2020-2022 MONTGOMERY COUNTY
Community Health Improvement Plan

A Healthy, Safe, and Thriving Community
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Introduction

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. 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. Workgroups were then formed to create workplans outlining specific goals, objectives, and strategies that will be used to address each priority.

While the CHIP is a community driven and collectively owned health improvement plan, Public Health - Dayton & Montgomery County (PHDMC) is charged with providing administrative support, tracking, and collecting data, and reporting implementation progress on a quarterly and annual basis. This annual report outlines the progress the community has made during the first year of implementation of the 2020-2022 CHIP.

Special Note: The COVID-19 pandemic presented many challenges for the Workgroups. Stay at home orders, social distancing, and shifting priorities at Public Health delayed progress in many of the identified objectives. When activities fully return, ideally, the work toward implementing the CHIP can continue.

Vision Statement

Montgomery County
A Healthy, Safe, and Thriving Community
Priorities and Goals

Maternal & Infant Vitality

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

- Reduce the prevalence of chronic diseases among women of childbearing age during preconception and inter-conception periods
- Reduce the overall infant mortality rate with a focus on reducing infant mortality racial disparities

Chronic Disease Prevention

* Differences in circumstances like income, zip code, and education can make it more difficult for some individuals to adopt healthy lifestyles.*

- Increase physical activity
- Decrease tobacco use
- Decrease cardiovascular disease-related hospital visits
- Increase community food security in Montgomery County

Behavioral Health

* Behavioral health means the promotion of mental health, resilience and well-being, the treatment of mental and substance use disorders, and the support for those who experience and/or are in recovery from these conditions along with their families and communities.*

- Address trauma in the community
- Improve social connectedness of individuals in Montgomery County
- Improve equitable access to behavioral health prevention, intervention, and/or treatment services within primary care and hospital settings
- Reduce the number of fatal overdoses
CHIP Implementation Organizational Structure

CHIP Advisory Group

- MIV Co-leads
- CDP Co-leads
- BH Co-leads
- City & County Employees
- Community Members

Maternal & Infant Vitality

Chronic Disease Prevention

Behavioral Health

EveryOne Reach One Task Force

Tobacco and Vape Free Coalition

Food Equity Coalition

LGBTQ Health Initiatives

Prevention Coalition

Community Overdose Action Team (COAT)

Directly Associated Coalition/Task Force
UNDERSTANDING THIS REPORT

The purpose of the Community Health Improvement Plan (CHIP) is to look outside of the work of individual organizations that often serve only a specific segment of the community and instead focus on the activities that organizations can work on collaboratively that will contribute to overall community health improvement. With that in mind, many of the objectives and strategies associated with the goals and priorities reflect new initiatives that build on the progress that has already been made in each of the priority areas. The workplans are designed to suggest strategies that require the cooperation of several organizations to accomplish the stated goals and objectives.

Every year, CHIP priority Workgroups review workplan goals, objectives, strategies, measures, and target dates to determine if the plans need to be revised. Recommended changes should be based on at least one of the following criteria: availability of data to monitor progress, availability of resources, community readiness, significant progress, and/or alignment of goals with county, state, or local plans. The changes made to the current workplans that will be implemented in the second year of the CHIP can be found in Appendix A.

This annual report, as well as the complete Community Health Improvement Plan, is available on Public Health’s CHIP webpage, http://www.phdmc.org/report/community-health-improvement-plan. On a quarterly basis, progress will be updated on the CHIP Dashboard which is also available on the CHIP webpage. The complete CHIP Year 2 action plans are available upon request.

Report Key

Key Measure Progress Descriptions

Data trend is in the desired direction for progress.

Data trend is in the undesired direction for progress.

Data trend shows no directional change.

Objective Status Descriptions

Work associated with this objective is in progress.

Work associated with this objective has not started.

Objective has been accomplished and no other work will be needed.
**GOAL 1 - REDUCE THE PREVALENCE OF CHRONIC DISEASES AMONG WOMEN OF CHILDBEARING AGE (15-44 YEARS) DURING PRECONCEPTION AND INTER-CONCEPTION PERIODS**

<table>
<thead>
<tr>
<th>Key Measures</th>
<th>Baseline</th>
<th>Year 1</th>
<th>Progress</th>
<th>% Change from Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-pregnancy hypertension</td>
<td>4.5%</td>
<td>4.2%</td>
<td></td>
<td>6.7%</td>
</tr>
<tr>
<td>Pre-pregnancy diabetes</td>
<td>1.3%</td>
<td>1.5%</td>
<td></td>
<td>15.4%</td>
</tr>
<tr>
<td>Pre-pregnancy healthy weight</td>
<td>36.2%</td>
<td>37.4%</td>
<td></td>
<td>3.3%</td>
</tr>
<tr>
<td>Interpregnancy interval &lt;18 months</td>
<td>33.2%</td>
<td>32.4%</td>
<td></td>
<td>2.4%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement a preconception health module into the existing health education curriculum</td>
</tr>
<tr>
<td>Increase the percent of women with an interpregnancy interval of 18 months or more</td>
</tr>
</tbody>
</table>
**GOAL 2 - REDUCE THE OVERALL INFANT MORTALITY RATE WITH A FOCUS ON REDUCING INFANT MORTALITY RACIAL DISPARITIES**

<table>
<thead>
<tr>
<th>Key Measure</th>
<th>Baseline</th>
<th>Year 1</th>
<th>Progress</th>
<th>% Change from Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant mortality rate</td>
<td>6.8 per 1,000 live births</td>
<td>9.0 per 1,000 live births</td>
<td></td>
<td>32.4%</td>
</tr>
</tbody>
</table>

**Objectives**

<table>
<thead>
<tr>
<th>Objective</th>
<th>Baseline</th>
<th>Target</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce the rate of preterm births</td>
<td>10.8%</td>
<td>9.7%</td>
<td><img src="#" alt="Progress" /></td>
</tr>
<tr>
<td>Reduce the rate of sleep-related deaths</td>
<td>1.4 per 1,000 live births</td>
<td>1.3 per 1,000 live births</td>
<td><img src="#" alt="Progress" /></td>
</tr>
<tr>
<td>Reduce the Black infant mortality rate disparity based on the HP2030 goal of 5.0 per 1,000 live births</td>
<td>53%</td>
<td>0%</td>
<td><img src="#" alt="Progress" /></td>
</tr>
<tr>
<td>Implement the Community Pathways HUB in Montgomery County</td>
<td>N/A</td>
<td>HUB model implemented</td>
<td><img src="#" alt="Status" /></td>
</tr>
</tbody>
</table>

**REDUCE THE RATE OF SLEEP-RELATED DEATHS**

Safe Sleep Ambassadors

In 2020, Montgomery County began training parents, family members, and caregivers as Safe Sleep Ambassadors. Each Ambassador makes a commitment to spread the safe sleep message to family, friends, and others throughout the community. Even though COVID-19 restrictions made conducting in-person trainings impossible, 57 new Safe Sleep Ambassadors were trained through 11 virtual trainings.
IMPLEMENT THE COMMUNITY PATHWAYS HUB IN MONTGOMERY COUNTY

The Pathways Community HUB bridges the gap between clinical providers and the individual members of the community. The Pathways program pairs an individual with a community health worker (CHW) who serves as a non-clinical advocate to support the client in addressing barriers to care and stresses the importance of prenatal care, mental health care, maintaining health insurance, and having a medical home.

Upon enrollment, the CHW works with the client to complete a comprehensive risk assessment. Each identified risk is translated into a "pathway," for example, unmet needs for food, housing, and other social services. Risks are addressed one at a time, with clients helping to determine priorities.

Currently, the Dayton Regional Pathways HUB's focus has been on serving pregnant women in Montgomery County, specifically in zip codes 45402, 45405, 45406, 45414, 45415, 45416, 45417, and 45426.

The Dayton Regional Pathways HUB has identified the following goals of this initiative:

**Goal #1** Reduce Black infant mortality in Montgomery County.

**Goal #2** Increase the number of Black women reached by evidence-based interventions, including community health workers, home visitors and group prenatal care, in Montgomery County.

**Goal #3** Expand new promising community-based interventions to improve trust and make connections to make care more seamless for Black women in Montgomery County.

The Dayton Regional Pathways HUB works closely with EveryOne Reach One, Public Health - Dayton & Montgomery County, Department of Medicaid, CareSource, and Buckeye Health. The HUB plans to expand services to non-pregnant adults as well as other specific Montgomery County populations in the next year.
GOAL 1 - INCREASE PHYSICAL ACTIVITY

<table>
<thead>
<tr>
<th>Key Measure</th>
<th>Baseline</th>
<th>Year 1</th>
<th>Progress</th>
<th>% Change from Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of adults who are physically inactive</td>
<td>29.5%</td>
<td>25.7%</td>
<td>↑</td>
<td>12.9%</td>
</tr>
</tbody>
</table>

Objectives

<table>
<thead>
<tr>
<th>Objective</th>
<th>Baseline</th>
<th>Target</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase the percent of Black adults in Montgomery County that participate in leisure time physical activity</td>
<td>66.8%</td>
<td>70.8%</td>
<td>🔄</td>
</tr>
<tr>
<td>Increase the percent of adults in Montgomery County that meet both physical activity guidelines</td>
<td>18.4%</td>
<td>19.3%</td>
<td>🟢</td>
</tr>
</tbody>
</table>

INCREASE THE PERCENT OF ADULTS THAT MEET BOTH PHYSICAL ACTIVITY GUIDELINES

A healthy community does not happen by accident. It requires a comprehensive approach covering all aspects social, physical, and economic environments. Creating environments that promote healthy behaviors and improve health outcomes in our communities requires collaboration and partnerships between planning and health professionals.

Recognizing the relationship between social, physical, and economic environments and health, the Miami Valley Regional Planning Commission (MVRPC) launched its PLAN4Health – Miami Valley Initiative.

This multi-year effort intends to:

- Promote and advocate for “Health in All Plans and Policies.”
- Convene and engage partners to improve conditions that are known to be key determinants of health.
- Advance planning efforts aimed at creating conditions for healthy people and communities.

Current and proposed projects and programs include:

- a Health Environment Assessment that provides an overview of where the Region stands on key determinants of health (in progress),
- a Built Environment Assessment intended to evaluate current conditions for active living (Fall of 2021), and
- in collaboration with local health departments, a Community Health Assessment Mapping project that will compile and map a range of health GIS data at the sub-county level.
### Goal 2 - Decrease Tobacco Use

<table>
<thead>
<tr>
<th>Key Measures</th>
<th>Baseline</th>
<th>Year 1</th>
<th>Progress</th>
<th>% Change from Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of adults who currently smoke tobacco</td>
<td>20.8%</td>
<td>20.6%</td>
<td></td>
<td>1.0%</td>
</tr>
<tr>
<td>Percent of adults who currently use smokeless tobacco</td>
<td>3.3%</td>
<td>1.9%</td>
<td></td>
<td>42.4%</td>
</tr>
</tbody>
</table>

**Objective**

<table>
<thead>
<tr>
<th>Baseline</th>
<th>Target</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>34.3%</td>
<td>32.6%</td>
<td></td>
</tr>
</tbody>
</table>

### Goal 3 - Decrease Cardiovascular Disease-Related Hospital Visits

<table>
<thead>
<tr>
<th>Key Measure</th>
<th>Baseline</th>
<th>Year 1</th>
<th>Progress</th>
<th>% Change from Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total emergency/non-emergency hospital visits for Cardiovascular Disease</td>
<td>160,277</td>
<td>161,924</td>
<td></td>
<td>1.0%</td>
</tr>
</tbody>
</table>

**Objective**

<table>
<thead>
<tr>
<th>Baseline</th>
<th>Target</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>90,575</td>
<td>86,046</td>
<td></td>
</tr>
</tbody>
</table>
GOAL 4 - INCREASE COMMUNITY FOOD SECURITY IN MONTGOMERY COUNTY

<table>
<thead>
<tr>
<th>Key Measures</th>
<th>Baseline</th>
<th>Year 1</th>
<th>Progress</th>
<th>% Change from Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Food insecurity rate</td>
<td>17.0%</td>
<td>15.2%</td>
<td></td>
<td>10.6%</td>
</tr>
<tr>
<td>Number of Census Tracts that have been identified as a Food Desert</td>
<td>33</td>
<td>35</td>
<td></td>
<td>6.1%</td>
</tr>
</tbody>
</table>

ADDRESSING FOOD INSECURITY AND AVAILABILITY DURING THE PANDEMIC

Homefull’s new Mobile Grocery began serving Montgomery County’s food desert neighborhoods in October of 2020. This 42ft Freightliner box truck will offer a variety of meats, dairy, household items, and cleaning supplies and is scheduled to stop at local community centers, hospitals, churches, parks, and senior housing sites.

In collaboration with Public Health and Produce Perks Midwest, Dot’s Market on Patterson Rd is offering free delivery to customers residing in zip codes 45403, 45417, and 45426. Dot’s Market also began accepting Produce Perks. This service started in December of 2020, and after a brief hold, delivery service is set to resume by September of 2021.
## Goal 1 - Address Trauma in the Community

<table>
<thead>
<tr>
<th>Key Measures</th>
<th>Baseline</th>
<th>Year 1</th>
<th>Progress</th>
<th>% Change from Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide death rate</td>
<td>14.2 per 100,000</td>
<td>16.4 per 100,000</td>
<td>▲</td>
<td>16.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Baseline Y1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Baseline</th>
<th>Target</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decrease suicide rates across the lifespan</td>
<td>14.2 per 100,000</td>
<td>12.8 per 100,000</td>
<td>![Green Arrow]</td>
</tr>
<tr>
<td>Increase the number of culturally competent mental health providers in the LGBTQ community</td>
<td>6 providers</td>
<td>50 providers</td>
<td>![Green Arrow]</td>
</tr>
</tbody>
</table>
DECREASE SUICIDE RATES ACROSS THE LIFESPAN

Strategy #1 Implement the Zero Suicide Framework across two healthcare systems

- Implementation is in progress in 2 Federally Qualified Health Centers and 1 Behavioral Health system.
- All organizations have developed implementation teams that will champion suicide prevention efforts.
- All organizations have completed an Organizational Self Study to determine organizational readiness and subsequently are developing workplans to adopt all 7 elements of the Zero Suicide framework.

Strategy #2 Advocate for mandated universal screening tools in schools

- Universal screening for behavioral health issues will be provided in 7 public school districts, 1 parochial school, and 2 charter schools in the upcoming academic year.
- The Montgomery County Alcohol, Drug Addiction, and Mental Health Services (ADAMHS) and the Montgomery County Prevention Coalition (MCPC) worked with the Ohio Cosmetology Board to mandate Question, Persuade, Refer (QPR) trainings as part of the continuing education for all barbers and hair stylists in the state.

Strategy #3 Develop education and outreach to inform Montgomery County on the community impact of trauma and the resources available

- MCPC worked to promote the Get Help Now app by distributing 2500 Get Help Now cards and signs within the community.
- MCPC created a Firearms project group to implement crisis hotlines and text lines at firearms retailers throughout Montgomery County and provide training on signs of suicidality for employees.
## Goal 2 - Improve Social Connectedness of Individuals in Montgomery County

<table>
<thead>
<tr>
<th>Key Measures</th>
<th>Baseline</th>
<th>Year 1</th>
<th>Progress</th>
<th>% Change from Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital visits for depression</td>
<td>69.8 per 1,000</td>
<td>75.9 per 1,000</td>
<td></td>
<td>8.7%</td>
</tr>
<tr>
<td>Hospital visits for anxiety</td>
<td>103.2 per 1,000</td>
<td>112.9 per 1,000</td>
<td></td>
<td>9.4%</td>
</tr>
<tr>
<td>Ohio Social Wellbeing Rank*</td>
<td>5th quintile (154 of 186 communities)</td>
<td>3rd quintile (183 of 383 communities)</td>
<td></td>
<td>42.3%</td>
</tr>
</tbody>
</table>

* Measured as 1 of 10 domains of the Community Well-Being index. Social Well-Being is defined as having supportive relationships and love in your life.

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Baseline</th>
<th>Target</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implement Parks Rx Program in Montgomery County</td>
<td>N/A</td>
<td>Implementation of program</td>
<td></td>
</tr>
<tr>
<td>Create a community resource guide that connects individual and families to social support activities</td>
<td>N/A</td>
<td>Creation of community resource guide</td>
<td></td>
</tr>
</tbody>
</table>

## Goal 3 - Improve Equitable Access to Behavioral Health Prevention, Intervention, and/or Treatment Services Within Primary Care and Hospital Settings

<table>
<thead>
<tr>
<th>Key Measure</th>
<th>Baseline</th>
<th>Year 1</th>
<th>Progress</th>
<th>% Change from Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental health care provider ratio</td>
<td>450:1</td>
<td>380:1</td>
<td></td>
<td>15.6%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objectives</th>
<th>Baseline</th>
<th>Target</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocate for policies that would improve accessibility of behavioral healthcare</td>
<td>N/A</td>
<td>2</td>
<td>▶️</td>
</tr>
<tr>
<td>Increase the number of new healthcare settings offering behavioral health prevention, intervention, and/or treatment services</td>
<td>N/A</td>
<td>2 settings or programs</td>
<td>▶️</td>
</tr>
</tbody>
</table>
Dayton Children’s Hospital hosted hybrid online and in-person training for the 
[**Triple P – Positive Parenting Program ®**](#) for its healthcare providers. The 
program aims to equip parents with the skills and confidence they need to be 
able to manage family issues. Through the simple and practical strategies, 
Triple P helps parents confidently manage their children’s behavior and 
prevent problems developing. While it is almost universally successful in 
improving behavioral problems, parenting strategies also focus on developing 
strong, healthy, and positive relationships, attitudes, and conduct.

Triple P is flexible and designed to meet the needs of the individual. It is offered in a variety of setting and the 
interventions are offered at increasing levels of intensity for parents of children birth–16 years. This training was 
offered at 3 different levels:

- **Level 2 Selected Sessions** - a “light touch” intervention providing brief one-time assistance to parents who 
  are generally coping well but have one or two concerns with their child's behavior or development.

- **Level 3 Primary Care** - targeted counseling for parents of a child with mild to moderate behavioral 
difficulties, interventions deal with a specific problem behavior or issue.

- **Stepping Stones** – intervention for parents of pre-adolescent children who have a disability. It has been 
  shown to work with children with intellectual and physical disabilities who have disruptive behavior.

Overall, **30 providers** participated in this training opportunity offered by the hospital and are now able to able to 
work with families – 5 in Level 2, 24 in Level 3, and 1 in Stepping Stones. Triple P is also available through 
Montgomery County Educational Service Center for all Montgomery County families.

### Goal 4 - Reduce the Number of Fatal Overdoses

<table>
<thead>
<tr>
<th>Key Measure</th>
<th>Baseline</th>
<th>Year 1</th>
<th>Progress</th>
<th>% Change from Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of overdose deaths</td>
<td>291</td>
<td>288</td>
<td>1%</td>
<td></td>
</tr>
</tbody>
</table>

![Graph showing reduction in overdose deaths from 291 to 288, indicating a 1% change.](image)
**Next Steps**

The second year of implementation of the 2020-2022 Community Health Improvement Plan began in January 2021. The Workgroups will continue working on the goals and objectives identified in the updated workplans. The CHIP Advisory Group will meet quarterly to receive status updates. The community will continue to be informed of the status of the activities on the CHIP Dashboard located on Public Health’s webpage.

In December of 2021, the Workgroups will begin reviewing and modifying the workplans in preparation of the final year of implementation of the current CHIP.

Planning and development of the next Community Health Assessment will begin in early 2022. This assessment will help the community prioritize the health issues that will be the focus of the 2023-2025 Community Health Improvement Plan.
**APPENDIX A**

**Year 2 Workplan Changes**

Priority Workgroups reviewed their ongoing and planned activities, evaluated the feasibility of accomplishing current objectives, and forwarded any recommended changes to the action plans to the Advisory Group.

The following tables outline the changes that will be adopted for each priority area and the justification given by the Workgroups for the change. The changes are highlighted in red.

### MATERNAL & INFANT VITALITY

<table>
<thead>
<tr>
<th>Goal 1</th>
<th>Objective</th>
<th>Year 2 Proposed Change</th>
<th>Justification for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce the prevalence of chronic diseases among women of childbearing age (15-44 years) during preconception and inter-conception periods</td>
<td>By December 31, 2022, implement a preconception health module into the existing health education curriculum within one public school district.</td>
<td>Removed</td>
<td>Not being addressed</td>
</tr>
<tr>
<td></td>
<td>By December 31, 2022, increase the percent of women with an interpregnancy interval of 18 months or more by 10%.</td>
<td>Removed</td>
<td>Not being addressed</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal 2</th>
<th>Objective</th>
<th>Year 2 Proposed Change</th>
<th>Justification for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reduce the overall infant mortality rate with a focus on reducing infant mortality racial disparities.</td>
<td>By December 31, 2022, reduce the rate of preterm births by 10%.</td>
<td><strong>Added</strong> <strong>Strategy</strong> - Implement a Home Blood Pressure Monitoring program for high-risk pregnant mothers</td>
<td>Current community project</td>
</tr>
<tr>
<td></td>
<td>By December 31, 2022, reduce the Black infant mortality rate disparity by 43% (based on HP2030 goal of 5.0 per 1,000 live births).</td>
<td><strong>Updated</strong></td>
<td>Changed to match HP2030 goal</td>
</tr>
<tr>
<td></td>
<td>By December 31, 2022, increase the rate of mother’s breastfeeding at hospital discharge by 10%.</td>
<td><strong>New</strong></td>
<td>Branch of the EORO taskforce</td>
</tr>
</tbody>
</table>
## CHRONIC DISEASE PREVENTION

<table>
<thead>
<tr>
<th>Goal 3</th>
<th>Objective</th>
<th>Year 2 Proposed Change</th>
<th>Justification for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decrease cardiovascular disease-related hospital visits</td>
<td><strong>Baseline data updated</strong>&lt;br&gt;<strong>Key Measure</strong> – Emergency/ Non-emergency Heart Attack, Stroke, Hypertensive Disease baseline</td>
<td>By December 31, 2022, reduce cardiovascular disease related emergency department visits by 5%.</td>
<td>The baseline measure was updated from 2017 to 2018 data. Closer to CHIP start date.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Goal 4</th>
<th>Objective</th>
<th>Year 2 Proposed Change</th>
<th>Justification for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase community food security in Montgomery County</td>
<td><strong>Removed</strong>&lt;br&gt;<strong>Key Measure</strong> – Food Waste</td>
<td></td>
<td>Unable to be measured annually</td>
</tr>
</tbody>
</table>

## BEHAVIORAL HEALTH

<table>
<thead>
<tr>
<th>Goal 1</th>
<th>Objective</th>
<th>Year 2 Proposed Change</th>
<th>Justification for Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address trauma in the community</td>
<td><strong>Removed</strong>&lt;br&gt;<strong>Key Measure</strong> – Rate of Mental Health Diagnosis</td>
<td>By December 31, 2022, decrease suicide rates across the lifespan by 10%</td>
<td>Was not an accurate measure to gauge progress toward goal.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Generalized</td>
</tr>
</tbody>
</table>

Note: Complete Year 2 workplans are available upon request.
Appendix B

Acknowledgements

Implementation of the CHIP would not have been possible without the support of representatives from the following organizations and agencies at the state, county, city, and neighborhood level.

Advocates for Basic Legal Equality
Adaptation
Alzheimer’s Association Miami Valley Chapter
American Heart Association
Artemis Center
Board of County Commissioners Montgomery County
CareSource
Catholic Social Services of the Miami Valley
Central State University
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
Public Health - Dayton & Montgomery County
Epidemiology Department

http://www.phdmc.org/report/community-health-improvement-plan

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