



Montgomery County Community Health Improvement Plan (CHIP) Year 2 - 6 Month Update

April 2017 - September 2017

October 27, 2017

Birth Outcomes



Chronic Disease Prevention



Behavioral Health



Montgomery County:
 A Healthy, Safe, and Thriving Community!

Frequently Asked Questions about the CHIP Action Plans

What is an Action Plan?

“Most people don’t plan to fail,
they fail to plan.”

-John J. Beckley

Every vision needs a plan that will turn dreams into reality! An action plan serves as a “blueprint” that maps a clear course of action to support community change. It promotes collaborative, efficient, and purposeful work. The plan identifies what the community wants to accomplish and identifies specific action steps, lead organization(s), and timeline.

How were the Action Plans created for the CHIP?

Workgroups created the action plans for each priority area. Workgroups were comprised of members of the Stakeholder Group, members of active priority-related coalitions, and other critical community partners. After identifying any challenges, obstacles, or potential barriers; reviewing the responses from the community on-line survey, and considering the Community Health Assessment data, each group wrote goals, objectives, and action steps to complete the Action Plan for their priority.

The CHIP Action Plans are a continuous work in progress. Measures, objectives, action steps, and target dates are reviewed at least annually to determine if the plans need to be revised.

Why are the Action Plans a critical component of the CHIP?

The CHIP Action Plans are designed to keep the community on task and moving forward toward continuous health improvement. When developing each action plan, the Workgroups carefully considered the activities currently in place addressing the priorities. Therefore, many of the objectives identified in the plans were built upon existing initiatives addressing the priorities and goals but included steps that would support and further expand these activities and address any identified gaps.










Key

As CHIP progress is evaluated, the assessment is based on the community’s progress toward completing the identified action steps.







- All action steps associated with this objective are complete
- Action steps associated with this objective are in progress
- Action steps associated with this objective have not started
- Progress toward this objective are on hold
- New objective

Birth Outcomes













GOAL 1 – REDUCE PRETERM BIRTHS

Objectives	6 Months Year 1	End of Year 1	6 Months Year 2
Increase the number of outpatient clinics enrolled in the Ohio Perinatal Quality Collaborative (OPQC) Progesterone Project			
Expand implementation of evidence-based models of prenatal care to new prenatal care practice locations			
Increase the number of pregnant women enrolled in evidence-based home visiting programs			

GOAL 2 – REDUCE SUBSTANCE MISUSE IN PREGNANT WOMEN

Objectives	6 Months Year 1	End of Year 1	6 Months Year 2
Decrease the percent of women using tobacco during pregnancy			
Introduce evidence-based screening methods to address alcohol use during pregnancy in healthcare settings that see pregnant women currently not using an evidence-based screening method			

GOAL 3 - REDUCE THE INFANT MORTALITY RACIAL DISPARITY IN ZIP CODES: 45402, 45405, 45406, 45414, 45415, 45416, 45417, AND 45426

Objectives	6 Months Year 1	End of Year 1	6 Months Year 2
Increase awareness among the Black community regarding the infant mortality rate and infant mortality disparity and key risk factors by implementing a variety of awareness campaigns			
Reduce preterm births among Blacks			
Implement a plan aimed at increasing participation of Black women of reproductive age in patient-centered medical homes			
Implement a long-term plan/strategy to address Social Determinants of Health in majority Black communities (racial disparity)			



Addressing Smoking During Pregnancy

The BABY & ME - Tobacco Free Program™ is an evidence-based smoking cessation program that has proven successful in improving birth outcomes and the overall health of mothers and their families by offering support and resources to pregnant women.



Eligible pregnant women that are referred to the program:

- * attend four prenatal counseling cessation sessions where they receive education and support
- * submit to biomedical testing (carbon monoxide (CO) test or saliva) at each session
- * receive a \$25.00 diaper voucher at the 3rd and 4th prenatal session if they test tobacco free
- * continue to test for smoke-free status once a month after delivery for up to 12 months
- * receive vouchers for diapers each month they remain tobacco free (\$25 per month for the mom or \$50 per month if both the mom and her support partner remain tobacco free)

Goal 2 Objective 1

“Having the educational support about the damage smoking had on me and my unborn baby was sufficient to stop smoking for life.”

- Tamera Williams

Tamera was the first graduate of the program. She delivered a healthy 7lb. 15oz. baby girl on June 14, 2016.

This program is provided in partnership with:

CareSource, Community Health Centers of Greater Dayton, Elizabeth New Life Center, Five Rivers Health Centers, Kettering Health Network, and Public Health - Dayton & Montgomery County WIC

Dayton & Montgomery County Task Force’s First Annual Infant Mortality Conference

The conference **“EveryOne Reach One,”** kicked off with a formal dinner for dignitaries and state and local decision-makers. This event was held to stress the importance of using a collective impact approach to tackling the complex issue of infant mortality in Montgomery County. Over the next two days, September 22nd and 23rd, close to 200 local community residents, professionals, and health care providers from all over Ohio convened at the Dayton Convention Center for the conference.

The purpose of the conference was to inform the community about infant mortality, strengthen collaboration in support of policies to help reduce infant mortality, and address factors that contribute to infant mortality at the systems, community, and grassroots level. Speakers addressed topics such as social determinants of health, the importance of state and local partnerships, as well as the importance of prioritizing and embracing the community to impact infant mortality.

The conference would not have been possible without several sponsors, (Public Health - Dayton & Montgomery County, Montgomery County, Montgomery County Job & Family Services, Premier Health, Greater Dayton RTA, Thomas Funeral Home, Molina Healthcare, Dayton Children’s, Community Health Centers of Greater Dayton, and Paramount), vendors, and volunteers.



Goal 3 Objective 1

Chronic Disease Prevention

GOAL 1 – INCREASE ACCESS TO SAFE PHYSICAL ACTIVITY OPPORTUNITIES IN ZIP CODES: 45402 & 45406, 45417, AND 45416 & 45426

Objectives	6 Months Year 1	End of Year 1	6 Months Year 2
Conduct a Safe Physical Activity Study to determine safety (real and perceived) of existing parks and recreation facilities in targeted zip codes			
Implement an evidence-based strategy that addresses a recommendation identified in the Safe Physical Activity Study			
Increase the number of communities with local Complete Streets policies			
Implement awareness/education campaign to promote the use of existing infrastructure (bike trails, school gyms, and playgrounds) for physical activity			

GOAL 2 – INCREASE ACCESS TO HEALTHY FOODS

Objectives	6 Months Year 1	End of Year 1	6 Months Year 2
Add healthy choice sections/options in convenience stores located in food desert communities			
Increase the number of farmers' markets/ community gardens located in food desert communities			
Identify and revitalize food gardens that are inactive or struggling in food desert communities			

GOAL 3 – DECREASE TOBACCO USE

Objectives	6 Months Year 1	End of Year 1	6 Months Year 2
Increase the number of 100% smoke-free locations (schools, universities, public housing complexes)			
Pass local legislation to increase tobacco purchase age to 21 in Montgomery County jurisdictions			
Increase the average monthly number of Montgomery County smokers enrolling in the "Ohio Quit Line"			

GOAL 4 – INCREASE PHYSICAL ACTIVITY AND HEALTHY EATING IN CHILDREN

Objectives	6 Months Year 1	End of Year 1	6 Months Year 2
Increase the annual number of new Montgomery County childcare centers that apply for the GetUp Childcare Award			
Increase the number of physical activity programs in targeted areas, outside of schools, available for children during the summer			
Increase the number of children participating in summer meal programs			
Increase the number of childcare centers in Montgomery County designated as an Ohio Healthy Program			



Caution! - Children at Play

The young artists of Helping Adolescents Achieve Long-term Objectives (HAALO) Program and Carroll High School students volunteered to assist the Creating Healthy Communities (CHC) coalition complete three playground improvement projects. These projects were completed at East End Community Services, The Dakota Center, and St. Benedict the Moor School. These projects serve to increase the access children have to safe, physical activity opportunities.



Goal 1 Objective 1 & Goal 4

Lola Smith: Local Smoke-Free Champion

During a smoke-free public housing education series at Greater Dayton Premier Management, one community member shared her personal story about how second-hand smoke exposure had impacted her life.

Lola Smith, now 80 years old, spent half of her life working in a medical environment with smokers. During a routine physical, her doctor told her she could not go home, but needed to go to the hospital because she had a collapsed right lung. When asked how long she had been a smoker, Lola told them that she had never smoked a day in her life. After many unsuccessful attempts to inflate her lung, she had to endure invasive surgical procedures.

Her impromptu testimony at this meeting reinforced the importance of the new smoke-free public housing policy.

When tobacco prevention and cessation program funding was cut from the proposed state budget by the House, the American Cancer Society asked Lola to give her testimony in front of the Senate Finance Committee. The Senate restored funding for tobacco programs in their budget revisions.

Lola now serves on the Board of Greater Dayton Premier Management and is a strong community-level advocate for tobacco prevention initiatives.



Goal 3 Objective 1

Behavioral Health

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

Objectives	6 Months Year 1	End of Year 1	6 Months Year 2
Conduct county-wide needs, gaps, and system barriers analysis to include primary care and behavioral health capacity and accessibility of services			
Implement a minimum of two evidence-based practice models across the continuum of care that will effectively address the results of the needs, gaps, and system barriers analysis			
Implement a behavioral health public awareness campaign to reduce stigma and increase awareness of services offered			
Introduce evidence-based screening methods to address the use of opioids and other illicit substances during pregnancy in three healthcare settings that see pregnant women currently not using an evidence-based screening tool			

GOAL 2 – INCREASE INTEGRATION OF PRIMARY AND BEHAVIORAL HEALTHCARE SERVICES

Objectives	6 Months Year 1	End of Year 1	6 Months Year 2
Identify the number of primary care and behavioral health providers in Montgomery County who screen for both physical and behavioral health disorders			
Increase the knowledge base of behavioral health and primary care providers in integrated care models by offering a minimum of five cross trainings			

GOAL 3 – ENHANCE CARE COORDINATION AND INFORMATION SHARING ACROSS BEHAVIORAL HEALTH AND OTHER SYSTEM PARTNERS

Objectives	6 Months Year 1	End of Year 1	6 Months Year 2
Release a Request for Proposals (RFP) to conduct a feasibility study to explore the capability of improving cross-systems care coordination between physical and behavioral health care providers			
Release a Request for Proposals (RFP) to develop and implement a cross-systems coordination model			

GOAL 4 – REDUCE THE USE OF OPIOIDS AND OTHER ILLICIT SUBSTANCES

Objectives	6 Months Year 1	End of Year 1	6 Months Year 2
Finalize the Incident Management System framework of the Community Overdose Action Team (COAT), collective impact collaborative formed to address the present opioid epidemic			
Develop and implement the Incident Action Plans developed as part of the Community Overdose Action Team (COAT)			



Setting the Example: Integrating Physical and Behavioral Healthcare Services

Five Rivers Health Centers (FRHC) and Community Health Center of Greater Dayton (CHCGD) are two healthcare agencies that have successfully implemented the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model in combination with on-site behavioral health providers to improve behavioral healthcare access within the county. Both health centers continue to improve the services they offer their clients.



FRHC **screens** all patients 18 and older on an annual basis for alcohol and drug abuse, depression, and anxiety. Those patients who screen positive on a pre-screen are given a full screen using the Audit Alcohol Use Disorders Identification Test (AUDIT), Drug Abuse Test (DAST 10), Patient Health Questionnaire-9 (PHQ-9), and/or the Generalized Anxiety Disorder 7 (GAD-7). An on-site substance abuse counselor meets with the patients to perform the full screen, provide **brief intervention**, and then **referral to treatment** if needed. Currently, the Family Health Center, Center for Women's Health, Medical Surgical Health Center, and Samaritan Homeless Clinic have licensed social workers, substance abuse counselors, and case managers providing on-site services. In addition, FRHC have a psychiatrist on staff that is available provide services on-site, and they are working to provide telemedicine services for their patients. Recently, Five Rivers has been able to successfully bill for SBIRT and Behavioral Health services. Finally, they are currently hiring behavioral health staff for the new Greene County location.

CHCGD currently **screens** each patient 12 and older annually for the presence and severity of depression using a 9-question Patient Health Questionnaire (PHQ-9). Medical staff provide **brief intervention** and then **refer** patients to the on-site behavioral health staff or to off-site psychiatry, if deemed necessary. On-site staff include a combination of licensed social workers, psychologists, and Wright State University (WSU) School of Professional Psychology students. CHCGD has had on-site behavioral health staff since July 2008 and began using SBIRT to screen for depression in April 2015. To further enhance the integration of primary and behavioral healthcare at the CHCGD, they have begun working with Wright State Physicians Department of Psychiatry to offer on-site psychiatry services.

Goal 2

Youth-Led Prevention Programs

Making sure they and their peers avoid risky behaviors

Youth-Led Prevention (YLP) is a service that trains youth leaders who are willing to take a vocal and public drug-free stance to become agents of change within their schools. The framework trains youth leaders and their adult advisors on how to do effective peer-led prevention within their schools and communities.

Each group is committed to carrying out prevention efforts on their school campus every year. Successful efforts created and administered by youth leaders during the 2016-2017 school year include:

- * Implementing a 30-minute role modeling educational program for 7th and 8th graders
- * Displaying drug and alcohol facts on school monitors in the cafeteria
- * Creating an alcohol-and-drug-free pledge campaign for 7th-12th graders
- * Hosting special classroom programs in middle school health classes to enhance alcohol and drug refusal skills



YLP is currently in seven Montgomery County schools:

- Archbishop Alter High School
- Centerville High School
- Dunbar High School
- Kettering Fairmont High School
- Oakwood High School
- Meadowdale High School
- Miamisburg High School

As the 2017-2018 school year begins, the seven YLP sites will continue implementing peer-led prevention efforts, while also participating in the planning and execution of the second annual Youth Led Prevention Regional Summit in the Spring of 2018.

Goal 4

NEW Dayton Children's Health Priorities Align with the CHIP Priorities

the state of our children's health

three issues



1 mental health and addiction

9% of children experienced 2 or more **adverse** childhood experiences

parental incarceration
mental illness
DIVORCE
domestic violence
child abuse
parental death
discrimination
substance use

11% of fathers
19% of mothers

of children 0 to 5 rated their mental and emotional health as fair or poor

2 chronic disease

2017 greater dayton area child weight



9% of parents were told by a doctor that their child had asthma

50% of children ages 0 to 11 classified as overweight (14%) or obese (36%)

60% of children 0 to 5 under the federal poverty level experience food insecurity

3 maternal and infant health

11% of parents reported their child was born **premature** — increasing to 21% of african american parents

30% of children 0 to 5 were never **breastfed**

41% of infants experience **unsafe sleeping conditions**

Parents of children ages 0 to 11 surveyed. | Dayton Children's 2017 Community Health Needs Assessment | Funded by the Dayton Children's Foundation Board | childrensdayton.org

In early October, Dayton Children's Hospital released the 2017-2020 Dayton Children's Community Health Needs Assessment (CHNA). Based on feedback from the community, experts in public health and clinical care, and the health needs of vulnerable populations (including minorities, those with chronic illness, low-income populations and medically underserved populations), the health priorities were identified. Not only do the priorities align with state and national priorities, they align perfectly with priorities identified by Montgomery County's Community Health Improvement Plan. The hospital will address mental health and addiction, chronic disease, and maternal and infant health to reach the child population in the Greater Dayton Area.

View the full report at: <https://www.childrensdayton.org/community/advocacy-and-outreach/community-health-needs-assessment>

FIND OUT MORE . . .

The complete Community Health Improvement Plan is available on PHDMC's CHIP webpage, <http://www.phdmc.org/report/community-health-improvement-plan>. The complete CHIP Year 2 Action Plans are available upon request.

On a quarterly basis, progress will be updated on the Dashboard located on the CHIP webpage.

While the CHIP is a community-driven and collectively owned health improvement plan, PHDMC is charged with providing administrative support, tracking and collecting data, and preparing progress reports.

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