Miami County, OH

Community Health Improvement Plan 2025-2028

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Center for Public Policy and Health

Miami County Public Health
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Acknowledgements

Miami County Public Health (MCPH) partnered with the Center for Public Policy and Health (CPPH) at Kent State University to conduct its 2024 Community Health Assessment (CHA) and corresponding Community Health Improvement Plan (CHIP). A steering committee comprised of key stakeholders from local organizations was also convened to guide the assessment. The steering committee met regularly with the project team to review assessment activities and provide integral feedback. The authors would like to acknowledge the contributions of all involved in this work.

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Acronyms

ATC: Access to Care

CD: Chronic Disease

CDC: Centers for Disease Control and Prevention

CHA: Community Health Assessment

CHIP: Community Health Improvement Plan

CPPH: Center for Public Policy and Health

MCPH: Miami County Public Health

MH: Mental Health

NACCHO: National Association of County and City Health Officials

ODH: Ohio Department of Health

PHAB: Public Health Accreditation Board

PHF: Priority Health Factors

PHO: Priority Health Outcomes

SDOH: Social Determinants of Health

SHIP: State Health Improvement Plan

SVI: Social Vulnerability Index

About Miami County Public Health

MCPH serves residents in Miami County and works to improve their health through programs and collaboration with other community organizations. Their mission is “to prevent illness, promote healthy lifestyles, and protect every person who spends time in our community.”

About the Center for Public Policy & Health (CPPH)

The mission of the CPPH at Kent State University is to conduct research to develop and improve public policies aimed at improving the public’s health, and to provide targeted assistance to public, non-profit, and private sector organizations which share this health mission. The Center pursues its mission by engaging faculty, staff, students, outside experts and the community in scholarly activities that build capacity to make positive and beneficial public health contributions.

Table of Contents

Executive Summary

Miami County Public Health's (MCPH) 2025-2028 Community Health Improvement Plan (CHIP) addresses priority health issues identified in the 2024 Community Health Assessment (CHA). These include: Access to Care, Chronic Disease, and Mental Health. In collaboration with local stakeholders, strategies were developed to improve health outcomes and reduce health disparities for each identified issue. Each strategy includes: a goal, an indicator, action steps, a timeline, and lead agencies responsible for implementation. The table below reports the key information included in the CHIP.

Priority Health Factor: Access to Care	
Goal	**Strategy**
Decrease the percentage of Miami County residents without a usual place for medical care.	Collaborate with partner organizations to promote free and low-cost health services for residents.
Decrease the percentage of Miami County residents with unmet mental health care needs.	Collaborate with partner organizations to promote free and low-cost mental health services in the county.
Improve knowledge about available services and resources for women who are pregnant or planning to become pregnant.	Develop a comprehensive educational campaign around pregnancy needs and services in Miami and surrounding counties.
Priority Health Factor: Chronic Disease	
Goal	**Strategy**
Decrease the number of new diabetes cases and coronary heart disease deaths that occur each year in the county.	Work with partner organizations to establish a large-scale community chronic disease screening event and promote health services in high-need areas.
Increase the percentage of residents who have access to healthy food choices.	Promote healthy eating as a method for preventing chronic diseases.
Decrease the number of falls among senior citizens in the county.	Expand the Bingocize fall prevention program.
Priority Health Factor: Mental Health	
Goal	**Strategy**
Develop a baseline understanding of youth health outcomes in the county and a method for tracking data over time.	Develop a policy to establish a data collection tool to collect youth well-being data in collaboration with Tri-County Board and other stakeholders.
Reduce the number of suicide attempts and deaths in the county.	Develop a policy to establish a Suicide Fatality Review committee according to Section 307.641 - Ohio Revised Code | Ohio Laws and prevent future suicide attempts and deaths through coordinated community response efforts.

Introduction

The 2025-2028 MCPH CHIP systematically addresses key health issues identified in the 2024 CHA. The purpose of the CHIP is to set priorities, describe and implement community health programs and policies, and determine how to best use local resources to improve health outcomes. This plan represents the collaborative work of stakeholders committed to improving the health and well-being of Miami County residents, with a focus on the following priority health factors: ***Access to Care, Chronic Disease, and Mental Health.*** In addition to highlighting these factors, this report also outlines the necessary strategies to address them and describes disparities in health outcomes within the community. This report also highlights the plan's alignment with national and state health frameworks.

PHAB Requirements

The Public Health Accreditation Board (PHAB) is the national accrediting body in the United States that supports health departments' efforts to improve and enhance public health practice. PHAB standards and measures are requirements that must be met for public health departments to be accredited. PHAB standards necessitate the use of a community health improvement model during the CHA and CHIP process. NACCHO's Mobilizing for Action through Planning and Partnerships (MAPP) 2.0 framework was used to inspire desired community health improvements. MAPP is a strategic planning process that is driven by the community to identify health priorities, determine what resources are available to address them, and develop strategies to bridge gaps in health outcomes and provide for a healthier future. MAPP is rooted in principles of systems thinking, shared vision, the use of evidence to create understanding and develop strategies, and partnership. MAPP 2.0 builds on these concepts while also emphasizing the importance of community engagement, data-driven assessments, and a focus on health equity.[1]

Alignment to National and State Standards

Ohio State Health Improvement Plan

The Miami County CHIP uses the 2020-2022 Ohio Department of Health (ODH) State Health Improvement Plan (SHIP) as a guiding framework. The purpose of the SHIP is to "strengthen state and local efforts to improve health, well-being, and economic vitality in Ohio."[2] This is accomplished through a variety of measurable priority health issue areas, the creation of strategies, and an evaluation plan. Per its guidance to local health

[1] https://www.naccho.org/uploads/card-images/public-health-infrastructure-and-systems/MAPP-2.0-Launch-V3.pdf

[2] *State Health Improvement Plan.* April 2020. https://odh.ohio.gov/about-us/sha-ship/state-health-improvement-plan.

departments, the Miami County CHIP includes: one priority health factor (PHF), one priority health outcome (PHO), and one indicator and strategy from the SHIP. The table below reports the selected PHFs and PHOs included in the Miami County CHIP and their alignment with SHIP priorities. Corresponding indicators and strategies can be found later in this document.

Miami County CHIP Priority Health Factors and Outcomes (* Indicates a SHIP priority)

Access to Care*	Chronic Disease*	Mental Health*
Access to a Usual Place for Care	Diabetes	Suicide Attempts and Deaths
Maternal and Infant Health*	Health Behaviors*	Youth Mental Health
Access to Mental Health Care	Heart Disease	

National Standards

Throughout the CHA, health needs and outcomes within Miami County were reported using Healthy People 2030 as a framework.[3] Healthy People 2030 is an initiative of the U.S. Department of Health and Human Services that sets a series of measurable health objectives and targets that the public health and associated systems can work toward for the decade. Where possible, data reported in the CHA aligns with Healthy People 2030. CHA data is subsequently used to inform the work of the CHIP.

Social Determinants of Health

The social determinants of health (SDOH) are "the conditions in the environment where people are born, live, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."[4] They are also referred to as the "causes of the causes."[5] SDOH are upstream factors that impact health, including the social and policy context, neighborhood characteristics, the environment, interpersonal relationships, institutions, and more.[6]

[3] *Healthy People 2030.* U.S. Department of Health and Human Services. https://health.gov/healthypeople.
[4] *Social Determinants of Health.* Centers for Disease Control and Prevention. January 2024. Social Determinants of Health (SDOH) | About CDC | CDC.
[5] *The Social Determinants of Health: Coming of Age.* Braverman, P., Egerter, S., & Williams, D.R. 2011. The social determinants of health: coming of age - PubMed
[6] *The Ecology of Human Development: Experiments by Nature and Design.* Bronfenbrenner, U. 1979. https://doi.org/10.2307/j.ctv26071r6.

Priority populations within Miami County were identified using the Centers for Disease Control and Prevention's (CDC) Social Vulnerability Index (SVI). The SVI is a measure of the demographic and socioeconomic factors that can result in health disparities, including poverty, housing, and transportation.[7] Social vulnerability within the county places individuals at risk for a number of health-related hazards, including natural disasters, disease outbreaks, and poor health outcomes. Across each SVI indicator, Miami County is experiencing low levels of vulnerability overall and by Socioeconomic Status and Housing Type & Transportation. Miami County is experiencing low to medium vulnerability based on Household Characteristics and medium to high vulnerability based on Racial & Ethnic Minority Status. These factors were used to determine portions of the county that could benefit most from targeted strategies. For more information about the SVI and associated maps, please see Appendix B.

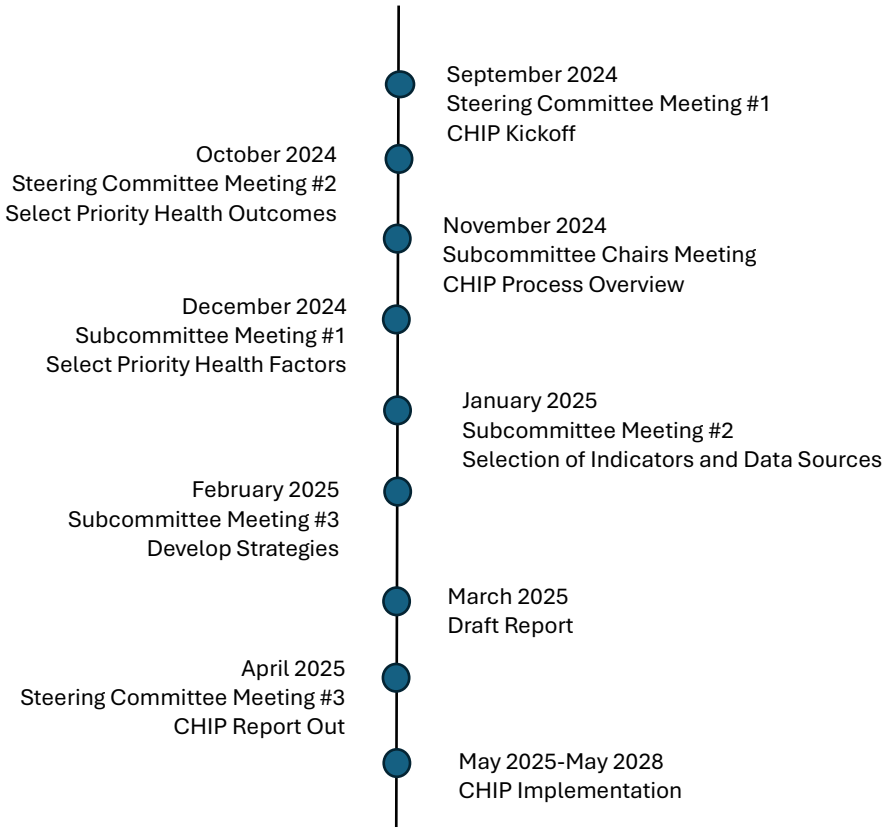
Health Equity

Related to SDOH, health equity is "the state in which everyone has a fair and just opportunity to attain their highest level of health."[8] Health equity is achieved through equitable access to the resources necessary to live a healthy life, regardless of age, gender, gender identity, disability status, economic status, sexual orientation, race, or ethnicity. Throughout the CHIP process, achieving health equity was a guiding principle, resulting in strategies aimed at improving health outcomes for disadvantaged groups as per PHAB requirements.

[7] *Social Vulnerability Index.* Centers for Disease Control and Prevention. https://www.atsdr.cdc.gov/placeandhealth/svi/index.html.
[8] *What is Health Equity?* Centers for Disease Control and Prevention. 2024. What is Health Equity? | Health Equity | CDC.

CHIP Process

CHIP development began in September 2024, with the conclusion of the CHA. The timeline below displays key activities within the process. Priority health outcomes and factors were identified, indicators for tracking progress were selected, and strategies were developed through a series of steering and subcommittee meetings. Ongoing implementation and monitoring for progress will continue through May 2028. For a complete timeline and project work plan, please see Appendix C.



Community Served

Miami County is the 70th largest county out of Ohio's 88 counties, covering 407 square miles. As of the 2020 Census, Miami County is estimated to be home to 108,774 residents. With an unemployment rate of 3.8%, and the median household income is $71,457, Miami County is among the state's most economically stable counties. Based on the County Health Rankings, Miami County fares better than average in general health and health outcomes than other Ohio counties. While Miami County's health outcomes are ranked well, there are factors that impact residents' health negatively. Through the CHIP, significant health needs within the community are addressed.

Prioritization of Health Issues

A total of three steering committee meetings and three subcommittee meetings were held to complete the CHIP process. The purpose of the first steering committee meeting was to introduce stakeholders to the goal and activities of the CHIP. The focus of the second steering committee meeting was the selection of priority health factors. Steering committee members were asked to come to the meeting with a list of three potential factors they believed the CHIP should address. The list was then presented for a vote, where the top factors were identified using the following criteria:

- Cost and/or return on investment
- Availability of solutions
- Impact of the problem
- Availability of resources to solve the problem (e.g., staff, time, funding)
- Urgency of solving the problem
- Size of the problem (number affected)
- Health equity
- Social vulnerability

The steering committee identified the following priority health factors as the focus of the 2025-2028 CHIP:

- Access to Care
- Chronic Disease
- Mental Health

Subcommittees were then formed around each of these focal areas, where additional work for the CHIP was carried out. A third steering committee meeting was held to review the subcommittee strategies and CHIP report.

Miami County CHIP Priority Health Factors and Outcomes

Priority Health Factors (PHF) are broad, high level-public health issues that the CHIP addresses. The CHIP works to improve health conditions identified under these overarching PHF. Priority Health Outcomes (PHO) are more specific public health problems within each PHF. Throughout the CHIP process, stakeholders were engaged to identify relevant PHF and PHO and design strategies to improve the health conditions of Miami County. The sections below report each PHF, its corresponding PHO, and indicators and strategies to address them.

Priority Health Factor #1: Access to Care

Access to care means "having the timely use of personal health services to achieve the best health outcomes."[9] This includes coverage (e.g., access to health insurance), access to services (e.g., having a usual source of care), and more. Healthy People 2030 includes a goal to "Increase Access to Comprehensive, High-Quality Health Care Services."[10] Access to care was identified as a PHF in the SHIP and identified as a need in the CHIP process. According to the 2024 CHA, Miami County is meeting Healthy People 2030 targets for health insurance coverage, healthcare utilization, and dental care utilization. It was identified, however, that challenges persist in access to maternal and infant health care, continuity of care, and access to mental health care, which were identified as PHOs in the CHIP.

[9] *Topic: Access to Care.* Agency for Healthcare Research and Quality. https://www.ahrq.gov/topics/access-care.html.
[10] *Health Care Access and Quality.* Healthy People 2030. https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/health-care-access-and-quality.

Indicators

The table below reports PHOs related to Access to Care that were identified during the CHIP process. Corresponding indicators for each PHO are also reported, in addition to key health disparities. The baseline column reports the current status within Miami County and a target to reach by 2028.

PHF 1. Access to Care					
Priority Health Outcomes	**Indicator**	**Source**	**Baseline**	**Target**	**Key Health Disparities**
ATC-PHO 1. Maternal and Child Health	Percentage of women who travel outside the county to give birth	2023 Ohio Department of Health, DataOhio, live birth protected data	95%	N/A*	Medicaid was the primary payor for 30.3% of births in Miami County in 2024. 5.8% of births were to mothers who self-paid. 10.5% of births were preterm. 17.4% of mothers first received prenatal care in the 2nd trimester and 2.4% in the 3rd trimester. 4.4% of mothers smoked during their pregnancy.
	Number of home births	2023 Ohio Department of Health, DataOhio, live birth protected data	26	N/A*	
ATC-PHO 2. Access to Primary Health Care	Percentage of people in Miami County without a usual place for medical care	2023 Ohio Medicaid Assessment Survey	13.1%	11%	A higher percentage of male residents (14.3%) reported not having a usual place for care compared to female residents (11.8%). 17.1% of residents with disabilities and 22% of adults on Medicaid also did not have a usual place for care.
ATC-PHO 3. Access to Mental Health Care	Percentage of people in the county with unmet mental health care needs in the past 12 months	2019 Ohio Medicaid Assessment Survey	5%	3%	Asian, Black, and Hispanic adults are more likely to have an unmet mental health care need than White adults.

***Note:** With the closure of the local labor and delivery hospital in Miami County, it is not feasible to reduce the number of births that occur outside the county and home births due to this limitation. The focus of this strategy is to assist pregnant women in developing a plan for birth in advance that can support a healthy pregnancy and delivery.*

Strategies

The table below reports a strategy for each PHO and indicators for tracking progress.

ATC-PHO 1: Maternal and Child Health			
Goal: Improve knowledge about available services and resources for women who are pregnant or planning to become pregnant.			
Indicator: The percentage of women who travel outside the county to give birth and the number of home births **Data Source:** Ohio Department of Health, DataOhio, live birth protected data, 2023 **Baseline – Births outside the county:** 95% ***Target:** N/A **Baseline – Home births:** 26 ***Target:** N/A			
Key Health Disparities: Medicaid was the primary payer for 30.3% of births in Miami County in 2024. 5.8% of births were to mothers who self-paid. 10.5% of births were preterm. 17.4% of mothers first received prenatal care in the second trimester, and 2.4% in the third trimester. 4.4% of mothers smoked during their pregnancy.			
Strategy: Develop a comprehensive educational campaign focused on pregnancy needs and services in Miami and surrounding counties.			
Action Step	**Timeline**	**Indicator**	**Lead Agency**
Develop a list of maternity care providers in the county and where they deliver.	June 2025-December 2025	# of providers listed	MCPH
Develop an education campaign about what to do when you are pregnant, how to develop a birth plan, how to choose a provider, what to do if you need transportation for care, information about home births, and other general resources.	January 2026-May 2028	# of informational pieces created	MCPH
Promote resources via social media and other outlets.	January 2026-May 2028	# of people reached	MCPH
Update resource list as needed.	January 2026-May 2028	# of updates	MCPH

ATC-PHO 2: Access to Primary Health Care
Goal: Reduce the percentage of Miami County residents without a usual place for medical care.
Indicator: The percentage of people in Miami County without a usual place for medical care **Data Source:** Ohio Medicaid Assessment Survey, 2023 **Baseline:** 13.1% **Target:** 11%
Key Health Disparities: A higher percentage of male residents (14.3%) reported not having a usual place for care compared to female residents (11.8%). 17.1% of residents with disabilities and 22% of adults on Medicaid also did not have a usual place for care.
Strategy: Collaborate with partner organizations to promote free and low-cost health services for residents.

Action Step	Timeline	Indicator	Lead Agency
Engage with providers of free and low-cost health services in the county.	June 2025-December 2025	# of providers engaged	MCPH
Develop a resource list of free/low-cost care options.	June 2025-December 2025	# of community resources included	MCPH
Identify areas of high-need (i.e., areas with limited providers, residents without insurance, residents without a usual place for care, etc.).	January 2026	# of sites identified	MCPH
Distribute list to agencies that serve Miami County residents, particularly in high-need areas.	January 2026-May 2028	# of resource lists distributed	MCPH
Collaborate with local health systems to promote 211.	January 2026-May 2028	# of resource lists distributed	MCPH, local health system
Promote available free/low-cost health services in the county.	January 2026-May 2028	# of promotional campaigns	MCPH
Update the resource list as needed.	January 2026 -May 2028	# of updates	MCPH

ATC-PHO 3: Access to Mental Health Care			
Goal: Reduce the percentage of Miami County residents with unmet mental health care needs.			
Indicator: The percentage of people in the county with unmet mental health care needs in the past 12 months **Data Source:** Ohio Medicaid Assessment Survey, 2019 **Baseline:** 5% **Target:** 3%			
Key Health Disparities: Asian, Black, and Hispanic adults are more likely to have an unmet mental health care need than White adults.			
Strategy: Collaborate with partner organizations to promote free and low-cost mental health services in the county.			
Action Step	**Timeline**	**Indicator**	**Lead Agency**
Engage with providers of free and low-cost health services in the county.	June 2025-December 2025	# of providers engaged	MCPH, Tri-County Board
Develop a resource list of free/low-cost mental health care in the community.	June 2025-December 2025	# of resources listed	MCPH, Tri-County Board
Identify areas of high-need (i.e., areas with limited providers, residents without insurance, etc.).	January 2026	# of sites identified	MCPH, Tri-County Board
Distribute list, along with Tri-County Board's "What to Do When You Need Help" resource guide, to high-need areas.	January 2026-May 2028	#of resource lists identified	MCPH, Tri-County Board
Promote available free/low-cost mental health services in the county.	January 2026-May 2028	# of promotional campaigns	MCPH, Tri-County Board
Update resource list as needed.	January 2026-May 2028	# of updates	MCPH, Tri-County Board

Priority Health Factor #2: Chronic Disease

Chronic diseases are long-term conditions that require ongoing medical care. Heart disease and diabetes are two of the most impactful chronic diseases in the United States. According to the CDC, heart disease is the leading cause of death in the U.S., being the cause for about one in every five deaths.[11] The CDC estimates that approximately 38.4 million people, or about 11.6% of the U.S. population, have diabetes.[12] According to the 2024 CHA, Miami County is not currently meeting the Healthy People 2030 targets for coronary heart disease, stroke deaths, and the number of diabetes cases diagnosed annually.

Indicators

The table below reports the PHOs related to Chronic Disease. Corresponding indicators for each PHO are also reported, in addition to key health disparities. The baseline column reports the current status within Miami County and a target to reach by 2028.

PHF 2. Chronic Disease					
Priority Health Outcomes	**Indicator**	**Source**	**Baseline**	**Target**	**Key Health Disparities**
CD-PHO 1. Diabetes	Number of newly diagnosed diabetes cases per year per 1,000	2019 CDC United States Diabetes Surveillance System	6.3	4.8*	Miami County is in the 0.092 SVI percentile, higher than 9.2% of other Ohio counties
CD-PHO 2. Coronary Heart Disease	Number of adults who died due to CHD per 100,000	2018-2022 NIH Heart Disease Death Rates	213.6	71.1*	Men had significantly higher rates of CHD deaths (270) compared to females (169), as did Black residents (286.3). Rates also increased with age.

** Denotes a Healthy People 2030 target*

[11] https://www.cdc.gov/heart-disease/data-research/facts-stats/index.html#:~:text=Heart%20disease%20in%20the%20United,lost%20productivity%20due%20to%20death.

CD-PHO 3. Health Behaviors	Number of newly diagnosed diabetes cases per year per 1,000; Number of adults who died due to CHD per 100,000	2019 CDC United States Diabetes Surveillance System; 2018-2022 NIH Heart Disease Death Rates	6.3; 213.6	4.8*; 71.1*	Miami County is in the 0.092 SVI percentile, higher than 9.2% of other Ohio counties; Men had significantly higher rates of CHD deaths (270) compared to females (169), as did Black residents (286.3). Rates also increased with age.
CD-PHO 4. Health Education and Promotion	Number of falls among adults 59+	2024 EpiCenter surveillance tool by Miami County resident's home address	1,761	1,673 (5% decrease)	The rate of falls among females was higher from 2020 to 2024 compared to males. There is a higher rate of falls relative to the size of the population 60 and older in the 45326 and 45337 zip codes. The largest rate of falls occurs in the 45383 zip code.

Strategies

The table below reports a strategy for each PHO and indicators for tracking progress.

CD-PHO 1 and 2: Diabetes and Heart Disease			
Goal: Reduce the number of new diabetes cases and coronary heart disease deaths that occur each year in the county.			
Indicator: The number of newly diagnosed diabetes cases per year and the number of coronary heart disease deaths. **Data Source:** CDC Diabetes Surveillance System, 2019; NIH Heart Disease Death Rates, 2018-2022 **Baseline – Newly Diagnosed Diabetes Cases:** 6.3 per 1,000 ***Target:** 4.8 per 1,000 **Baseline – CHD Deaths:** 213.6 per 100,000 ***Target:** 71.1 per 100,000 *Targets are based on Healthy People 2030 indicators for diabetes and CHD deaths: https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/diabetes/reduce-number-diabetes-cases-diagnosed-yearly-d-01 https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/heart-disease-and-stroke/reduce-coronary-heart-disease-deaths-hds-02			
Key Health Disparities: Men had significantly higher rates of CHD deaths (270) compared to females (169), as did Black residents (286.3). Rates also increased with age.			
Strategy: Work with partner organizations to establish a large-scale community chronic disease screening event and promote health services in high-need areas.			
Action Step	**Timeline**	**Indicator**	**Lead Agency**
Identify and engage stakeholders.	June 2025-December 2025	# of stakeholders identified	MCPH
Plan logistics of screening event.	June 2025-April 2026	# of planning meetings	MCPH
Organize community outreach and promotion.	January 2026-April 2026	# of promotional materials distributed	MCPH
Host the event.	April 2026	# of attendees	MCPH
Evaluate the success of the event.	April 2026-May 2028	Completed evaluation	MCPH
Plan for the sustainability of the event.	April 2026-May 2028	# of planning meetings	MCPH
Promote health services in high-need areas.	January 2026-May 2028	# of people reached	MCPH

CD-PHO 3: Health Behaviors
Goal: Increase the percentage of residents who have access to healthy food choices.
Indicator: The number of newly diagnosed diabetes cases per year and the number of coronary heart disease deaths **Data Source:** CDC Diabetes Surveillance System, 2019; NIH Heart Disease Death Rates, 2018-2022 **Baseline – Newly Diagnosed Diabetes Cases:** 6.3 per 1,000 **Target:** 4.8 per 1,000 **Baseline – CHD Deaths:** 213.6 per 100,000 **Target:** 71.1 per 100,000 *Targets are based on Healthy People 2030 indicators for diabetes and CHD deaths: https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/diabetes/reduce-number-diabetes-cases-diagnosed-yearly-d-01 https://odphp.health.gov/healthypeople/objectives-and-data/browse-objectives/heart-disease-and-stroke/reduce-coronary-heart-disease-deaths-hds-02
Key Health Disparities: Men had significantly higher rates of CHD deaths (270) compared to females (169), as did Black residents (286.3). Rates also increased with age.
Strategy: Promote healthy eating as a strategy for preventing chronic diseases

Action Step	Timeline	Indicator	Lead Agency
Develop a list of healthy food options to look for while shopping.	June 2025-December 2025	# of food options listed	MCPH
Compile a resource that includes the list of food retailers and healthy eating shopping guide.	June 2025-December 2025	# of resources created	MCPH
Create a resource with healthy recipe ideas and assemble ingredients.	June 2025-December 2025	# of resources created	MCPH
Distribute recipe tips and ingredients at the health department.	January 2026-May 2028	# of kits collected	MCPH

CD-PHO 4: Health Education and Promotion
Goal: Reduce the number of falls among senior citizens in the county.
Indicator: The number of falls among adults 59+ **Data Source:** EpiCenter surveillance tool by Miami County resident's home address, 2024 **Baseline – Number of falls:** 1,761 **Target:** 1,673 (5% decrease)
Key Health Disparities: The rate of falls among females was higher from 2020 to 2024 compared to males. There is a higher rate of falls relative to the size of the population 60 and older in the 45326 and 45337 ZIP Codes. The largest rate of falls occurs in the 45383 ZIP Code.
Strategy: Expand the Bingocize fall prevention program.

Action Step	Timeline	Indicator	Lead Agency
Identify and engage stakeholders.	June 2025 to December 2025	# partners engaged	MCPH
Secure a funding source for program expansion.	June 2025-April 2026	Funding source secured	MCPH
Secure a location for program expansion.	January 2026 - July 2026	Location secured	MCPH
Train volunteers who will run the program sessions.	October 2026-December 2026	# of volunteers trained	MCPH
Purchase program materials.	October 2026-December 2026	Materials purchased	MCPH
Host 10-week session.	January 2027-May 2027	# of sessions held	MCPH
Evaluate the program's effectiveness.	May 2027-May 2028	Completed evaluation	MCPH

Priority Health Factor #3: Mental Health

Mental health is the "component of behavioral health that includes our emotional, psychological, and social well-being."[13] Mental health is important to personal well-being at every stage of life, and mental health problems can affect an individual's thinking, mood, and behavior. According to the 2024 CHA, Miami County is not currently meeting Healthy People 2030 targets for suicide deaths. 14% of Miami County residents also report frequent mental distress.

Indicators

The table below reports the PHOs related to Mental Health. Corresponding indicators for each PHO are also reported, in addition to key health disparities. The baseline column reports the current status within Miami County and a target to reach by 2028.

PHF 3. Mental Health					
Priority Health Outcomes	**Indicator**	**Source**	**Baseline**	**Target**	**Key Health Disparities**
MH-PHO 1. Suicide Attempts and Deaths	Number of suicide attempts (1st attempt), number of subsequent suicide attempts, number of suicide deaths	EpiCenter, 2024; DataOhio, 2003			First suicide attempts and subsequent attempts are higher among female residents and individuals younger than 18 years old. Suicide deaths are higher among male residents and individuals 45 and older.
MH-PHO 2. Youth Well-being	N/A	N/A	N/A	N/A	N/A

[13] *About Mental Health.* August 2024. Centers for Disease Control and Prevention. https://www.cdc.gov/mental-health/about/index.html.

Strategies

The table below reports a strategy for each PHO and indicators for tracking progress.

MH-PHO 1: Suicide Attempts and Deaths
Goal: Reduce the number of suicide attempts and deaths in the county.
Indicator: Number of suicide attempts (1st attempt), number of subsequent suicide attempts, number of suicide deaths **Data Source:** EpiCenter, 2024; DataOhio, 2023 **Baseline – Number of Suicide Attempts (1st Attempt):** 101 **Target:** 95 **Baseline – Number of Subsequent Suicide Attempts:** 61 **Target:** 55 **Baseline – Number of Suicide Deaths:** 20 **Target:** 0
Key Health Disparities: First suicide attempts and subsequent attempts are higher among females and individuals younger than 18 years old. Suicide deaths are higher among males and individuals 45 and older.
Strategy: Develop a policy to establish a Suicide Fatality Review committee according to Section 307.641 - Ohio Revised Code | Ohio Laws and prevent future suicide attempts and deaths through coordinated community response efforts.

Action Step	Timeline	Indicator	Lead Agency
Support and engage with the work of the Suicide Prevention Coalition, including the development of a Suicide Fatality Review Board.	June 2025-May 2028	# of engagement opportunities	MCPH, Tri-County Board, Suicide Prevention Coalition
Implement the Suicide Fatality Review Board.	June 2026-May 2028	Implementation of the board	MCPH, Tri-County Board, Suicide Prevention Coalition
Assess the functions of the Suicide Fatality Review Board.	May 2027-May 2028	Implementation of evaluation tool	MCPH, Tri-County Board, Suicide Prevention Coalition
Develop a decision tree to assist residents in determining when to call 911 for a mental health	June 2025-December 2025	Completion of the tool	MCPH, Tri-County Board, Suicide Prevention Coalition

emergency and who to call for non-emergency situations.			
Distribute decision tree to local agencies.	January 2026-May 2028	# of resources distributed	MCPH, Tri-County Board, Suicide Prevention Coalition

MH-PHO 2: Youth Well-Being			
Goal: Develop a baseline understanding of youth health outcomes in the county and a method for tracking data over time.			
Indicator: Data not currently collected for Miami County youth. **Data Source:** N/A **Baseline:** N/A **Target:** N/A			
Key Health Disparities: Unknown due to lack of data.			
Strategy: Develop a policy to establish a data collection tool to collect youth well-being data in collaboration with Tri-County Board and other stakeholders.			
Action Step	**Timeline**	**Indicator**	**Lead Agency**
Collaborate with local school districts to share the importance of data collection for youth health.	June 2025-May 2028	# of school districts engaged	MCPH, Tri-County Board
Develop a data collection tool.	June 2026-June 2027	Completion of the tool	MCPH, Tri-County Board
Implement the data collection tool.	August 2027-May 2028	# of school districts distributing the survey	MCPH, Tri-County Board

Progress Reporting and Plan Revision

Key activities of the CHIP will be reviewed annually by MCPH and the steering committee. The CHIP report will be published on the MCPH website. Progress toward goals will be monitored using ClearImpact, a data reporting platform operated by MCPH. Any revisions to the plan will be documented and reported to the community and stakeholders. The plan will also be subject to any changes to state or federal policy related to the reporting and tracking of health outcomes. An implementation workplan and timeline can be found in Appendix C. For questions about the CHIP, please contact Miami County Public Health at info@miamicountyhealth.net.

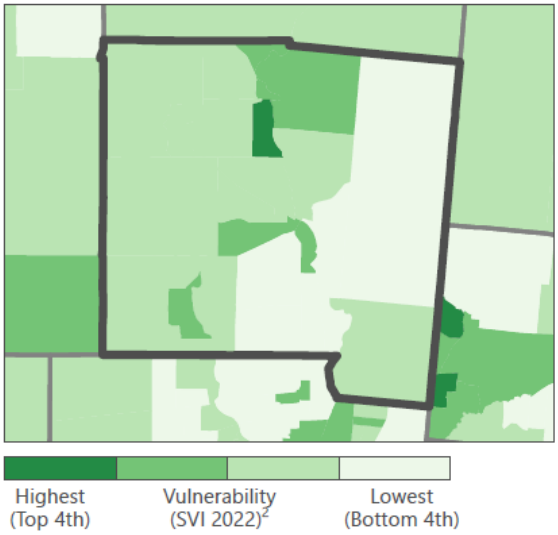
Appendix A: Community Resources

Organization	Services Provided
Alexander-Davis YMCA Childcare Center	Childhood Education
Bethany Center	Food Pantry
Bethel Hope	Food Pantry
Buckeye Men's Shelter	Homeless Shelter
Community Housing	Housing Assistance
Deaf Services Center Inc.	Disability Services, Employment
Family Abuse Shelter	Family Support, Abuse Shelter
Family Resource Center of Northwest Ohio Inc.	Mental Health, Substance Abuse Recovery
First United Methodist Church/ First Place Food Pantry	Food Pantry
FISH	Emergency Financial Assistance
Franklin House Women's Shelter	Homeless Shelter
Greene Street Preschool	Childhood Education
Greene Street United Methodist Church	Food Pantry
Health Partners Free Clinic	Healthcare
Legal Aid of Western Ohio Inc.	Legal Aid
Kettering Health	Medical
Local History Library	Special Library, Records
Miami County Community Action Council	Utility Assistance
Miami County Department of Job and Family Services	Rent Assistance
Supplemental Nutrition Assistance Program	Food Assistance
Miami County Business Advisory Council - ESC	Job Assistance, Educational Services
Miami County Dental Clinic	Dental Assistance
Miami County Parks	Parks Services
Miami County Public Health Department	Public Health Needs
Miami County Recovery Council	Legal Aid, Substance Abuse Recovery
Miami County Right to Life Society	Baby Needs, Food Pantry
Miami County Transit	Transportation
Miami Valley Regional Planning Commission	Regional Planning, Transportation, Environment
Miami County Veterans Service Office	Rent & Food Assistance
Milton-Union Public Library	Library
Needy Basket of Southern Miami County, Inc.	Food Pantry
The New Path, Inc.	Rent Assistance, Food Pantry
Tri-County Board of Recovery and Mental Health Services	Mental Health and Recovery Services
Oakes-Beitman Memorial Library	Library
OSU Extension	Education, Health Programs
Partners in Hope	Crisis Relief
Piqua Compassion Network	Basic Needs
Premier Upper Valley Medical Center	Medical

For additional Miami County resources, please scan the QR code below:

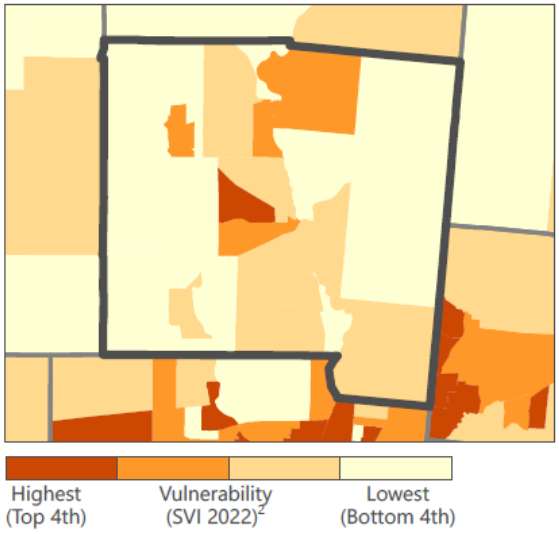
Appendix B: CDC Social Vulnerability Index

Socioeconomic Status



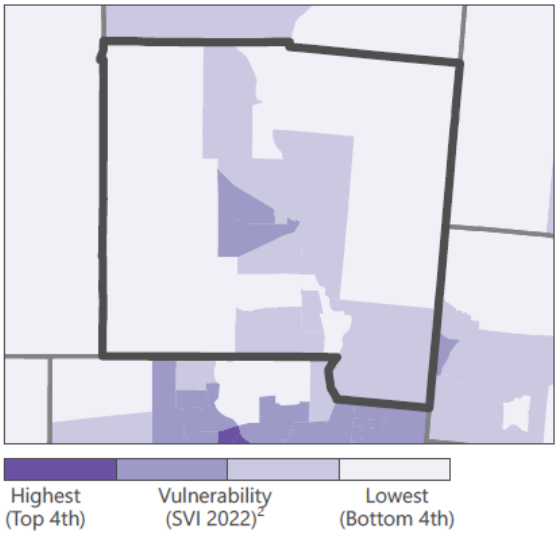
Highest (Top 4th) Vulnerability (SVI 2022)[2] Lowest (Bottom 4th)

Household Characteristics



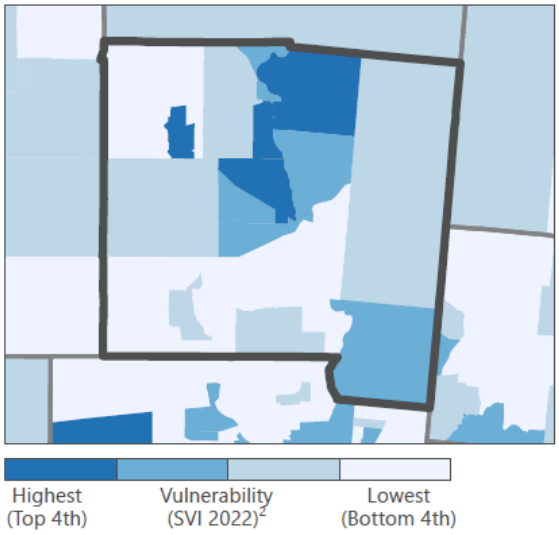
Highest (Top 4th) Vulnerability (SVI 2022)[2] Lowest (Bottom 4th)

Racial and Ethnic Minority Status



Highest (Top 4th) Vulnerability (SVI 2022)[2] Lowest (Bottom 4th)

Housing Type/Transportation



Highest (Top 4th) Vulnerability (SVI 2022)[2] Lowest (Bottom 4th)

Appendix C: Implementation Work Plan and Timeline

Priority Health Factor 1: Access to Care												
ATC-PHO 1. Maternal and Infant Health												
Goal: Improve knowledge about available services and resources for women who are pregnant or planning to become pregnant.												
Strategy: Develop a comprehensive educational campaign focused on pregnancy needs and services in Miami and surrounding counties.												
	2025		**2026**				**2027**				**2028**	
	Q3	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
Develop a list of maternity care providers in the county and where they deliver.	Start	Finish										
Develop an education campaign about what to do when you are pregnant, how to develop a birth plan, how to choose a provider, what to do if you need transportation for care, what is a home birth, and other general resources.			Start									Finish
Promote resources via social media and other outlets.			Start									Finish
Update resource list as needed.			Start									Finish

Priority Health Factor 1: Access to Care												
ATC-PHO 2. Access to Primary Health Care												
Goal: Reduce the percentage of Miami County residents without a usual place for medical care.												
Strategy: Collaborate with partner organizations to promote free and low-cost health services for residents.												
	2025		**2026**				**2027**				**2028**	
	Q3	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
Engage with providers of free and low-cost primary health care services in the county.	Start	Finish										
Develop a resource list of free and low-cost primary health care options in the county.	Start	Finish										
Identify areas of high-need (i.e., areas with limited providers, residents without insurance, residents without a usual place for care, etc.).			Start/Finish									
Distribute list to agencies that serve Miami County residents, particularly in high-need areas.			Start									Finish
Collaborate with local health systems to promote 211.			Start									Finish
Promote available free/low-cost health services in the county.			Start									Finish
Update the resource list as needed.			Start									Finish

Priority Health Factor 1: Access to Care												
ATC-PHO 3. Access to Mental Health Care												
Goal: Reduce the percentage of Miami County residents with unmet mental health care needs.												
Strategy: Collaborate with partner organizations to promote free and low-cost mental health services in the county.												
	2025		**2026**				**2027**				**2028**	
	Q3	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
Engage with providers of free and low-cost mental health services in the county.	Start	Finish										
Develop a resource list of free and low-cost mental health care options in the county.	Start	Finish										
Identify areas of high-need (i.e., areas with limited providers, residents without insurance, etc.).			Start/Finish									
Distribute list, along with Tri-County Board's "What to Do When You Need Help" resource guide, to high-need areas.			Start									Finish
Promote available free/low-cost mental health services in the county.			Start									Finish
Update resource list as needed.			Start									Finish

Priority Health Factor 2: Chronic Disease												
CD-PHO 1 and 2. Diabetes and Heart Disease												
Goal: Reduce the number of new diabetes cases and coronary heart disease deaths that occur each year in the county.												
Strategy: Work with partner organizations to establish a large-scale community chronic disease screening event and promote health services in high-need areas.												
	2025		**2026**				**2027**				**2028**	
	Q3	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
Identify and engage stakeholders.	Start	Finish										
Plan logistics of screening event.	Start			Finish								
Organize community outreach and promotion.			Start	Finish								
Host the event.				Start/Finish								
Evaluate the success of the event.				Start								Finish
Plan for the sustainability of the event.				Start								Finish
Promote health services in high-need areas.			Start									Finish

Priority Health Factor 2: Chronic Disease												
CD-PHO 3. Health Behaviors												
Goal: Increase the percentage of residents who have access to healthy food choices.												
Strategy: Promote healthy eating as a strategy for preventing chronic diseases.												
	2025		**2026**				**2027**				**2028**	
	Q3	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
Develop a list of healthy food options to look for while shopping.	Start	Finish										
Compile a resource that includes the list of food retailers and healthy eating shopping guide.	Start	Finish										
Create a resource with healthy recipe ideas and assemble ingredients.	Start	Finish										
Distribute recipe tips and ingredients at the health department.			Start									Finish

Priority Health Factor 2: Chronic Disease												
CD-PHO 4. Health Education and Promotion												
Goal: Reduce the number of falls among senior citizens in the county.												
Strategy: Expand the Bingocize fall prevention program.												
	2025		**2026**				**2027**				**2028**	
	Q3	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q1**
Identify and engage stakeholders.	Start	Finish										
Secure a funding source for program expansion.	Start			Finish								
Secure a location for program expansion.			Start		Finish							
Train volunteers who will run the program sessions.						Start/Finish						
Purchase program materials.						Start/Finish						
Host 10-week session.							Start/Finish					
Evaluate the program's effectiveness.								Start				Finish

Priority Health Factor 3: Mental Health												
MH-PHO 1: Suicide Attempts and Deaths												
Goal: Reduce the number of suicide attempts and deaths in the county.												
Strategy: Develop a policy to establish a Suicide Fatality Review committee according to Section 307.641 - Ohio Revised Code | Ohio Laws and prevent future suicide attempts and deaths through coordinated community response efforts.												
	2025		**2026**				**2027**				**2028**	
	Q3	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
Support and engage with the work of the Suicide Prevention Coalition, including the development of a Suicide Fatality Review Board.	Start											Finish
Implement the Suicide Fatality Review Board.				Start								Finish
Assess the functions of the Suicide Fatality Review Board.								Start				Finish
Develop a decision tree to assist residents in determining when to call 911 for a mental health emergency and who to call for non-emergency situations.	Start	Finish										
Distribute decision tree to local agencies.			Start									Finish

Priority Health Factor 3: Mental Health												
MH-PHO 2: Youth Well-Being												
Goal: Develop a baseline understanding of youth health outcomes in the county and a method for tracking data over time.												
Strategy: Develop a policy to establish a data collection tool to collect youth well-being data in collaboration with Tri-County Board and other stakeholders.												
	2025		**2026**				**2027**				**2028**	
	Q3	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**	**Q2**
Collaborate with local school districts to share the importance of data collection for youth health.	Start											Finish
Develop a data collection tool.				Start				Finish				
Implement the data collection tool.									Start			Finish