Public Health
Prevent. Promote. Protect.
Greene County

ABSTRACT

This is a companion document to the Community Health Assessment, which resulted in the selection of strategic priorities. This plan outlines the work that will be done to improve health outcomes by addressing the priorities. It will be used by community partners as a guide for the collaborative process of improving health in Greene County.

COMMUNITY HEALTH IMPROVMENT PLAN

2023-2026

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Table of Contents

*Note: Throughout the report, hyperlinks will be highlighted in **bold, gold text.** If using a hard copy of this report, please see Appendix II for links to websites.*

Executive Summary

Introduction

A community health improvement plan (CHIP) is a community-driven, long-term, systematic plan to address issues identified in a community health assessment (CHA). The purpose of the CHIP is to describe how hospitals, health departments, and other community stakeholders will work to improve the health of the county. A CHIP is designed to set priorities, direct the use of resources, and develop and implement projects, programs, and policies. The CHIP is more comprehensive than the roles and responsibilities of health organizations alone, and the plan's development must include participation of a broad set of community stakeholders and partners. This CHIP reflects the results of a collaborative planning process that includes significant involvement by a variety of community sectors.

Growing Healthy Together Greene County has been conducting CHAs since 1995 for the purpose of measuring community health status. The most recent Greene County CHA was cross-sectional in nature and included a written survey of adults within Greene County. The questions were modeled after the survey instruments used by the Centers for Disease Control and Prevention (CDC) for their national and state Behavioral Risk Factor Surveillance System (BRFSS). This has allowed Greene County to compare their CHA data to national, state, and local health trends. Community stakeholders were actively engaged in the early phases of CHA planning and helped define the content, scope, and sequence of the project.

The Greene County Health Department contracted with the Hospital Council of Northwest Ohio (HCNO), a neutral, regional, nonprofit hospital association, to facilitate the CHA and CHIP. The Greene County Health Department then invited various community stakeholders to participate in the community health improvement process. Data from the most recent CHA were carefully considered and categorized into community priorities with accompanying strategies. This was done using the National Association of County and City Health Officials' (NACCHO) 1.0 national framework: Mobilizing for Action through Planning and Partnerships (MAPP). Over the next three years, these priorities and strategies will be implemented at the county-level with the hope to improve population health and create lasting, sustainable change. It is the hope of Growing Healthy Together Greene County that each agency in the county will tie their internal strategic plan to at least one strategy in the CHIP.

Public Health Accreditation Board (PHAB) Requirements

National Public Health Accreditation status through the Public Health Accreditation Board (PHAB) is the measurement of health department performance against a set of nationally recognized, practice-focused and evidenced-based standards. The goal of the national accreditation program is to improve and protect the health of the public by advancing the quality and performance of Tribal, state, local, and territorial public health departments. PHAB requires that CHIPs be completed at least every five years, however, Ohio state law (ORC 3701.981) requires that health departments and hospitals collaborate to create a CHIP every 3 years. Additionally, PHAB is a voluntary national accreditation program; however the State of Ohio requires that all local health departments become accredited by 2020, making it imperative that all PHAB requirements are met. The Greene County Health Department received accreditation through the Public Health Accreditation Board (PHAB) in 2018.

PHAB standards also require that a community health improvement model is utilized when planning CHIPs. This CHIP was completed using NACCHO's MAPP 1.0 process. MAPP is a national, community-driven planning process for improving community health. This process was facilitated by HCNO in collaboration with various local agencies representing a variety of sectors.

Inclusion of Vulnerable Populations (Health Disparities)

Health disparities (including age, gender, and income-based disparities) were identified throughout the 2022 Greene County Health Assessment. Income-based disparities are particularly prevalent in Greene County. For this reason, data is broken down by household income (less than $25,000 and $25,000 or higher) throughout the report to show disparities.

Mobilizing for Action through Planning and Partnerships (MAPP)

NACCHO's strategic planning tool, MAPP 1.0, guided this community health improvement process. The MAPP framework includes six phases which are listed below:

1. Organizing for success and partnership development
2. Visioning
3. The four assessments
4. Identifying strategic issues
5. Formulate goals and strategies
6. Action cycle

The MAPP process includes four assessments: community themes and strengths, forces of change, local public health system assessment, and the community health status assessment. These four assessments were used by Growing Healthy Together Greene County to prioritize specific health issues and population groups which are the foundation of this plan. Figure 1.1 illustrates how each of the four assessments contributes to the MAPP process.

Figure 1.1 The MAPP model

Alignment with National and State Standards

The 2023-2025 Greene County CHIP priorities align with state and national priorities. Greene County will be addressing the following priorities: access to care, health behaviors, mental health and addiction, and maternal and infant health.

Healthy People 2030

Greene County's priorities also fit specific Healthy People 2030 goals. For example:

- Health Care Access and Quality (AHS) – 04: Reduce the proportion of people who can't get medical care when they need it
- Nutrition and Healthy Eating (NWS) – 03: Reduce the proportion of adults with obesity
- Mental Health and Mental Disorder (MHMD) – 01: Reduce the suicide rate
- Pregnancy and Childbirth (MICH) – 07: Reduce preterm births.

Please visit **Healthy People 2030** for a complete list of goals and objectives.

Ohio State Health Improvement Plan (SHIP)

The 2020-2022 SHIP serves as a strategic menu of priorities, objectives, and evidence-based strategies to be implemented by state agencies, local health departments, hospitals and other community partners and sectors beyond health including education, housing, employers, and regional planning.

The SHIP includes a strategic set of measurable outcomes that the state will monitor on an annual basis. Given that the overall goal of the SHIP is to ensure all Ohioan's achieve their full health potential, the state will track the following health indicators: self-reported health status (reduce the percent of Ohio adults who report fair or poor health) and premature death (reduce the rate of deaths before age 75).

The SHIP also takes a comprehensive approach to improving Ohio's greatest health priorities by identifying 3 priority factors (community conditions, health behaviors, and access to care) that impact the 3 priority health outcomes (mental health and addiction, chronic disease, and maternal and infant health).

The three priority factors include the following:

1. **Community Conditions** (includes housing affordability and quality, poverty, K-12 student success, and adverse childhood experiences)
2. **Health Behaviors** (includes tobacco/nicotine use, nutrition, and physical activity)
3. **Access to Care** (includes health insurance coverage, local access to healthcare providers, and unmet needs for mental health care)

The three priority health outcomes include the following:

1. **Mental Health and Addiction** (includes depression, suicide, youth drug use, and drug overdose deaths)
2. **Chronic Disease** (includes conditions such as heart disease, diabetes and childhood conditions [asthma and lead])
3. **Maternal and Infant Health** (includes infant and maternal mortality and preterm births)

The Greene County CHIP was required to select at least 1 priority factor, 1 priority health outcome, 1 indicator for each identified priority, and 1 strategy for each selected priority to align with the 2020-2022 SHIP. As outlined in figure 1.2, the following priority outcome, priority factors, priority indicators, and strategies very closely align with the 2020-2022 SHIP.

Figure 1.2 2023-2026 Greene CHIP Alignment with the 2020-2022 SHIP

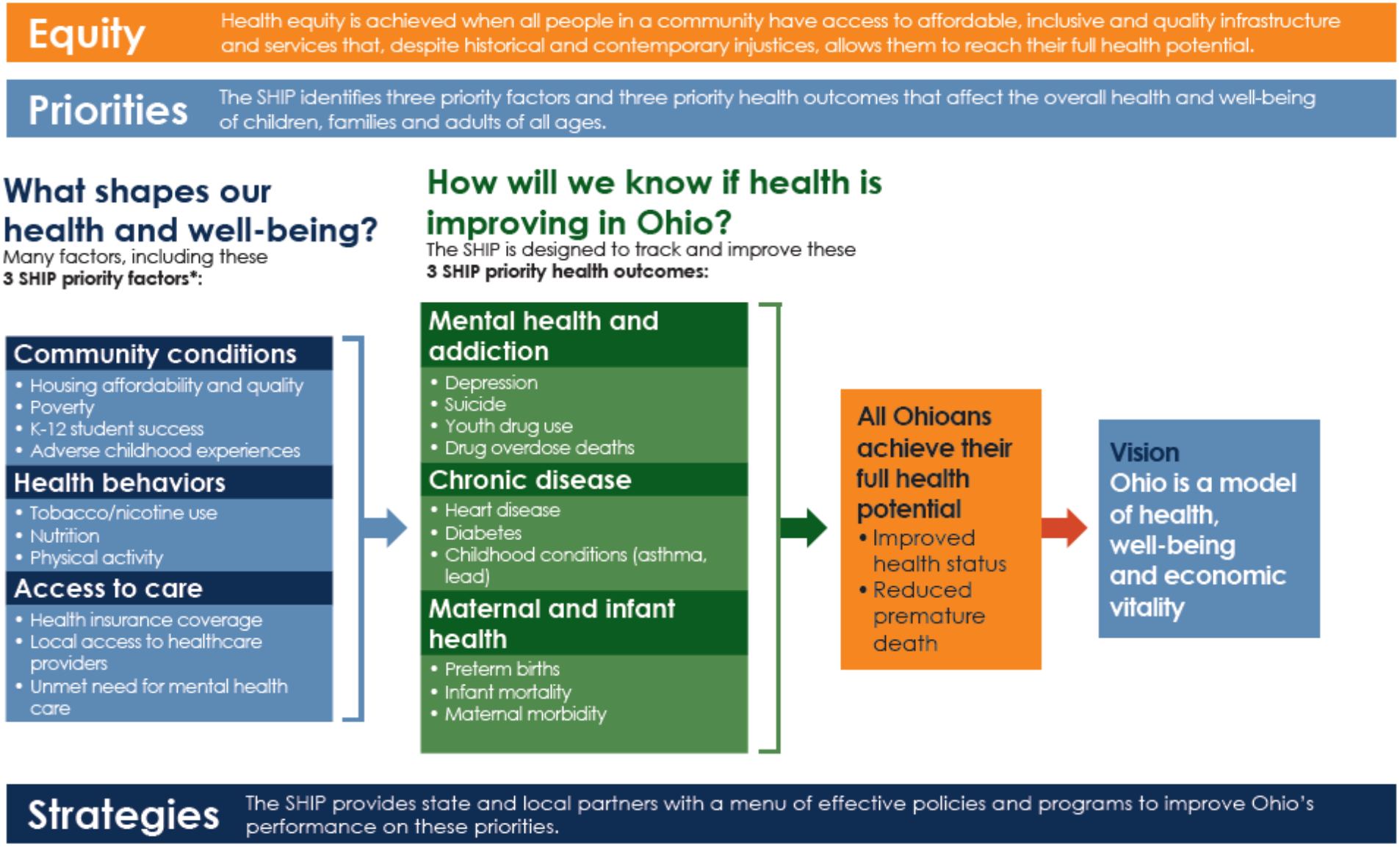
Priority Factors	State Aligned Priority Indicators	Strategies to Impact State Priority Indicators
Access to Care	• Not available	• Not available
Health Behaviors	• Adult physical inactivity	• Multi-component obesity prevention interventions
Priority Outcome	**State Aligned Priority Indicators**	**Strategies to Impact State Priority Indicators**
Mental Health & Addiction	• Adult suicide deaths • Youth suicide deaths • Unintentional drug overdose deaths	• Crisis lines • School-based social and emotional instruction • Naloxone education/distribution programs & syringe service programs
Maternal & Infant Health	• Not available	• Not available

Note: This symbol will be used throughout the report when a priority, indicator, or strategy directly aligns with the 2020-2022 SHIP.

Note: This symbol √ will be used throughout the report when a strategy has been rated by **What Works for Health** as "likely to decrease disparities" and/or recommended by **The Community Guide** as effective strategies for achieving health equity. These sources consider potential impact on disparities and inequities by racial/ethnic, socio-economic, geographic, or other characteristics.

Alignment with National and State Standards, continued

Figure 1.3 2020-2022 State Health Improvement Plan (SHIP) Overview



Vision and Values

Vision statements define a mental picture of what a community wants to achieve over time while the values outline the core principles that guide and direct the organization and its culture.

The Vision of Greene County

A vibrant health conscious community concerned with preserving the environment, where all people are informed, have equitable opportunity and are empowered to access what they need to be healthy.

The Values of Greene County

Collaboration, Equity and Inclusion, Environment, and Resiliency

Community Partners

The CHIP was planned by various agencies and service-providers within Greene County. From August 2023 to October 2023, Growing Healthy Together Greene County reviewed many data sources concerning the health and social challenges that Greene County residents are facing. They determined priority issues which, if addressed, could improve future outcomes; determined gaps in current programming and policies; examined best practices and solutions; and determined specific strategies to address identified priority issues. We would like to recognize these organizations and thank them for their dedication to this process:

Growing Healthy Together Greene County Committee

Beavercreek Chamber of Commerce
Beavercreek Township Board of Trustees
Buckeye Health
CareSource
Central State University
City of Xenia
Clark State Community College
Council on Rural Services
Dayton Children's Hospital
Fairborn Municipal Court
Family and Children First Council
Five Rivers Health Center - Xenia
Greene CATS Public Transit
Greene County Board of County Commissioners
Greene County Board of Developmental Disabilities
Greene County Council on Aging
Greene County Department of Job and Family Services
Greene County Drug-Free Coalition
Greene County Educational Service Center
Greene County Emergency Management Agency
Greene County Housing
Greene County Parks & Trails
Greene County Public Health
Kettering Health Greene Memorial
Layh & Associates, Inc.
Mental Health & Recovery Board of Clark, Greene & Madison Counties
Ohio State University Extension Office
Soin Medical Center – Kettering Health
TCN Behavioral Health Services
United Way of the Greater Dayton Area
Village of Yellow Springs

Hospital Council of Northwest Ohio (HCNO)

The community health improvement process was facilitated by Jodi Franks, MPH, CHES, Community Health Improvement Coordinator from HCNO.

Community Health Improvement Process

Beginning in August 2023, Growing Healthy Together Greene County met four (4) times and completed the following planning steps:

1. Initial Meeting
    - Review the process and timeline
    - Finalize committee members
    - Create or review vision
2. Choose Priorities
    - Use of quantitative and qualitative data to prioritize target impact areas
3. Community Themes and Strengths Assessment
    - Open-ended questions for committee on community themes and strengths
4. Forces of Change Assessment
    - Open-ended questions for committee on forces of change
5. Local Public Health Assessment
    - Review the Local Public Health System Assessment with committee
6. Gap Analysis
    - Determine discrepancies between community needs and viable community resources to address local priorities
    - Identify strengths, weaknesses, and evaluation strategies
7. Quality of Life Survey
    - Review results of the Quality of Life Survey with committee
8. Strategic Action Identification
    - Identification of evidence-based strategies to address health priorities
9. Best Practices
    - Review of best practices, proven strategies, evidence continuum, and feasibility continuum
10. Resource Assessment
    - Determine existing programs, services, and activities in the community that address specific strategies
11. Draft Plan
    - Review of all steps taken
    - Action step recommendations based on one or more of the following: enhancing existing efforts, implementing new programs or services, building infrastructure, implementing evidence-based practices, and feasibility of implementation

Community Health Status Assessment

Phase 3 of the MAPP process, the Community Health Status Assessment, or CHA, is a 100+ page report that includes primary data with over 100 indicators and hundreds of data points related to health and well-being, including social determinants of health. Numerous sources of secondary data are also included throughout the report. The CHA serves as the baseline data in determining key issues that lead to priority selection. The full report can be found on the **Greene County Public Health** website. Below is a summary of county primary data and the respective state and national benchmarks.

Trend Summary

Adult Indicators	Greene County 2019	Greene County 2023	Ohio 2021	U.S. 2021
Health Care Coverage				
Uninsured	3%	**5%**	6%	7%
Access and Utilization				
Had at least one person they thought of as their personal doctor or health care provider	85%	**83%**	86%	84%
Visited a doctor for a routine checkup in the past year	71%	**73%**	77%	76%
Visited a doctor for a routine checkup five or more years ago	4%	**6%**	5%	5%
Preventive Medicine				
Had a pneumonia vaccination (age 65 and over)	67%	**77%**	71%	71%
Had a flu vaccine in the past year (age 65 and over)	74%	**61%**	66%	67%
Women's Health				
Had a mammogram within the past two years (age 40 and older)	71%	**73%**	71%*	72%*
Had a Pap smear within the past three years (age 21-65)	69%	**72%**	77%*	78%*
Men's Health				
Had a PSA test within the past two years (age 40 and over)	N/A	**47%**	32%*	32%*
Oral Health				
Visited a dentist or dental clinic in the past year	73%	**69%**	65%*	66%*
Health Status Perceptions				
Rated health as excellent or very good	53%	**51%**	51%	53%
Rated health as fair or poor	14%	**14%**	17%	15%
Rated physical health as not good on four or more days (in the past 30 days)	21%	**27%**	21%	20%
Average days that physical health not good in past month	3.5	**4.7**	4.2**	3.1**
Rated mental health as not good on four or more days (in the past 30 days)	30%	**32%**	31%	29%
Average days that mental health not good in past month	4.5	**4.8**	5.2**	4.5**
Poor physical or mental health kept them from doing usual activities, such as self-care, work, or recreation (on at least one day during the past 30 days)	29%	**36%**	N/A	N/A

Note: 2023 Indicators in green font indicate improvement from 2019, indicators in red indicate a decline from 2019, and indicators in black font indicate no change from 2019

Indicates alignment with the Ohio State Health Assessment (SHA)
**2020 BRFSS*
***2019 BRFSS data as compiled by 2022 County Health Rankings*

Adult Indicators	Greene County 2019	Greene County 2023	Ohio 2021	U.S. 2021
Weight Status				
Obese, including severely and morbidly obese (BMI of 30.0 and above)	30%	**39%**	38%	34%
Overweight (BMI of 25.0 – 29.9)	33%	**37%**	33%	34%
Tobacco Use				
Current smoker (currently smoke some or all days)	10%	**10%**	18%	14%
Former smoker (smoked 100 cigarettes in lifetime & now do not smoke)	24%	**20%**	25%	25%
Current e-cigarette user (vaped on some or all days)	1%	**6%**	8%	7%
Alcohol Consumption				
Current Drinker (drank alcohol at least once in the past month)	66%	**58%**	53%	53%
Binge drinker (defined as consuming more than four [women] or five [men] alcoholic beverages on a single occasion in the past 30 days)	22%	**22%**	17%	15%
Drove after having perhaps too much alcohol to drink (in the past month)	3%	**2%**	N/A	N/A
Cardiovascular Disease				
Had angina or coronary heart disease	2%	**2%**	5%	4%
Had a heart attack or myocardial infarction	4%	**4%**	5%	4%
Had a stroke	2%	**2%**	4%	3%
Had high blood pressure	30%	**33%**	36%	32%
Had high blood cholesterol	37%	**43%**	37%	36%
Had blood cholesterol checked within past 5 years	84%	**84%**	85%	85%
Asthma and Other Respiratory Diseases				
Ever been told they have asthma	18%	**19%**	15%	15%
Ever diagnosed with chronic obstructive pulmonary disease (COPD), emphysema, or chronic bronchitis	6%	**6%**	9%	6%
Arthritis				
Ever diagnosed with some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia	32%	**38%**	30%	25%
Diabetes				
Ever been told by a doctor they have diabetes (not pregnancy-related)	8%	**10%**	12%	11%
Had been diagnosed with pre-diabetes or borderline diabetes	8%	**7%**	2%	2%

Note: 2023 Indicators in green font indicate improvement from 2019, indicators in red font indicate a decline from 2019, and indicators in black font indicate no change from 2019

Indicates alignment with the Ohio State Health Assessment (SHA)

Key Issues

Growing Healthy Together Greene County reviewed the 2023 Greene County Health Assessment. The detailed primary data for each individual priority area can be found in the section it corresponds to. Each organization completed an "Identifying Key Issues and Concerns" exercise via an online survey. The following tables were the group results.

What are the most significant health issues or concerns identified in the 2023 health assessment report? Examples of how to interpret the information include: 6% of Greene County adults had been diagnosed with COPD, emphysema, or chronic bronchitis; including 11% of adults ages 65+, 15% of adults with annual household incomes below $25,000; and 11% of African Americans.

Key Issue or Concern	Percent of Population At risk	Gender Most at Risk	Age Group Most at Risk	Income Level Most at Risk	Race Most at Risk
Adult weight status (9 votes)					
Categorized as obese (including severely and morbidly obese, according to BMI)	39%	Female (40%)	30-64 (41%) 65 & over (41%)	<$25K (72%)	African American (60%)
Categorized as overweight (according to BMI)	37%	Male (43%)	<30 (52%)	>$25K (37%)	White (39%)
Experienced one or more food insecurity issues (in the past year)	12%	N/A	N/A	N/A	N/A
Access to nutritious food (focus group theme)	N/A	N/A	N/A	N/A	N/A
Did not participate in any physical activity in the past week	19%	N/A	N/A	N/A	N/A
Reported no leisure time physical activity outside of work *(2020 BRFSS as compiled by 2023 County Health Rankings)*	21%	N/A	N/A	N/A	N/A
Mental health (5 votes)					
Rated their mental health as not good on four or more days in the past month	32%	Female (37%)	<30 (47%)	>$25K (32%)	African American (35%)
Used a program or service for help with depression, anxiety, or other emotional problems for themselves or a loved one	12%	N/A	N/A	N/A	N/A
Considered attempting suicide (in the past year)	4%	N/A	N/A	N/A	N/A
Youth depression (reported feeling sad or hopeless for two weeks or more in a row in the past year that they stopped doing some usual activities) *(2018-2019 OHYES! Report for Mental Health & Recovery Services Board of Clark, Greene, & Madison Counties)*	28%	N/A	N/A	N/A	N/A
Adult suicide deaths (Ages 19+) *(ODH Warehouse, 2018-2020)*	61 deaths	N/A	N/A	N/A	N/A
Youth suicide deaths (Ages <19) *(ODH Warehouse, 2018-2020)*	6 deaths	N/A	N/A	N/A	N/A

N/A- Not Available

Key Issue or Concern	Percent of Population At risk	Gender Most at Risk	Age Group Most at Risk	Income Level Most at Risk	Race Most at Risk
Adult cardiovascular health (5 votes)					
Diagnosed with high blood cholesterol (in their lifetime)	43%	N/A	65 & over (71%)	<$25K (52%)	White (44%)
Diagnosed with high blood pressure (in their lifetime)	33%	Male (39%)	65 & over (61%)	<$25K (55%)	African American (58%)
Survived a stroke (in their lifetime)	2%	Female (3%)	65 & over (7%)	<$25K (9%)	African American (6%)
Adult quality of life (3 votes)					
Reported they were limited in some way because of a physical, mental, or emotional problem	29%	N/A	65 & over (34%)	<$25K (54%)	African American (36%)
Reported stress, depression, anxiety, or emotional problems limited their activities	11%	Female (13%)	<30 (19%)	<$25K (17%)	White (12%)
Reported chronic pain limited their activities	10%	Female (11%)	30-64 (13%)	<$25K (27%)	White (11%)
Adult arthritis (3 votes)					
Diagnosed with arthritis (in their lifetime)	38%	Female (40%)	65 & over (66%)	<$25K (57%)	White (39%)
Tobacco use (2 votes)					
Current e-cigarette user (used an electronic vapor product in their lifetime and currently use it some or all days)	6%	Female (8%)	<30 (15%)	<$25K (8%)	N/A
Youth current electronic vapor product user (used an electronic vapor product at least once in the past month) *(2018-2019 OHYES! Report for Mental Health & Recovery Services Board of Clark, Greene, & Madison Counties)*	16%	N/A	N/A	N/A	N/A
Youth cigarette purchase (percent of current youth smokers who bought cigarettes from a store in the past month) *(2018-2019 OHYES! Report for Mental Health & Recovery Services Board of Clark, Greene, & Madison Counties)*	14%	N/A	N/A	N/A	N/A
Adult adverse childhood experiences (ACEs) (2 votes)					
Experienced four or more ACEs	14%	Female (19%)	<30 (26%)	<$25K (17%)	African American (16%)
Maternal and infant health (2 votes)					
Infant mortality rate *(Greene County, 2022)*	8.57 infant deaths per 1,000 births	N/A	N/A	N/A	N/A

N/A- Not Available

Key Issue or Concern	Percent of Population At risk	Gender Most at Risk	Age Group Most at Risk	Income Level Most at Risk	Race Most at Risk
Oral health (2 votes)					
Had not been to a dentist or dental clinic in the past year	31%	Female (32%)	<30 (44%)	<$25K (67%)	African American (58%)
Youth who visited a dentist in the past year *(2018-2019 OHYES! Report for Mental Health & Recovery Services Board of Clark, Greene, & Madison Counties)*	70%	N/A	N/A	N/A	N/A
Adult diabetes (1 vote)					
Diagnosed with diabetes (in their lifetime)	10%	N/A	65 & over (20%)	<$25K (23%)	African American (17%)
Adult alcohol consumption (1 vote)					
Current drinker (consumed one or more alcoholic drinks in the past month)	58%	Male (62%)	30-64 (62%)	>$25K (62%)	White (63%)
Adult access to care (1 vote)					
Uninsured	5%	N/A	<30 (7%)	<$25K (13%)	African American (13%)
Did not have a routine check-up (in the past year)	27%	Males (31%)	<30 (31%)	<$25K (33%)	African American (33%)
Access to care (focus group theme)	N/A	N/A	N/A	N/A	N/A
Poverty (1 vote)					
Greene County residents in poverty *(U.S. Census Bureau Poverty and Median Income Estimates)*	10.3%	N/A	N/A	N/A	N/A
Inflation (focus group theme)	N/A	N/A	N/A	N/A	N/A
Substance use (1 vote)					
Medication misuse (in the past 6 months)	11%	N/A	30-64 (12%)	<$25K (16%)	White (13%)
Drug overdose deaths *(ODH Public Health Data Warehouse, 2020)*	43 deaths	N/A	N/A	N/A	N/A
Naloxone Administration: Number of EMS events involving naloxone administration *(OIBHD, 2020)*	146 events	N/A	N/A	N/A	N/A

Key Issue or Concern	Percent of Population At risk	Gender Most at Risk	Age Group Most at Risk	Income Level Most at Risk	Race Most at Risk
Transportation (1 vote)					
Reported "difficult to find/no transportation" as a top reason for not accessing medical care in the past year	2%	N/A	N/A	N/A	N/A
Indicated "there are accessible transportation services available" in Greene County	44%	N/A	N/A	N/A	N/A
Reported "limited or no public transportation available or accessible"	2%	N/A	N/A	N/A	N/A
Reported transportation prevented them from accessing dental care in the past year	3%	N/A	N/A	N/A	N/A

N/A- Not Available

Priorities Chosen

Based on the 2023 Greene County Health Assessment, key issues were identified for adults. Overall, there were 15 key issues identified by Growing Healthy Together Greene County. The committee then voted and came to a consensus on the priority areas Greene County will focus on over the next three years. The key issues and their corresponding votes are described in the table below.

Key Issues	Votes
1. Adult weight status	9
2. Adult mental health	5
3. Adult cardiovascular health	5
4. Adult quality of life	3
5. Adult arthritis	3
6. Adult tobacco use	2
7. Adult adverse childhood experiences (ACEs)	2
8. Maternal and infant health	2
9. Adult oral health	2
10. Adult diabetes	1
11. Adult alcohol consumption	1
12. Adult access to care	1
13. Poverty	1
14. Substance use	1
15. Transportation	1

Greene County will focus on the following 4 priority areas over the next three years:

Priority Factor(s):

1) Health behaviors (focus: nutrition, physical activity, nicotine use)
2) Access to care (focus: transportation, oral health, insurance coverage)

Priority Health Outcome(s):

1) Mental health and addiction (focus: mental health, suicide, ACEs)
2) Maternal and infant health (focus: infant mortality)

Community Themes and Strengths Assessment (CTSA)

The Community Themes and Strengths Assessment (CTSA) provides a deep understanding of the issues that residents felt were important by answering the questions: "What is important to our community?" "How is quality of life perceived in our community?" and "What assets do we have that can be used to improve community health?" The CTSA consisted of two parts: open-ended questions to the committee and the Quality of Life Survey. Votes are displayed in parentheses if more than one organization identified the same or similar response to the below questions. Below are the results:

Open-ended Questions to the Committee

1) **What do you believe are the 2-3 most important characteristics of a healthy community?**

- Health equity (4)
- Safe/affordable/healthy homes (4)
- Access to quality education (4)
- Access to healthy food (3)
- Adequate employment (3)
- Access to resources (3)
- Physical activity (2)
- Safe recreation (2)
- Reliable/affordable/accessible transportation (2)
- Access to care (2)
- Strong not-for-profits and private citizens willing to invest into community (2)
- Quality health care
- Low mortality rate compared to peer counties
- Low morbidity rate compared to peer counties
- Limited poverty
- Strong work relationship between all service-oriented groups
- Beautification and resourcing of all areas in the community
- Quality of life
- Strong families
- Robust economic opportunity
- Community ethos
- Low crime rate

2) What makes you most proud of our community?

- Natural spaces via parks and recreation (6)
- Local agencies and organizations working together (3)
- Community (welcoming and friendly) (2)
- Great family atmosphere for having children and raising a family (2)
- The higher health rating from the County Health Rankings
- Public transportation exists
- Diversity
- Safe and caring environment
- Social services network
- Community ethos
- Colleges and universities
- Public services are robust
- Investment of private citizens and strong not-for-profits
- We work together to care for others less fortunate and a better quality of life for all
- Availability of healthcare
- Safe place to age

3) What are some specific examples of people or groups working together to improve the health and quality of life in our community?

- Greene County Public Health (5)
- Emergency Preparedness and Response community (3)
- Churches (e.g., Xenia Area Association of Christian Churches & Ministries) (2)
- The YMCA (2)
- Drug-free coalitions (2)
- Senior services (2)
- Food pantries (FISH) (2)
- Families and Children First Council (2)
- Collaboration on community events (2)
- School systems
- Local colleges and universities
- Disability community
- Mental health community
- Internship program our PH organization has with dozens of educational institutions across the county
- County entities working with city government
- CHIP process
- Linkage group
- Athletes in Action
- Celebrate Recovery
- Five Rivers Health Centers
- MRC and Citizen's Corps
- Community outreach and education workers at various agencies/organizations
- Safe communities coalition

4) What do you believe are the 2-3 most important issues that must be addressed to improve the health and quality of life in our community?

- Mental health (7)
- Healthy food access (4)
- Obesity/weight status (4)
- Physical activity (3)
- Health care access (3)
- Transportation (2)
- Affordable housing (2)
- Wages
- Health equity
- Educational opportunities for health and wellness
- ACEs
- Poverty
- Substance abuse
- Immunizations
- Access to holistic health care
- GCPH needs a data person
- Health and quality of life issues with chronic disease
- Lack of knowledge or specific resources
- Improve the social and economic determinants of health
- Invest in our schools and social service agencies and programs
- Engage vulnerable populations in identifying root causes of problems and in developing workable solutions with full support of local government, businesses, and organizations
- Proximity to resources and care

5) What do you believe is keeping our community from doing what needs to be done to improve health and quality of life?

- Funding (5)
- People to run programs/teamwork (2)
- Lack of awareness (2)
- Lack of knowledge of specific resources (2)
- Limited access
- Misinformation
- Social media
- Individual lifestyles are difficult to change
- People only caring for themselves, greed and pride
- Larger cultural issues outside of our control are impacting mental health
- Poverty
- Silent racism
- Lack of understanding by those who are privileged and take for granted resources and upbringing
- Ethnocentrism
- Lack of ongoing holistic support that help individuals
- Isolation from pandemic or life circumstances
- High cost for food
- High cost for housing
- Stress
- Burnout

6) What actions, policy, or funding priorities would you support to build a healthier community?

- Programs with partnerships to address the educational, health, workforce, and quality of life for our community (4)
- Focus on prevention for children and youth (policy surrounding vaping/tobacco in schools) (2)
- Development of data team to support evidence-based decision making in the health department (2)
- Funding for health behaviors
- Funding for health and safety
- Prioritizing infant mortality
- Increased capacity to access mental health care
- Mental health dollars for substance use disorder
- Childhood trauma and mental illness
- Adult mental illness
- Expansion of public transportation services
- Educational and recreational opportunities
- Food banks
- Community health fairs
- Diversity Equity and Inclusion
- Workforce Development
- Provide a holistic approach when working with individuals providing all the resources needed
- Incentivize health professionals to work in rural communities (e.g., higher pay)

7) What would excite you enough to become involved (or more involved) in improving our community?

- Statewide initiatives
- Inclusiveness of all
- Shared resources/funding
- Expand the services we offer with Five Rivers Health Centers in Xenia
- A collaborative project that made a positive difference in the lives of individuals, families, and the community as a whole
- Participating in this assessment has made me become more excited to help reach Healthy People 2030 goals in Ohio
- Having clear goals, objectives, and actions outlines and working with people committed to going the distance and tackling the hard things together
- Seeing some progress in the right direction
- Fundraisers for those in need

Quality of Life Survey

Growing Healthy Together Greene County urged community members to fill out a short quality-of-life survey via an online platform (SurveyMonkey) from August to September 2023. There were **201** Greene County community members who completed the survey. This tool will assist Growing Healthy Together Greene County in understanding the overall quality of life in Greene County. In the table below, the anchored Likert scale responses were converted to numeric values ranging from 1 to 5, with 1 being lowest and 5 being highest. For example, an anchored Likert scale of "Very Satisfied" = 5, "Satisfied" = 4, "Neither Satisfied or Dissatisfied" = 3, "Dissatisfied" = 2, and "Very Dissatisfied" = 1. When a respondent left a response blank, the choice was considered a non-response and the response was not used in averaging responses or calculating descriptive statistics.

Quality of Life Questions	Likert Scale Average Response
	2023 n=201
1. Are you satisfied with the quality of life in our community? (Consider your sense of safety, well-being, participation in community life and associations, etc.)	3.73
2. Are you satisfied with the health care system in the community? (Consider access, cost, availability, quality, options in health care, etc.)	3.57
3. Is this community a good place to raise children? (Consider school quality, day care, after school programs, recreation, etc.)	3.75
4. Is this community a good place to grow old? (Consider elder-friendly housing, transportation to medical services, churches, shopping; elder day care, social support for the elderly living alone, meals on wheels, etc.)	3.42
5. Is there economic opportunity in the community? (Consider locally owned and operated businesses, jobs with career growth, job training/higher education opportunities, affordable housing, reasonable commute, etc.)	3.39
6. Is the community a safe place to live? (Consider residents' perceptions of safety in the home, the workplace, schools, playgrounds, parks, and the mall. Do neighbors know and trust one another? Do they look out for one another?)	3.71
7. Are there networks of support for individuals and families (neighbors, support groups, faith community outreach, agencies, or organizations) during times of stress and need?	3.58
8. Do all individuals and groups have the opportunity to contribute to and participate in the community's quality of life?	3.47
9. Do all residents perceive that they — individually and collectively — can make the community a better place to live?	3.27
10. Are community assets broad-based and multi-sectoral? (There are a variety of resources and activities available county-wide)	3.26
11. Are levels of mutual trust and respect increasing among community partners as they participate in collaborative activities to achieve shared community goals?	3.19
12. Is there an active sense of civic responsibility and engagement, and of civic pride in shared accomplishments? (Are citizens working towards the betterment of their community to improve life for all citizens?)	3.20

Forces of Change Assessment

The Forces of Change Assessment focuses on identifying forces such as legislation, technology, and other impending changes that affect the context in which the community and its public health system operate. This assessment answers the questions: "What is occurring or might occur that affects the health of our community or the local public health system?" and "What specific threats or opportunities are generated by these occurrences?" Growing Healthy Together Greene County was asked to identify positive and negative forces which could impact community health improvement and overall health of this community over the next three years. This group discussion covered many local, state, and national issues and change agents which could be factors in Greene County in the future. HCNO categorized the forces of change and their potential impacts based on common themes, which are displayed in the table below:

Force of Change	Threats Posed	Opportunities Created
General Health Forces		
1. COVID-19 (3)	• Lack of trust in public health • Decrease in access to care • Students require more early intervention and support for school success and wellness • Families need additional services to get children back on track • Decreased mobility • Increased health problems • Worsen pre-existing conditions • Increase in uninsured	• Increase in education to public • Education surrounding oral health • Cross-systems collaboration between child-serving programs to strengthen child and family resilience and supports • Unified community level focus on the wellness of children and youth • Prevention increased (masks and vaccines) • Better hygiene when in public places • Increased collaboration with emergency preparedness managers/organizations
2. Increasing obesity rates (2)	• Increase in chronic conditions • Decreased quality of life • Increased medical needs/costs • Access to nutritious food • Lack of knowledge in preparing food	• Wellness program opportunities • Built environment improvements • Additional food nutrition program for families • More community gardens near schools
3. Increase in sedentary lifestyle	• Increased obesity • Increased mental health risks	• Communal outdoor activities • Strategic events to get people outside • Moving and talking to each other • Healthy food nights in different parts of Greene County at different times to encourage family/friends dining together with healthy eating options

Forces of Change	Threats Posed	Opportunities Created
General Health Forces, continued		
4. Food benefits reduced for low-income families	• Malnutrition • Poor results at work and school • Mental health risk • Risk for home environment	• Increase in information about where to access affordable food • More food pantry resources created • Increased transportation to healthy foods • Increased employment/educational opportunities to access higher paying jobs
5. Increase in newborns requiring special care for complex developmental and medical conditions	• Early childhood intervention system feeling strained/stress due to the result of pandemic and opioid epidemic	• Develop the capacities and capabilities of the early childhood professionals to meet the increased need for services locally • Children serving agencies collaborate by sharing information and providing support
6. Maternal and Infant Health	• Racial disparities • Cuts to Medicaid	• Education (e.g., safe sleep, substance abuse, fetal alcohol syndrome, preventative care recommendations, etc.) • Improve access to care for baby and mother
7. Increase in cost of health insurance	• Inability to afford	• Expanding coverage
8. Access to health professionals	• Lack of providers • Long wait-times	• Education/awareness of other resources (e.g., telehealth) • Community health worker certification classes • Central State and Wright State mental/behavioral health workforce initiatives
9. High cost of prescriptions	• Worsening health conditions • Inflation	• Raise awareness of supportive services
10. Energy drink use among youth	• Increasing use of high-dose caffeinated beverages	• Education for youth surrounding health impacts

Forces of Change	Threats Posed	Opportunities Created
Demographic Forces		
11. Aging population (3)	• Chronic conditions (3) • Transportation barriers • Isolation • Decreased access to services outside the home • Falls • Decrease in affordability and availability of senior living options • Decrease in workforce	• Wellness programs (3) • Senior center programs • Community-led initiatives to support the elderly with access to food • Entertainment/enrichment and healthcare • Mentoring programs • Second careers • Increase in volunteerism
Mental/Behavioral Health Forces		
12. Mental Health and Addiction	• Lack of support from family • Increase drug and alcohol usage and associated problems • Isolation	• Drug treatment • Children services • Counseling for families with drug and alcohol problems • Reduce stigma of seeking help • OhioRISE (Resilience through Integrated Systems and Excellence) Alternative to suspension policies in schools
13. Rise in Mental Health Issues—Adults and Youth	• Increase need for mental health professionals • Lack of knowledge from community members	• Additional access to mental health professionals • Additional resource fairs for families and community members
14. Maternal health (depression and mental illness)	• Mothers may not access treatment for fear of losing custody • Mothers may suffer in silence and the children in their care can suffer significant threat to their mental health and overall development	• We can have touch points and opportunities to provide outreach to all organizations and providers who come in contact with mother • Raise awareness and link mental health services at the start
15. Increasing vaping rates	• Increased youth smoking • Increased chronic conditions	• Tobacco retail licensing • Education for youth and parents • Organizing outreach to schools • Education surrounding long-term health impacts
16. Increase awareness of ACEs	• Lack of understanding how events could impact the individuals • Lack of effectively managing stress	• More education in the community and schools

Force of Change	Threats Posed	Opportunities Created
Mental/Behavioral Health Forces, continued		
17. Marijuana legislation	• Increased mental health issues • Negative impact on social skills contributing to isolation and potential violence	• Advancing "remote" school and work to new models that account for the socialization piece • Preparedness for future pandemics • MHRB declaring stance using evidence • Training (e.g., QPR), especially for high-risk populations (e.g., veterans, LGBTQIA+, etc.)
Employment and Occupational Forces Forces		
18. Lack of livable wage employment	• Decreased access to preventative healthcare • Increased mental/behavioral issues • Lack of housing • Poor access to healthy foods • "Working poor" ineligible for social support programs	• Better transportation networks to job • Food and housing resources • Address barriers to obtaining employment
19. Increased need to provide daily reliable transportation to workplace	• New employees losing jobs due to missing work	• Additional programs dedicated to work transportation
Economic Forces		
20. Inflation (2)	• Lack of housing/homelessness (2) • Limited/no transportation (2) • Job loss • Limited access to healthy food	• Wellness programs • Job training • Low-income housing • Food bank • Increase of knowledge of services
21. Increase in the cost of living/food (2)	• Low-income people already experiencing poor health outcomes may decline further • Starvation • Famine • Violence	• Minimum wage increases for a more livable wage • Farming • Weight control (food consumption) • Lab grown food
22. Poverty	• Lack of housing • Food insecurity	• Community resources • Housing affordability • Food banks

Forces of Change	Threats Posed	Opportunities Created
Environmental Forces		
23. Climate change (3)	• Emergency response on a large scale • Lack of housing • Food insecurity • Lack of clean water • More severe weather effects may increase deployments • Severe weather • Property damage • Rising insurance rates	• Emergency preparedness plans • Community collaboration • More opportunity to engage volunteers in a meaningful way • Updated advance weather alerts • Recycling • Hybrid to electric vehicles
Social Forces		
24. Excess use of screen time	• Children are primed for addiction • Adults and children less active and less likely to play in outdoor spaces • Children and youth are vulnerable to exploitation and mental distress as the result of unsupervised usage	• Public health awareness can create family level awareness that technology and screen time are a necessary part of our lives but must be managed in order to prevent tragic outcomes for individuals and significant problems for our families, schools and communities • Develop community consensus on screen time guidance for children and students
25. Technology	• AI • Scams • Sedentary lives • Less community and interaction • Misinformation more easily spread	• AI • Telehealth • Access to information • Ability to participate in things even if homebound • Ability to reach and inform people with good information
26. Safety	• More mass shootings • Increased crime • Violence	• Community coming together to help keep each other safe • Safety education (e.g., gun locks)
27. Dynamic volunteer pool	• Increasing administrative costs to manage the MRC and Citizen's Corps'	• External funding may be increased at the federal level • New volunteers may be more willing to fulfill roles to serve more upstream in the causal chain of health (such as things causing health inequities, etc.)
28. Increased awareness about the impact of volunteers	• More requests for volunteer services from a variety of sources may dilute resources from primary mission	• More visibility of the MRC and Citizen's Corps programs

Forces of Change	Threats Posed	Opportunities Created
Developmental Forces		
29. Safe and affordable childcare	• Stressed parents miss work • Stressed kids miss school • Inadequate child care impacts the workforce and employer's bottom lines • Students who are expelled or asked to leave center due to behavior concerns • Inadequate care may lose access to their local schools specialized services	• Opportunity to provide wrap-around stabilization supports to children and families by developing a network of before and after care and programs • Recognizing family kinship care providers • Create a network to look at gaps in care for children collectively • Provide local support for child wellness
30. Reduced reimbursement for providing trips to specialized populations	• Limiting distance and or area trips provided	• Obtaining funding from other sources
31. Increased need of transportation for elderly and disabled	• Mobility of elderly and disabled limited or non-existent	• Increase volunteer drivers by raising awareness of programs that transport elderly and disabled to medical appointment and other essential trips
32. Lack of affordable housing near places of employment	• Greater travel distances needed to access employment	• Developing shared ride programs
33. Increased collaboration with emergency preparedness managers	• Expansion of mission away from primary public health prevention efforts not seen as emergencies	• More remediation of all hazards emergencies by MRC and CC
34. Automation of administrative functions at the state level for local MRC units (such as background checks, license validation, etc.)	• Decreased control of unit functions	• Increased efficacy of administrative functions at the local level

Forces of Change	Threats Posed	Opportunities Created
Political Forces		
35. Political climate (2)	• Potentially changing priorities and values related to poverty and health programs • War • Funding cuts to vital programs and services • Distrust • Confusion • Damaging legislation due to partisan clashes and a misunderstanding of public health authority or other public service related authorities and practices	• Local and state advocacy for various public programs that positively impact our communities (2) • Bridging the divide

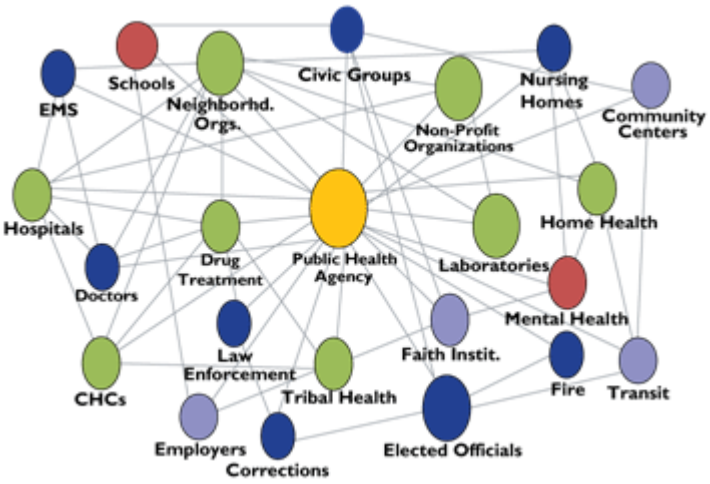
Local Public Health System Assessment

The Local Public Health System

Public health systems are commonly defined as "all public, private, and voluntary entities that contribute to the delivery of essential public health services within a jurisdiction." This concept ensures that all entities' contributions to the health and well-being of the community or state are recognized in assessing the provision of public health services.

The public health system includes:

- Public health agencies at state and local levels
- Healthcare providers
- Public safety agencies
- Human service and charity organizations
- Education and youth development organizations
- Recreation and arts-related organizations
- Economic and philanthropic organizations
- Environmental agencies and organizations



The 10 Essential Public Health Services

The 10 Essential Public Health Services describe the public health activities that all communities should undertake and serve as the framework for the National Public Health Performance Standards (NPHPS) instruments.

Public health systems should:

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and action to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure competent public and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

(Source: **Centers for Disease Control; National Public Health Performance Standards; The Public Health System and the 10 Essential Public Health Services**)

The Local Public Health System Assessment (LPHSA)

The LPHSA answers the questions, "What are the components, activities, competencies, and capacities of our local public health system?" and "How are the Essential Services (ES) being provided to our community?"

This assessment involves the use of a nationally recognized tool called the **National Public Health Performance Standards Local Instrument.**

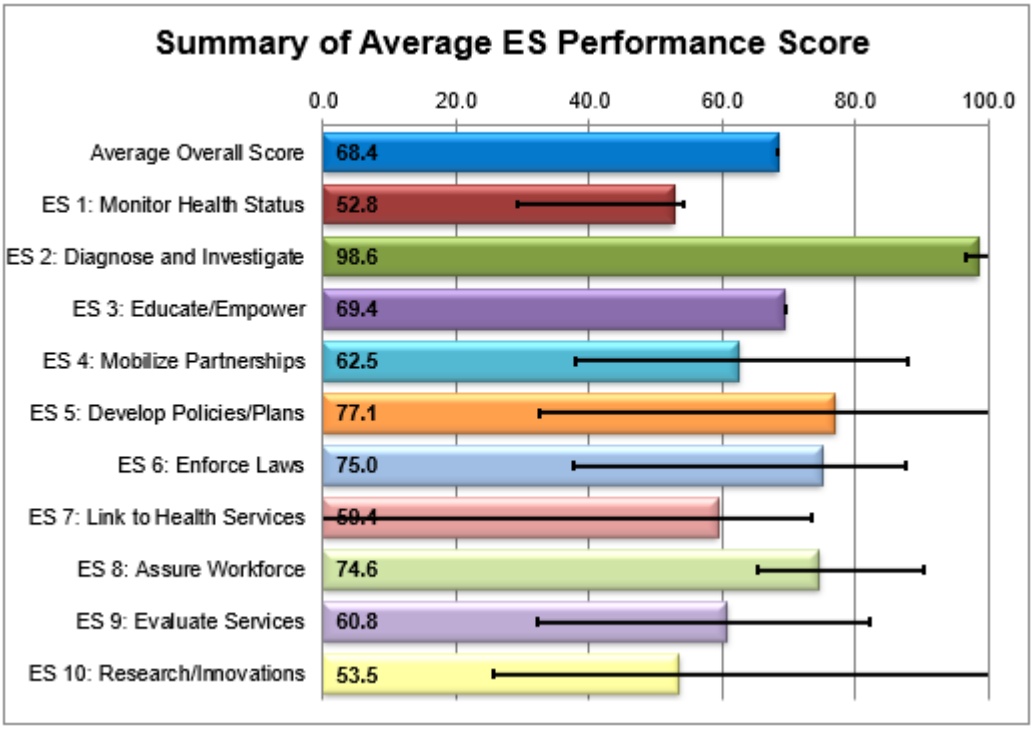
Members of Greene County Public Health completed the performance measures instrument. The LPHSA results were then presented to the Growing Healthy Together Greene County Committee for discussion. The 10 Essential Public Health Services and how they are being provided within the community as well as each model standard was discussed, and the group came to a consensus on responses for all questions. The challenges and opportunities that were discussed were used in the action planning process.

The CHIP committee identified 6 indicators that had a status of "minimal" and 2 indicators had a status of "no activity." The remaining indicators were all moderate, significant, or optimal.

As part of minimum standards, local health departments are required to complete this assessment at least once every five years.

To view the full results of the LPHSA, please contact Greene County Public Health at (937)-374-5600.

Greene County Local Public Health System Assessment 2023 Summary



Note: The black bars identify the range of reported performance score responses within each Essential Service

Gap Analysis and Strategic Planning Terminology

Gaps Analysis

A gap is an area where the community needs to expand its efforts to reduce a risk, enhance an effort, or address another target for change. A strategy is an action the community will take to fill the gap. Evidence is information that supports the linkages between a strategy, outcome, and targeted impact area. Growing Healthy Together Greene County was asked to determine gaps in relation to each priority area, consider potential or existing resources, and brainstorm potential evidence-based strategies that could address those gaps. To view the completed gap analysis exercise, please view Appendix I.

Strategy Selection

Based on the chosen priorities, Growing Healthy Together Greene County was asked to identify strategies for each priority area. Considering all previous assessments, including but not limited to the CHA, CTSA, quality of life survey, and gap analysis, committee members determined strategies that best suited the needs of their community. Members referenced a list of evidence-based strategies recommended by the Ohio SHIP, as well as brainstormed for other impactful strategies.

Evidence-Based Practices

As part of the gap analysis and strategy selection, Growing Healthy Together Greene County considered a wide range of evidence-based practices, including best practices. An evidence-based practice has compelling evidence of effectiveness. Participant success can be attributed to the program itself and evidence that the approach will work for others in a different environment. A best practice is a program that has been implemented and evaluation has been conducted. While the data supporting the program is promising, its scientific rigor is insufficient. Each evidence-based practice can be found with its corresponding strategy.

Resource Inventory

Based on the chosen priorities, Growing Healthy Together Greene County was asked to identify resources for each strategy. The resource inventory allowed the committee to identify existing community resources, such as programs, policies, services, and more. Each resource inventory can be found with its corresponding strategy.

Further information about community resources in Greene County can be found by contacting United Way of the Greater Dayton Area by phone 937-255-3060 or visiting their **website**.

Strategic Planning Terminology

Action Steps: The specific steps that need to be taken to meet the objective(s).
Timeline: The timeframe in which activities will take place.
Priority Population: The population the strategy focuses on, with emphasis on specific populations at higher risk or impact (based on Key Issues).
Indicators: The specific metric(s) used to measure long term progress and success of the strategy.
Lead Contact/Agency: Who will be responsible for ensuring the objective is met?
Strategy identified as likely to decrease disparities: Strategy has been rated by **What Works for Health** as "likely to decrease disparities" and/or recommended by **The Community Guide** as effective strategies for achieving health equity. These sources consider potential impact on disparities and inequities by racial/ethnic, socio-economic, geographic, or other characteristics.
Evidence Rating: The strategy has been rated by **What Works for Health** based on the amount, type, and quality of evidence available regarding the strategy.
Policy development or enforcement strategies: Evidence-based health policies can help prevent disease and promote health. The Public Health Accreditation Board (PHAB) requires at least two strategies or activities to include a policy recommendation, one of which must be aimed at alleviating the causes of health inequities. Strategies fitting this criteria are marked with a ^ icon throughout the CHIP.

Priority #1: Access to Care

Strategic Plan of Action

To work toward improving access to care, the following strategies are recommended

Priority #1: Access to Care				
Strategy 1: Promote and maintain transportation options				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Create/update a community transportation resource list annually according to transportation resources that are available in the county. Include: • **Public transportation systems** • Human Services transportation providers • Reduced/free transportation services and eligibility criteria (e.g., income, Medicaid, etc.) • Private transportation providers (e.g., Uber, taxi) Spread awareness of transportation services using various formats (e.g., social media, email, committee websites, flyers with QR code, etc.). Assess gaps and opportunities regarding current volunteer driver initiatives. Collaborate to recruit additional volunteer drivers. Participate in update of Greater Regional Mobility Initiative Plan Update 2024 Participate in the Miami Valley Regional Active Transportation Plan	October 31, 2024	Adults	Barriers to care: Percent of adults reporting "difficult to find/no transportation" as a top reason for not accessing medical care in the past year *(2023 CHA)* Accessible transportation: Percent of adults indicating "there are accessible transportation services available" in Greene County *(2023 CHA)* Transportation issues: Percent of adults reporting limited or no public transportation available or accessible *(2023 CHA)*	Greene CATS Public Transit
Year 2: Continue efforts of year 1. Publish Greene County resource guide of combined public and active transportation options. Provide travel training for public health students and practitioners on transportation policy and its effects on health.	October 31, 2025			
Year 3: Continue efforts of years 1 and 2. Assess gaps and opportunities from years 1 and 2. Search for grants and funding opportunities to support efforts. Evaluate transportation needs yearly in coordination with county and regional plans and adapt accordingly.	October 31, 2026			
Resources to address strategy: Miami Valley Regional Planning Commission (MVRPC) – Greater Region **Mobility Initiative (goals and strategy process)**, **Transportation Coordination Plan**, & **Active Transportation Plan**; CDC Transportation Policy Recommendations – **Expand Public Transportation** & **Promote Active Transportation**				

- Ohio SHIP aligned priority/strategy/indicator
- Policy development, enforcement, or advocacy strategy

Priority #1: Access to Care				
Strategy 2: School dental programs ** ✓				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Assess current activity of **school dental programs** in Greene County (e.g., school participation, age range of youth served, types of services offered, frequency of service offerings, etc.). Identify ways to expand school dental program offerings (e.g., all schools in Greene County, frequency of service offerings, etc.).	October 31, 2024	Youth	Youth dental visit: Visited a dentist in the past year *(2018-2019 OHYES! Report for Mental Health & Recovery Services Board of Clark, Greene, & Madison Counties)*	Greene County Public Health
Year 2: Facilitate planning and expansion of school dental programs. Search for grants and funding opportunities to support efforts. Evaluate programming yearly and adapt accordingly.	October 31, 2025			
Year 3: Continue efforts of year 2.	October 31, 2026			
Resources to address strategy: County Health Rankings – **school dental programs**				

*** Strategy is scientifically supported. Strategies with this rating are most likely to make a difference. These strategies have been tested in many robust studies with consistently positive results.*

*✓ Strategy is likely to reduce disparities based on review by **What Works for Health** or health equity strategy in **The Community Guide**.*

- Ohio SHIP aligned priority/strategy/indicator

Priority #2: Health Behaviors

Strategic Plan of Action

To work toward improving health behaviors, the following strategies are recommended:

Priority #2: Health Behaviors				
Strategy 1: Multi-component obesity prevention interventions **				
Action Step	Timeline	Priority Population	Indicator (s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Assess the built environment to identify improvements to increase access to healthy foods. Create Community Food Mapping to highlight food establishments and maintain community food resource guide. Review the **Move Your Way Community Playbook** and complete Phase 1: Planning and Strategy Development. When selecting strategies, consider interests and activities for specific populations, such as seniors or families. Explore programming that includes group sports as well as individual fitness opportunities (e.g., weightlifting, running club, etc.). Assess the feasibility of integrating physical activity opportunities into planned events (e.g., festivals, farmer's markets, etc.). Identify ways to incorporate nutrition initiatives into strategies (e.g., **community gardens***, **healthy food initiatives in food banks***). Identify ways to advocate on behalf of policies related to nutrition, food insecurity, and physical activity (e.g., advocate for improved school nutrition and physical activity standards, expansion of WIC/SNAP benefits, etc.). Search for grants and funding opportunities to support efforts (e.g., incentives, free events).	October 31, 2024	Adults Youth/Children	Adult physical inactivity: Percent of adults, age 18 and older, reporting no leisure time physical activity *(County Health Rankings)* Adult physical inactivity: Percent of adults reporting they did not participate in any physical activity in the past week *(2023 CHA)* Adult obesity: Percent of adults considered obese according to BMI *(2023 CHA)* Adult cholesterol: Percent of adults who have ever been diagnosed with high blood cholesterol *(2023 CHA)* Adult hypertension: Percent of adults who have ever been diagnosed with high blood pressure *(2023 CHA)*	Greene County Public Health
Year 2: Continue efforts of year 1. Explore healthy food initiatives to incorporate into strategies (e.g., **community gardens**, **healthy food initiatives in food banks**). Complete implementation steps for Phase 2 from the Move Your Way Community Playbook.	October 31, 2025			
Year 3: Continue efforts of years 1 and 2. Complete evaluation steps for Phase 2 from the Move Your Way Community Playbook.	October 31, 2026			
Resources to address strategy: Greene County Parks and Trails, Extension Offices, Food Banks, County Health Rankings – **Community-based social support for physical activity**, **Healthy People 2030**, USDA – **Healthy Eating and Active Living (HEAL) Toolkit for Community Educators**, CDC – **Supports for Healthy Eating and Active Living**				

*** Strategy is scientifically supported. Strategies with this rating are most likely to make a difference. These strategies have been tested in many robust studies with consistently positive results.*

** Strategy is noted to have some evidence. Strategies with this rating are likely to work, but further research is needed to confirm effects. These strategies have been tested more than once and results trend positive overall.*

- Ohio SHIP aligned priority/strategy/indicator

- Policy development, enforcement, or advocacy strategy

Priority #2: Health Behaviors				
Strategy 2: Retail tobacco and paraphernalia sales licensing program (Tobacco 21 Model Policy) ✓				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Gather data on current substance use, specifically tobacco and e-cigarette use, among youth. Consider participating in Greene County OHYES! survey to collect youth data. Reach out to schools to encourage participation in youth surveying. Increase awareness and education of youth tobacco use and social norms campaigns within the schools, various community partners, and GCPH. Using the **Tobacco 21 Retail License Model Policy**, assess the feasibility of implementation and enforcement of retail tobacco licensing policy in Greene County. Educate and gather support from stakeholders to advocate for retail tobacco licensing policy in Greene County.	October 31, 2024	Youth	Youth current electronic vapor product use: Percent of youth who used an electronic vapor product at least once in the past month *(2018-2019 OHYES! Report for Mental Health & Recovery Services Board of Clark, Greene, & Madison Counties)* Youth cigarette purchase: Percent of current youth cigarette smokers that bought cigarettes from a store in the past month *(2018-2019 OHYES! Report for Mental Health & Recovery Services Board of Clark, Greene, & Madison Counties)*	Greene County Public Health
Year 2: Continue efforts of year 1. Draft and propose tobacco retail license ordinance to local government for approval.	October 31, 2025			
Year 3: Enact tobacco retail license ordinance in Greene County. Search for grants and funding opportunities to support enforcement efforts.	October 31, 2026			
Resources to address strategy: Preventing Tobacco Addiction Foundation/Interact for Health (Model Policy, Why TRL, Ohio TRL Landscape)				

✓ *Strategy is likely to reduce disparities based on review by* ***What Works for Health*** *or health equity strategy in* ***The Community Guide***.

- *Policy development, enforcement, or advocacy strategy*

- *Ohio SHIP aligned priority/strategy/indicator*

Priority #3: Mental Health and Addiction

Strategic Plan of Action

To work toward improving mental health and addiction outcomes, the following strategies are recommended:

Priority #3: Mental Health and Addiction				
Strategy 1: Crisis lines *				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Continue to monitor **crisis line** utilization regularly in Greene County. Identify follow-up methods that can be implemented to connect crisis line users to care and supportive services.	October 31, 2024	Adults Youth	Adult suicide deaths: Number of deaths due to suicide for adults, ages 18 and older, per 100,000 population *(ODH Public Health Data Warehouse)* Suicide attempt: Percent of adults who reported they attempted suicide in the past year *(2023 CHA)* Youth suicide deaths: Number of deaths due to suicide for youth, ages 8-17, per 100,000 population *(ODH Public Health Data Warehouse)*	Mental Health & Recovery Board of Clark, Greene, Madison Counties
Year 2: Continue efforts of year 1. Implement follow-up and connection to care protocol for crisis line users.	October 31, 2025			
Year 3: Continue efforts of years 1 and 2. Evaluate crisis line utilization and effectiveness yearly.	October 31, 2026			
Resources to address strategy: TCN Behavioral Health; DeCoach's Behavioral Health Urgent Care TCN's See U Now (SUN) Clinic (funded by MHRB through SOS grant); 988 Call Center; 911 (collaboration/integration); MHRB Warmline (937-662-9080); Crisis line resource cards/information distributed to community; MHRB QPR presentations; Training embedded about crisis lines in MHRB's Crisis Intervention Team (CIT) courses to law enforcement, fire/EMS, public safety telecommunicators, and behavioral health professionals				

** Strategy is noted to have some evidence. Strategies with this rating are likely to work, but further research is needed to confirm effects. These strategies have been tested more than once and results trend positive overall.*

- Ohio SHIP aligned priority/strategy/indicator

Priority #3: Mental Health and Addiction				
Strategy 2: School-based social and emotional instruction **				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Assess current **social and emotional instruction** being implemented in schools. Work with school social workers, care coordinators, and counselors to identify: • Types of programming currently being offered in different schools and grades • How often programming is incorporated • Admin/teacher satisfaction with current programming • Capacity and barriers to implementing social and emotional instruction • Feasibility of extending programming to families • Opportunities for diverse, youth-led programming • Incorporating connections to care for students and their families Gather feedback from school administration and teachers regarding current programming and interest or need in additional/new social and emotional instruction programming. Collect information from schools regarding admin approval, selection of social and emotional learning program, teacher buy-in, capacity to train staff, etc. Explore evidence-based prevention programs such as the **PAX Good Behavior Game, ROX (Ruling Our Experience), Sources of Strength,** Disconnect to Connect, etc. Considering feedback from schools, decide which program(s) to implement or expand within schools.	October 31, 2024	Youth	Youth suicide deaths: Number of deaths due to suicide for youth, ages 8-17, per 100,000 population *(ODH Public Health Data Warehouse)* Youth depression: Percent of youth who reported feeling sad or hopeless for two weeks or more in a row *(2018-2019 OHYES! Report for Mental Health & Recovery Services Board of Clark, Greene, & Madison Counties)*	Greene County Educational Service Center
Year 2: Introduce or re-introduce the evidence-based program(s) to the school districts. Train staff to implement programming. Pilot any new programs in at least one district.	October 31, 2025			
Year 3: Expand programming to all districts in all grade levels.	October 31, 2026			
Resources to address strategy: Greene County Drug-Free Coalition, **Ohio School Based Mental Health and Wellness Resources**, **Ohio Prevention Education**, **National Center for School Based Mental Health**, **Ohio Center of Excellence for Prevention and Wellness**, **Ohio Bold Beginnings Resources**				

*** Strategy is scientifically supported. Strategies with this rating are most likely to make a difference. These strategies have been tested in many robust studies with consistently positive results.*

- Ohio SHIP aligned priority/strategy/indicator

Priority #3: Mental Health and Addiction				
Strategy 3: Naloxone education/distribution programs * ✓ and syringe service programs (SSPs) ** ✓				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Expand **SSP** and **naloxone access** to community locations based on data trends. Address stigma surrounding drug use and harm reduction using evidence-based educational materials. Implement an overdose surveillance system for Greene County, Ohio by expanding the number of partners utilizing ODMAPs.	October 31, 2024	Adults	Unintentional drug overdose deaths: Number of deaths due to unintentional drug overdose, per 100,000 population (age adjusted) *(ODH Public Health Data Warehouse)* Naloxone Administration: Number of EMS events involving naloxone administration *(OIBHD)*	Greene County Public Health
Year 2: Continue efforts from year 1. Expand harm reduction education and secondary Naloxone distribution partnerships (e.g., **Naloxbox** placement) to treatment providers, law enforcement/first responders, health systems, and businesses to ensure multiple points of contact are available 24 hours per day. Expand access to SSPs via partnership with local organizations and street outreach. Analyze overdose trends based on surveillance system and develop a Community Response Plan to Overdose Anomalies.	October 31, 2025			
Year 3: Continue implementing Community Response Plan to Overdose Anomalies and expand SSP and naloxone access to community locations based on data trends. Create and distribute community harm reduction education materials.	October 31, 2026			
Resources to address strategy: ODMAP, Greene Couty Drug Free Coalition, SafeTrade, Treatment and Recovery facilities TCN Behavioral Health), DeCoach Rehabilitation, Women's Recovery, Her Story, Emerge Recovery & Trade Initiative, etc.), Fairborn FISH Pantry, Xenia FISH Pantry, Bridges of Hope, Fire & EMS jurisdictions within Greene County, NACCHO funding, State funding, Mental Health & Recovery Board				

** Strategy is noted to have some evidence. Strategies with this rating are likely to work, but further research is needed to confirm effects. These strategies have been tested more than once and results trend positive overall.*

*** Strategy is scientifically supported. Strategies with this rating are most likely to make a difference. These strategies have been tested in many robust studies with consistently positive results.*

*✓ Strategy is likely to reduce disparities based on review by **What Works for Health** or health equity strategy in **The Community Guide**.*

- Ohio SHIP aligned priority/strategy/indicator

Priority #4: Maternal and Infant Health

Strategic Plan of Action

To work toward improving maternal and infant health outcomes, the following strategies are recommended:

Priority #4: Maternal and Infant Health				
Strategy 1: Multi-component infant mortality prevention interventions				
Action Step	Timeline	Priority Population	Indicator(s) to measure impact of strategy:	Lead Contact/Agency
Year 1: Develop goals and objectives to be addressed by the lead agency (e.g., Safe Sleep, prenatal care, etc.).	October 31, 2024	Mothers Infants	Infant mortality: Number of deaths for infants under age 1, per 1,000 live births *(ODH Public Health Data Warehouse)*	Greene County Public Health
Year 2: Work to address the goals and objectives created. Search for grants and funding opportunities to support efforts.	October 31, 2025			
Year 3: Continue efforts from years 1 and 2. Evaluate programming yearly and adapt accordingly.	October 31, 2026			
Resources to address strategy: Help Me Grow, Nurse Family Partnership, WIC, Kettering Health – Soin				

- Ohio SHIP aligned priority/strategy/indicator

Progress and Measuring Outcomes

Progress will be monitored with measurable indicators identified for each strategy. May of the indicators align directly with the SHIP. The individuals or agencies that are working on strategies will meet on an as-needed basis. The full committee will meet as needed to report out progress. The committee will create a plan to disseminate the CHIP to the community. Strategies, responsible agencies, and timelines will be reviewed annually by the committee. As this CHIP is a living document, edits and revisions will be made accordingly.

Greene County will continue facilitating CHA every three years to collect data and determine trends. Primary data will be collected for adults using national sets of questions to not only compare trends in Greene County, but also be able to compare to the state and nation. This data will serve as measurable outcomes for each priority area. Indicators have already been defined throughout this report and, and state-aligned indicators are identified with the icon.

In addition to outcome evaluation, process evaluation will also be used on a continuous basis to focus on the success of the strategies. Areas of process evaluation that the CHIP committee will monitor include the following: number of participants, location(s) where services are provided, number of policies implemented, economic status and racial/ethnic background of those receiving services (when applicable), and intervention delivery (quantity and fidelity).

Furthermore, all strategies have been incorporated into a "Progress Report" template that can be completed at all future meetings, keeping the committee on task and accountable. This progress report may also serve as meeting minutes.

Contact Us

For more information about any of the agencies, programs, and services described in this report, please contact:

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Appendix I: Gaps and Strategies

The following tables indicate priority related gaps and potential strategies that were identified by Growing Healthy Together Greene County. The committee identified gaps and potential strategies via an online platform (SurveyMonkey). The results were compiled and presented to the committee. Additional gaps and potential strategies were identified and incorporated.

Note: parentheses indicate the number of organizations who reported the same or similar gaps/potential strategies

Priority Factor: Health Behaviors

Priority Factor #1: Health Behaviors (focus: nutrition/food insecurity, physical activity, vaping)	
Gaps	**Potential Strategies**
1. Adult weight status (7)	• Community-wide fitness programs (tailored to specific populations such as adults with disabilities/older adults) and campaigns (community challenges through apps) (3) ⛊ * • Healthy food options at local food banks (2) ⛊ √ * • Green spaces and parks ⛊ √ • Multi-component obesity prevention interventions ⛊ • Community gardens – link with non-profits & churches/religious organizations ⛊ • Mass-media campaigns • Increase marketing of food pantries and farmers markets for fruits and vegetables specifically • Free community health educational opportunities (e.g., nutrition) • Continued emphasis on Disconnect to Connect (challenges)
2. Increased vaping/nicotine use (4)	• Retail tobacco and paraphernalia sales licensing program (Tobacco 21 Model Policy) ⛊ ^ • Tobacco 21 policy enforcement - penalties for selling to underage buyers ⛊ ^ • Mass media campaigns against tobacco use ⛊ • Tobacco cessation program focus ⛊ • Required education on effects ^
3. Youth weight status (4)	• Work with local schools to offer healthier food options (2) ⛊ √ • School-based physical education enhancements ⛊ • Family-style meal brochures or recipe pamphlets • Events partnered with Central State Extension for family meal night/weekend events

⛊ = Ohio SHIP supported strategy
√ = likely to reduce disparities
* = aligned with previous Greene County CHIP
^ = policy development, enforcement, or advocacy strategy

Priority Factor: Access to Care

Priority Factor #2: Access to Care (focus: transportation, insurance coverage, oral health)	
Gaps	**Potential Strategies**
1. Transportation (3)	• Improve and maintain public transportation systems ✓ • Develop volunteer driver programs • Education • Availability
2. Insurance coverage/uninsured (3)	• Continue to market MCPs, FQHCs, RHCs to the uninsured demographic ✓ • Insurance enrollment assistance - hold free community education sessions regarding health insurance with assistance to sign up for insurance • Work with state representatives to lower insurance costs
3. Access to providers – long wait times for appointments (2)	• Increase transportation availability to allow for wider area to look for providers • Health career recruitment for minority students - healthcare workforce professional development for minorities and lower income populations (primary care shortage) ✓
4. Oral health care (2)	• School dental programs • Mass media campaigns about the correlation to overall health
5. Quality of care	• Community health care opportunities

= Ohio SHIP supported strategy
✓ = likely to reduce disparities
* = aligned with previous Greene County CHIP
= policy development, enforcement, or advocacy strategy

Priority Outcome: Mental Health and Addiction

Priority Health Outcome #1: Mental Health & Addiction (focus: mental health/suicide, substance abuse (opioids), bullying/violence, ACEs)	
Gaps	**Potential Strategies**
1. Access to mental health care (3)	• Telehealth (2) * • Mental health benefits legislation - work with state representatives to improve insurance coverage for mental health assistance √
2. Youth bullying, mental health, and suicide (3)	• Youth-led programming • Digital health interventions (support) • Crisis lines education • Experts in mental health hold sessions at all local schools regarding the issue to educate students and school staff • Mass media campaigns
3. Skills to address depression, anxiety, and other emotional problems (2)	• Mental Health First Aid * • Develop, support, and expand the role of peer support specialists
4. Stigma of seeking help for a mental illness (2)	• Have an event to showcase mental and behavioral health resources (i.e., a "Mental Wellness Expo") • Educate population on types of mental health and harms of addictions by using well-known people's real stories
5. Child behavioral health	• GCPH can work with OhioRise/ODJFS/ODM to have small groups for parents of children with behavioral health issues to discuss strategies, stories, could have presentations from professionals for them as well, in small group settings
6. Increased depression/suicide	• Depression screenings in schools • Digital health interventions (education and support) • Community-wide fitness programs and campaigns

= Ohio SHIP supported strategy
√ = likely to reduce disparities
* = aligned with previous Greene County CHIP
= policy development, enforcement, or advocacy strategy

Priority Outcome: Maternal and Infant Health

Priority Health Outcome #2: Maternal & Infant Health (focus: infant mortality)	
Gaps	**Potential Strategies**
1. Infant mortality/pre-term births (6)	• Pre- and post- natal home visiting programs (2) ✓ • Community health workers ✓ • Centering pregnancy ✓ • Mobile clinics ✓ • Continue to have and market incentives to keep pregnant moms and infants covered with healthcare and connected to social community caretaking resources • Increase number of women completing Notice of Pregnancy to their health insurance companies and ODJFS • Link with WIC, OB/GYN offices, and other free clinics in educating parents on risks and prevention • Nurse family partnership
2. Maternal Health	• Link awareness to October breast cancer events – stress mom taking care of herself which affects the whole family

= Ohio SHIP supported strategy
✓ = likely to reduce disparities
* = aligned with previous Greene County CHIP
= policy development, enforcement, or advocacy strategy

Appendix II: Links to Websites

Title of Link	Website URL
CDC Transportation Policy Recommendations – Expand Public Transportation	https://www.cdc.gov/transportation/expand-public-transportation.html
CDC Transportation Policy Recommendations – Promote Active Transportation	https://www.cdc.gov/transportation/active-transportation.html
CDC; National Public Health Performance Standards; The Public Health System and the 10 Essential Public Health Services	https://www.cdc.gov/publichealthgateway/nphps/index.html
Community-based social support for physical activity	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/community-based-social-support-for-physical-activity
Community gardens	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/community-gardens
Crisis lines	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/crisis-lines
Greene County Public Health	https://www.gcph.info/
Healthy Eating and Activity Living (HEAL) Toolkit for Community Educators	https://snaped.fns.usda.gov/library/materials/healthy-eating-and-active-living-heal-toolkit-community-educators
Healthy food initiatives in food banks	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/healthy-food-initiatives-in-food-pantries
Healthy People 2030	https://health.gov/healthypeople/objectives-and-data
Insurance enrollment assistance	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/health-insurance-enrollment-outreach-support
Move Your Way Community Playbook	https://health.gov/our-work/nutrition-physical-activity/move-your-way-community-resources/community-playbook
Multi-component workplace supports for active commuting	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/multi-component-workplace-supports-for-active-commuting
MVRPC Active Transportation Plan	https://www.mvrpc.org/transportation/bikeways-pedestrians/active-transportation-plan
MVRPC Mobility Initiative (goals and strategy process)	https://www.mvrpc.org/sites/default/files/regional_plan_goals_strategy_progress.pdf
MVRPC Transportation Coordination Plan	https://www.mvrpc.org/sites/default/files/grmi_transportation_coordination_plan_website_version.pdf
Naloxbox	https://naloxbox.org/
Naloxone education and distribution programs	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/naloxone-education-distribution-programs
National Center for School0Based Mental Health	https://www.schoolmentalhealth.org/
Ohio Bold Beginnings Resources	https://boldbeginning.ohio.gov/providers
Ohio Healthy Youth Environments Survey (OHYES!)	https://www.rand.org/pubs/research_reports/RR1002.html
Ohio Prevention Education	https://education.ohio.gov/Topics/Student-Supports/School-Wellness/Prevention-Education

Title of Link	Website URL
Ohio School-Based Mental Health and Wellness Resources	https://education.ohio.gov/Topics/Student-Supports/School-Wellness/School-based-Mental-Health
Ohio Source of Excellence for Prevention and Wellness	https://miamioh.edu/cas/centers-institutes/school-based-mental-health-programs/index.html?_ga=2.49588005.2020561902.1663497858-1912986749.1663149733
Ohio State Health Improvement Plan	https://odh.ohio.gov/about-us/sha-ship/state-health-improvement-plan
PAX Good Behavior Game	https://www.hazelden.org/HAZ_MEDIA/gbg_insert.pdf
Public Transportation Systems	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/public-transportation-systems
ROX (Ruling Our Experience)	https://rulingourexperiences.com/#!about_us/csgz
School dental programs	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/school-dental-programs
Social and emotional instruction	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/school-based-social-and-emotional-instruction
Sources of Strength	https://sourcesofstrength.org/
Supports for Healthy Eating and Active Living	https://www.cdc.gov/nccdphp/dnpao/division-information/data-stats/cbs-heal/index.html
Syringe service programs (SSPs)	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/syringe-services-programs
The Community Guide	https://www.thecommunityguide.org/
Tobacco 21 Retail License Model Policy	https://tobacco21.org/ohiotrl/
United Way of Greene County	https://dayton-unitedway.org/
What Works for Health	https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies

Appendix III: Secondary Data Sources – Strategy Indicators

Priority Indicator(s)	Secondary Data Source(s)	Secondary Data Source URL(s)	Applicable Strategy
Priority #1: Access to Care			
Youth dental visit: Visited a dentist in the past year	Ohio Healthy Youth Environments Survey (OHYES!)	https://youthsurveys.ohio.gov/our-surveys/ohyes	Strategy 3: School dental programs
Priority #2: Health Behaviors			
Adult physical inactivity: Percent of adults reporting no leisure-time physical activity in the past month	Behavioral Risk Factor Surveillance System, as compiled by Kaiser Family Foundation	https://www.countyhealthrankings.org/explore-health-rankings/ohio/williams?year=2022	Strategy 1: Multi-component obesity prevention interventions
Youth current electronic vapor product use: Percent of youth who used an electronic vapor product at least once in the past month	Ohio Healthy Youth Environments Survey (OHYES!)	https://youthsurveys.ohio.gov/our-surveys/ohyes	Strategy 2: Retail tobacco and paraphernalia sales licensing program (Tobacco 21 Model Policy)
Youth cigarette purchase: Percent of current youth cigarette smokers that bought cigarettes from a store in the past month	Ohio Healthy Youth Environments Survey (OHYES!)	https://youthsurveys.ohio.gov/our-surveys/ohyes	Strategy 2: Retail tobacco and paraphernalia sales licensing program (Tobacco 21 Model Policy)
Priority #3: Mental Health and Addiction			
Adult suicide deaths: Number of deaths due to suicide for adults, ages 18 and older; and youth, ages 8-17, per 100,0000 population	Ohio Department of Health Public Health Data Warehouse	https://publicapps.odh.ohio.gov/EDW/DataBrowser/Browse/Mortality	Strategy 1: Crisis lines
Youth suicide deaths: Number of deaths due to suicide for youth, ages 8-17, per 100,000 population	Ohio Department of Health Public Health Data Warehouse	https://publicapps.odh.ohio.gov/EDW/DataBrowser/Browse/Mortality	Strategy 1: Crisis lines Strategy 2: School-based social and emotional instruction
Unintentional drug overdose deaths: Number of deaths due to unintentional drug overdose, per 100,000 population (age adjusted)	Ohio Department of Health Public Health Data Warehouse	https://publicapps.odh.ohio.gov/EDW/DataBrowser/Browse/Mortality	Strategy 3: Naloxone education/distribution programs and syringe service programs
Naloxone Administration: Number of EMS events involving naloxone administration	Ohio Integrated Behavioral Health Dashboard	https://data.ohio.gov/wps/portal/gov/data/view/ohio-ibhd	Strategy 3: Naloxone education/distribution programs and syringe service programs