision and coordinate activities to address infant mortality, food equity, the drug overdose epidemic, LGBTQ health, and the prevention of youth substance use.

Together, we can work to make Montgomery County a healthy, safe, and thriving community!

Jeffrey A. Cooper, M.S.
Montgomery County Health Commissioner
The Community Health Improvement Plan (CHIP) is a three-year plan that identifies priorities, goals, objectives, and strategies selected to improve the health of Montgomery County residents. After reviewing current data from the 2019 Montgomery Community Health Assessment (CHA), numerous community stakeholders came together to identify the priorities for the CHIP. Based on the findings of the CHA, the community chose to continue the work started on the priorities of the 2016-2019 CHIP - Birth Outcomes (changed to Maternal & Infant Vitality), Chronic Disease Prevention, and Behavioral Health.

Following the selection of the priorities of the 2020-2022 CHIP, Workgroups met over several months to create workplans to address each priority. When creating the workplans, Workgroups considered four guiding principles in all their decisions. These principles included:

- ✔ the concept of Collective Impact
- ✔ the alignment of CHIP priorities with state and national health improvement initiatives
- ✔ the impact of the Social Determinants of Health
- ✔ the selection of Policy, Systems, and Environmental Change strategies.

As this CHIP is implemented over the next three years, Public Health will monitor and evaluate CHIP progress by reviewing quarterly progress updates from Workgroups, publishing a publicly available annual outcomes report, and considering workplan revisions based on progress and recommendations of the Workgroups. A new CHA will be completed in 2022, followed by the selection of new priorities for the next Community Health Improvement Plan.
A healthy, safe, and thriving community!
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What is a Community Health Improvement Plan?

The Community Health Improvement Plan (CHIP) is the second part of a two-part health improvement planning process. The first step was the completion of the 2019 Community Health Assessment (CHA) which evaluated health status and issues impacting Montgomery County’s population. Representatives from a variety of organizations throughout the county, as well as citizens, met to first select health priorities based on the issues identified in the CHA and then worked to collaboratively create workplans to select strategies to address these issues.

The CHIP is a three-year community-driven plan that outlines goals and strategies that will be used by coalitions, task forces, organizations, and citizens to address the identified health priorities in the community.

How was the Plan Developed?

Public Health - Dayton & Montgomery County (PHDMC) contracted with The Ohio State University (OSU) Center for Public Health Practice in the College of Public Health to facilitate the priority selection discussion and development of the priority workplans.

Representatives from county and city government, education, hospitals and healthcare providers, managed care companies, non-profit organizations, local businesses, foundations, and civic organizations participated in a CHIP community meeting to select new health priorities and Workgroup meetings to create three-year workplans for each priority.
### Community Health Improvement Plan Timeline

<table>
<thead>
<tr>
<th>Date</th>
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| August 2019 - October 2019 | CHIP Preplanning Discussions
  - Premier Health
  - Dayton Children’s Hospital
  - United Way
  - Montgomery County
  - Greater Dayton Area Hospital Association
  - Montgomery County Alcohol, Drug Addiction & Mental Health Services |
| October 1, 2019       | • 2019 Community Health Assessment Published
  • Community Partner Meeting - Priority Selection |
| January 14, 2020      | • Workgroup Meeting #1
  • Priorities Defined & Goals Selected |
| February 4, 2020      | • Workgroup Meeting #2
  • Key Measures, Objectives, & Strategies Selection |
| February 26, 2020     | • Workgroup Meeting #3
  • Continued Strategy Selection |
| March 2020            | • Continued Development of Workplans |
| May 2020              | • CHIP Workplans Finalized |
The Five Conditions of Collective Impact

- **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 selected CHIP priorities align with and/or complement health improvement efforts at the state and national level, ensuring a collective focus on these health issues. The figure illustrates how the 2020-2022 CHIP health priorities align with Ohio’s State Health Improvement Plan (SHIP) priority factors and health outcomes as well as Healthy People 2020 topic areas.
As Workgroups created workplans, the objectives and strategies chosen for each priority reflect how the community intends to approach health equity by addressing the Social Determinants of Health. Health is not only impacted by personal behaviors such as tobacco use, being physically active, and healthy eating but also by the social and environmental conditions in which people are born, grow, live, work, and age. These conditions are known as Social Determinants of Health. Communities that are disproportionately affected by poverty, unstable housing, unsafe neighborhoods, limited access to healthy food, and substandard education face disparities in health outcomes due to their environment (Healthy People 2020).
Incorporating **Policy, Systems, and Environmental (PSE) Change** strategies into the workplans of the CHIP ensures that long-term, sustainable improvements occur within our community. By addressing laws, rules, processes, and procedures and by shaping the physical environment in which we work, live, and play, the focus moves from programs that target individual behaviors to large scale changes that will impact population health.

**Policy**
changes to laws, regulations, resolutions ordinances, or rules

**Systems**
changes to processes or procedures within an organization

**Environmental**
changes that involve physical or material changes to the economic, social, or physical environment

A “Health Equity in All Policies” resolution was passed by Public Health’s Board of Health in December 2019. This approach encourages Public Health, in addition to all community stakeholders, to incorporate health and equity into decision-making processes across all policies, programs, and services.

The PSE change strategies suggested in the priority workplans should integrate health and equity as they are planned and implemented.
Health Priority Selection

Based on a review of the successes and challenges of the 2016-2019 CHIP and the data of the 2019 CHA, attendees of the CHIP community meeting discussed options for the health priorities of the 2020-2022 CHIP. Group consensus determined that progress was still needed to improve birth outcomes, chronic disease, and behavioral health.

*The three priorities for the 2020-2022 Community Health Improvement Plan are:

- **Maternal & Infant Vitality**
- **Chronic Disease Prevention**
- **Behavioral Health**

*Birth Outcomes was changed to Maternal & Infant Vitality*
Creating the Roadmap for Health Improvement

Over four months, Workgroups met with a skilled facilitator from The Ohio State University Center for Public Health Practice in the College of Public Health to identify goals, measurable objectives, potential strategies, and lead organizations to create priority workplans. These workplans create a roadmap for how the county will achieve priority goals and measure health improvement over the next three years.

**STEP 01** Define Priorities

Through the completion of a Root Cause Analysis, Workgroup members first sought to identify the primary causes of the priority. To further define the priorities, each group conducted a gap analysis considering, “Where are we (community) now?”, “Where do we wish we were?”, and “How are we going to close the gap?”

**STEP 02** Goal Selection

The themes that arose from answering the question, “Where do we wish we were?” became the new goals for each priority.

**STEP 03** Develop Objectives

To achieve these goals, the ideas proposed based on the question, “How are we going to close the gap?”, were refined into specific, measurable, actionable, realistic, and timely (SMART) objectives. Ideally, these objectives implement policies that impact the social determinants of health.

**STEP 04** Strategies

Finally, Workgroups identified the strategies the community could implement to accomplish the objectives.

**Relationship Between The CHIP And Other Initiatives**

The CHIP was designed to complement and build upon work already in place to improve the health of Montgomery County. Rather than conflicting with or duplicating the work of existing task forces and coalitions, the goals and objectives associated with the health priorities were incorporated into the workplans of the CHIP when possible.

Complete workplans are available upon request.
Maternal and Infant Vitality is a measurement of the overall health of the community. We believe that healthy moms and healthy babies will lead to a more educated, healthier community. We will leverage our resources to identify and target pregnant women, which will give us a starting point for improving the health of the overall community.

Healthy mothers and healthy babies are integral to the community’s future.

**GOAL 01**

Reduce the Prevalence of Chronic Diseases Among Women of Childbearing Age (15 - 44 years) during Preconception and Inter-conception Periods

Key Measures

✔ Reduce the percent of women (15 - 44 years) who have diabetes or hypertension prior to pregnancy

✔ Reduce the percent of women (15 - 44 years) who are overweight or obese prior to pregnancy

✔ Decrease the percent of women who become pregnant less than 18 months after giving birth

**GOAL 02**

Reduce the Overall Infant Mortality Rate with a Focus on Reducing Infant Mortality Racial Disparities

Key Measure

✔ Decrease the overall infant mortality rate
Montgomery County has a higher infant mortality rate (IMR) than the state and the Healthy People 2020 goal of 6.0 deaths per 1,000 live births.¹

Most babies die because they are born too early and too small. Prematurity & related conditions are the leading cause of infant death.

10.8% of babies are born too early.²

2 out of 7 infant deaths are prematurity related.²

A large portion of poor birth outcomes are preventable with good Preconception and Inter-conception health.³ A woman’s health prior to and in-between pregnancies can impact the health of her baby.

Having a pre-pregnancy chronic disease (hypertension and/or diabetes) increases the risk of having a preterm or low birth weight baby.

Women with a pre-pregnancy chronic disease are 2X more likely to experience a poor birth outcome.²

Pregnancies spaced less than 18 months after a live birth are also associated with an increased risk for preterm or low birth weight birth, as well as delayed prenatal care.⁴

¹Ohio Department of Health, Birth and Death Files (2017)
²Ohio Department of Health, Birth and Death Files (2018)
³National Institute for Child Health Quality, America’s Problem: Infant Mortality
⁴March of Dimes, Birth Spacing and Birth Outcomes Fact Sheet
Chronic Diseases have a tremendous impact on residents of Montgomery County; they represent 7 of the top 10 leading causes of death, and chronic disease-related healthcare costs have continued to rise. Risk factors for chronic diseases that affect community members include poor nutrition, a lack of physical activity, and tobacco use. Making healthy lifestyle changes like improving nutrition, increasing physical activity, and quitting tobacco can help prevent people from developing these diseases.

Differences in circumstances like income, zip code, and education can affect these behaviors, making it more difficult for some individuals to adopt healthy lifestyles. We will work together to help all residents live longer and healthier lives and to create thriving communities.

### GOAL 01
Increase Physical Activity

**Key Measure**

- Decrease the percent of adults who are physically inactive

### GOAL 02
Decrease Tobacco Use

**Key Measures**

- Decrease the percent of adults who currently smoke tobacco
- Decrease the percent of adults who currently use smokeless tobacco

### GOAL 03
Decrease Cardiovascular Disease-related Hospital Visits

**Key Measure**

- Decrease the number of emergency and non-emergency hospital visits for heart attacks, strokes, and hypertensive disease

### GOAL 04
Increase Community Food Security in Montgomery County

**Key Measures**

- Decrease food waste
- Decrease the percent of individuals considered food insecure
- Decrease the number of census tracts that are considered food deserts
Black men have a Heart Disease Death Rate MORE THAN 1.7X HIGHER and a Diabetes Death Rate 2.3X HIGHER than the overall rates for Montgomery County.

Risk Factors

- 69% of adults live at an unhealthy weight.²
  - 33% are overweight
  - 36% are obese
- 30% of adults are physically inactive.²
- 23% of adults currently smoke.²
  - 34% of current smokers have an annual income below $35,000
- 21% Eat Vegetables Less Than Once Per Day.²
- 41% Eat Fruit Less Than Once Per Day.²

Hospital

- 15% of adults DO NOT have an identified health care provider.²

- Of the 191,931 cardiovascular disease-related hospital visits, 96% were due to hypertensive disease³

1. Ohio Death Certificates, Ohio Department of Health (2016-2017)
3. Greater Dayton Area Hospital Association Healthcare Database
Behavioral Health encompasses both mental health and substance use disorders. We can help improve the behavioral health of Montgomery County residents by promoting resilience and wellbeing, treating mental and substance use disorders, and supporting those who are experiencing or who are in recovery from these conditions - along with their families and communities. Montgomery County has high suicide and drug overdose mortality rates. The number of hospital visits for mental health and substance use disorders increases each year. Behavioral health impacts overall physical health. Mental illness and addiction often occur along with other chronic diseases and can impact life expectancy and quality of life.

Mental illness and addiction affect all Montgomery County residents either personally or through a loved one or neighbor. Therefore, we will work together to improve behavioral health by creating greater connectedness in the community and increasing mental wellness. These efforts will also help improve physical health outcomes for our residents.
Suicide

In Montgomery County, men account for 41% of self-harm hospitalizations and 71% of deaths by suicide.

Montgomery County’s suicide rate: 14.2 per 100,000

HP2020 Goal: 10.2 per 100,000

In the past year, 1 in 12 Montgomery County residents reported having a substance use disorder.

People with serious mental illness are more than 2X more likely to develop cardiovascular and metabolic diseases.

Access to Mental Health Care

Of Americans who report any mental illness, blacks are 5 times more likely to report receiving no mental health care than Whites.

The rate (per 100,000 residents) of mental health providers:

Montgomery County: 220.7 or 450 residents for each provider

For every 100 Montgomery County residents, there are 10 hospital visits for anxiety and 7 hospital visits for depression per year.

One half of lesbian, gay and bisexual individuals report facing discrimination in healthcare settings.

Sources
1) National Alliance on Mental Illness, https://www.nami.org/mhstats  •  2) Greater Dayton Area Hospital Association Healthcare Database
3) CDC WONDER, 2018  •  4) OHYES  •  5) NSDUH 2016-2018  •  6) CMS National Provider Identifier Registry, 2018
7) Mental Health America https://www.mhanational.org/issues/lesbiangaybisexualtransgender-communities-and-mental-health
8) Ohio Death Certificates, Ohio Department of Health (2019)
Over the next three years, priority Workgroups will strive to accomplish the goals and objectives of the CHIP. Through the duration of this CHIP, Public Health will be responsible for ongoing monitoring and evaluation of the effectiveness and the progress made toward community health improvement through the CHIP strategies.

**Evaluation and monitoring will include:**

1. A quarterly progress narrative submitted by each priority Workgroup detailing the activities made toward implementing any strategies.

2. Yearly workplan revisions, if needed, based on the progress made yearly toward implementation.

3. A published annual report that shares progress updates with the community.

By the end of 2022, Public Health will complete the next Community Health Assessment. Using the data analyzed in that assessment, Montgomery County will once again select priorities for the next Community Health Improvement Plan that will begin in 2023.
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CONTRIBUTORS

Advocates for Basic Legal Equality
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City of Dayton
Citywide Development
Community Health Centers of Greater Dayton
Community Overdose Action Team (COAT)
Dayton Business Committee
Dayton Children’s Hospital
Dayton Human Relations Council
Drug-Free Coalition
EveryOne Reach One
Five Rivers Health Centers
Five Rivers MetroParks
Food Equity Coalition
Goodwill Easter Seals Miami Valley
Greater Dayton Area Hospital Association (GDAHA)
Help Me Grow Brighter Futures
Homeless Solutions
Kettering Health Network
LGBTQ Health Alliance
Miami Valley Regional Planning Committee
Montgomery County Administration
Montgomery County Alcohol, Drug Addiction, and Mental Health Services (ADAMHS)
Montgomery County Educational Service Center
Montgomery County Job and Family Services
Montgomery County Medical Society
Montgomery County Prevention Coalition
Montgomery County Residents
Physician’s Charitable Foundation
Physicians for a National Health Program (PNHP)
Premier Health
Public Health - Dayton & Montgomery County
Samaritan Behavioral Health
Sinclair Community College
Single-Payer Action Network (SPAN) Ohio
South Community, Inc
St. Mary Development Corporation
Stillwater Center
Wright State University
YMCA of Greater Dayton
DATA SOURCES AND RESOURCES


ADDITIONAL RESOURCES


Community Overdose Action Team (COAT). Retrieved from https://www.phdmc.org/coat

EveryOne Reach One Task Force. Retrieved from https://www.phdmc.org/health-data-reports/everyone-reach-one


KEY TERMS

**Cardiovascular Disease** - A group of diseases that affect the heart or blood vessels.

**Chronic Disease** - A health condition that takes many months or years to develop and is long-lasting in its effects.

**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.

**Cultural Competence** - The integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes.

**Food Desert** - Urban neighborhoods and rural towns without ready access to fresh, healthy, and affordable food. Instead of supermarkets and grocery stores, these communities may have no food access or are served only by fast food restaurants and convenience stores that offer few healthy, affordable food options.

**Food Insecurity** - The disruption of food intake or eating patterns because of lack of money or other resources.

**Health Disparities** - Differences in health outcomes among groups of people.

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

**Health in All Policies** - A collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas.

**Healthy People 2020** - A framework of national health objectives used to track progress towards national goals of improved health and reduced health threats.

**Infant Mortality** - The death of an infant before his or her first birthday.

**Inter-conception** - The period of time between pregnancies.

**Mental Illness** – A wide range of disorders that affect your mood, thinking, and behavior. Examples include depression, anxiety, schizophrenia, eating disorders, and addictive behaviors.

**Preconception** - The period of time before becoming pregnant.

**Preterm** - A birth occurring before 37 weeks of pregnancy have been completed.

**Sleep-related deaths** - The sudden and unexpected death of a baby less than one year of age in which the cause was not obvious. These deaths often occur within the baby’s sleep area.

**Social Determinants of Health** - Social and environmental conditions in which people are born, grow, live, work, and age.

**Substance Use Disorder** - The continued use of a substance despite experiencing negative consequences.
ACRONYMS

**CHA** - Community Health Assessment
**CHIP** - Community Health Improvement Plan
**COAT** - Community Overdose Action Team
**PHDMC** - Public Health - Dayton & Montgomery County
**PSE** - Policy, Systems, and Environmental Change
**SDOH** - Social Determinants of Health
**SHIP** - State Health Improvement Plan
Our community stands tall and proud – deeply rooted in the values of equality, diversity, innovation, determination, optimism, and teamwork.