

ALLEN COUNTY CHIP 2026-2029

Allen County's 3-Year Community Health Improvement Plan to promote optimal health and well-being for all in Allen County



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October 2026-September 2029

Executive Summary

This executive summary provides an overview of the Allen County Community Health Improvement Plan (CHIP) 2026–2029, outlining key priorities, strategies, and anticipated outcomes. The CHIP focuses on addressing the health needs of our community through a collaborative, data-driven, and equity-focused approach. We are dedicated to improving the overall health and well-being of Allen County residents by prioritizing the following four areas:

Thriving Communities. We are working to strengthen the community conditions that support health and safety, including community education, safer homes, lead hazard reduction, violence prevention, and accessible transportation. By improving these conditions, we aim to create communities where residents have greater opportunities to live, work, and thrive.

Mental Health and Well-Being. Recognizing the significant impact of mental health, substance use, and suicide on individuals, families, and communities, we are working to increase awareness and use of 988 and the Hopeline, expand mental health education and prevention, increase Employee Assistance Program utilization, improve naloxone access, support universal school mental health screenings, reduce overdose and suicide deaths, and expand access to behavioral health services.

Supports for Healthy Living. We are working to make healthy choices more accessible by increasing access to healthy food and nutrition assistance, expanding Green Rx and SNAP/EBT opportunities, supporting active transportation, preventing tobacco and vaping use, strengthening healthy food resources, promoting healthy aging, and reducing the burden of chronic diseases such as hypertension, obesity, and diabetes.

Maternal, Infant and Child Health. We are working to ensure that parents, infants, and children have the support they need for a healthy start in life through breastfeeding support, safe sleep resources, community input, well-child visits, Early Intervention, Help Me Grow, immunizations, and lead testing.

To achieve these goals, this CHIP incorporates collaborative partnerships, data-driven decision-making, community engagement and empowerment, and evaluation and continuous improvement. We will establish, strengthen, and expand partnerships among community stakeholders, including healthcare providers, community organizations, schools, local government agencies, transportation partners, and other organizations serving Allen County. By working together, we can leverage resources, expertise, and shared goals to create greater and more sustainable impact.

Our plan is grounded in comprehensive community health data and input that identify priority health needs, community conditions, and disparities within Allen County. These data inform the development of targeted strategies and help ensure that resources and efforts are directed

toward areas of greatest need. Community members will be engaged as active participants through education, outreach, surveys, and other opportunities to provide input and help shape implementation.

Evaluation and continuous improvement are essential to the success of the CHIP. Each priority area includes measurable objectives, baselines, and targets that will be monitored throughout 2026–2029. Partners will review progress, identify barriers and successes, and make adjustments as needed. Through continued collaboration, community participation, and measurement of outcomes, Allen County will work toward lasting improvements in health, safety, and quality of life for all residents.

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CHIP Framework

Allen County 2026 – 2029
Community Health Improvement Plan



Equity Focused

Everyone in Allen County has a fair opportunity to be healthy, safe, and thrive, regardless of factors like race, income, age, or where we live.



Vision

Allen County is a vibrant community where people of all ages can live, work, learn, and thrive in safe, healthy, and supportive environments.

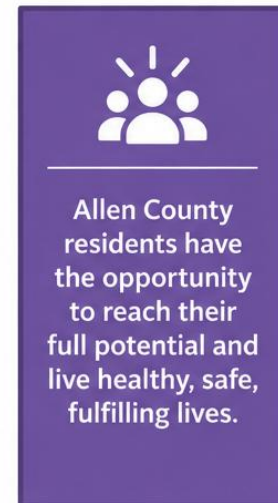
What shapes our health and well-being?

Our community's health is influenced by many conditions, including:



How will we know if Allen County is making progress?

The CHIP is designed to track and improve these priority areas and related outcomes:



We will use collaborative strategies and workplans to achieve the goals outlined in this plan, making a positive difference in the well-being of all Allen County residents.

Work Plan Overview

Allen County Community Health Improvement Plan 2026–2029

The Allen County Community Health Improvement Plan (CHIP) 2026-2029 provides a shared framework for community partners to work together to improve the health, safety, and well-being of Allen County residents. The work plans translate the CHIP priorities and strategies into specific, measurable actions that can be implemented, monitored, and adjusted throughout the three-year plan.

The work plans are designed to promote accountability while allowing flexibility for community partners to respond to changing needs, new data, emerging opportunities, and available resources. Each objective identifies the intended outcome, baseline information, target, responsible coordinator or partner, and action steps needed to move the work forward.

How the Work Plans Support the CHIP

- **Turn priorities into action:** Each CHIP priority is divided into strategies and objectives that identify practical steps community partners can take.
- **Establish measurable outcomes:** Baseline data and targets provide a way to measure progress and determine whether the community is moving toward its goals.
- **Encourage shared responsibility:** Work plans identify coordinators and partners while recognizing that meaningful community improvement requires collaboration across sectors.
- **Support continuous improvement:** Quarterly updates provide opportunities to review progress, identify barriers, celebrate successes, and make adjustments when needed.
- **Keep the plan responsive:** Objectives and action steps may be modified as community conditions, data, funding, policies, or partnerships change.

Work Plan Structure

Appendix C contains the detailed work plans for each CHIP priority. Each work plan follows a consistent format so progress can be tracked across the 2026-2029 implementation period.

- **Strategy / Objective:** Identifies the specific strategy and measurable objective being addressed.
- **Community Co-Ownership:** Describes how residents, community organizations, and partners can participate in or influence the work.
- **Evidence for the Strategy:** Summarizes the data, community input, or other information supporting the strategy.
- **Performance Measure:** Identifies how progress will be measured.
- **Baseline:** Provides the starting point against which progress will be evaluated.

- **Target:** Defines the desired level of improvement during the CHIP period.
- **Coordinator / Partners:** Identifies the organization or individuals responsible for coordinating implementation.
- **Action Steps:** Outlines the activities needed to achieve the objective.
- **Status / Progress Updates:** Provides a place to document accomplishments, barriers, changes, and next steps during quarterly and annual reviews.

Implementation and Accountability

Implementation of the CHIP will be a collaborative effort involving local government, nonprofit organizations, health and human service agencies, schools, businesses, transportation providers, community organizations, and residents. Partners will work within their areas of expertise while coordinating efforts around shared community goals.

Progress will be reviewed at least quarterly. Coordinators and responsible partners will provide updates on activities completed, progress toward performance measures, challenges encountered, and planned next steps. These updates will help the CHIP Collaborative identify areas that are on track, areas requiring additional support, and opportunities to strengthen collaboration.

Annual review of the work plans will provide an opportunity to examine data and determine whether objectives remain appropriate. Targets or action steps may be adjusted when warranted by changes in community conditions, new evidence, available resources, or partner capacity. Significant accomplishments and changes will be communicated through the annual CHIP update.

Measuring Progress

Evaluation of the CHIP will focus on both implementation and outcomes. Implementation measures will show whether planned activities are occurring, while outcome measures will show whether those activities are contributing to improvement in the community. Whenever possible, measures will use existing local data sources to reduce reporting burden and provide consistent information over time.

2026–2029 CHIP Work Plan Priorities

- **Priority 1: Thriving Communities:** Focuses on community conditions that support safety, stability, mobility, and quality of life, including housing, lead-safe homes, violence prevention, and transportation.

- **Priority 2: Mental Health and Well-Being:** Focuses on crisis services, mental health education, overdose and suicide prevention, naloxone access, school-based screening, and behavioral health services.
- **Priority 3: Supports for Healthy Living:** Focuses on healthy food access, active transportation, tobacco-free living, food pantry practices, age-friendly communities, and chronic disease prevention.
- **Priority 4: Maternal, Infant and Child Health:** Focuses on breastfeeding, safe sleep, community input, well-child care, developmental services, immunizations, and lead testing.

A Shared Commitment to Improvement

The CHIP work plans are more than a reporting tool; they are a shared commitment to action. By coordinating efforts, using data to guide decisions, engaging residents, and regularly reviewing progress, Allen County partners can work together to address community needs and create lasting improvements in health, safety, and quality of life. The work plans in Appendix C provide the roadmap for turning the goals of the 2026-2029 CHIP into measurable community action.

Priority 1: Thriving Communities

Safe and healthy communities depend on access to quality housing, reliable transportation, safe neighborhoods, and opportunities to connect with community resources. These conditions influence whether residents can access jobs, education, health care, recreation, and other services that support a good quality of life.

The 2026-2029 CHIP will build on community partnerships to improve housing safety, reduce lead hazards, prevent violence, and increase access to transportation. Together, these efforts will help create communities where residents can live, work, learn, and thrive.

Why it's important in Allen County:

- In 2025, 31 Allen County homes received lead hazard remediation; the CHIP target is to increase this to 40 homes.
- There were 46 gun-related incidents in 2025, highlighting the continued need for community violence prevention and neighborhood-based partnerships.
- RTA provided 214,791 rides in 2025, and UPLIFT provided 49,406 rides, demonstrating the importance of public transportation for community access and mobility.
- In the 2024 Allen County Community Health Survey, residents identified feeling safe (52.85%), neighbors helping one another (39.84%), and being able to walk or bike (35.77%) among the things they liked most about where they live.
- Among households with incomes below \$40,000, feeling safe was reported less often (41.01%), reinforcing the importance of equitable access to safe and supportive community conditions.

Vulnerable Populations Impacted by CHIP: Residents experiencing housing cost burden or poor housing conditions; low-income residents; older adults; residents who rely on public transportation; and residents in neighborhoods experiencing higher levels of violence or lead exposure.

**Sources: 2024 Allen County Community Health Survey; 2025 Allen County CHIP baseline data; CDC PLACES. Allen County Community Health Improvement Plan 2026–2029*

Priority 2: Mental Health and Well-Being

Mental health, suicide, substance use, and overdose continue to affect individuals, families, schools, workplaces, and neighborhoods throughout Allen County. Access to timely support, prevention education, crisis services, and treatment can reduce barriers and help residents get the support they need before a crisis occurs.

The 2026-2029 CHIP will strengthen awareness of 988 and Hopeline services, expand mental health education, support employee well-being, improve naloxone access, increase school-

based screening, and strengthen behavioral health services. These efforts focus on prevention, early intervention, and connecting residents with care.

Why it's important in Allen County:

- In 2025, Allen County recorded 20 suicide deaths and 17 overdose deaths, demonstrating the continued need for prevention and early intervention.
- Hopeline received 15,659 contacts in 2025, while 988 received more than 1,100 contacts, showing continued demand for crisis and emotional support services.
- In 2025, seven naloxone vending units were available in the community, with 2,850 naloxone doses distributed; expanding access remains a key overdose-prevention strategy.
- The 2024 Allen County Community Health Survey identified depression and stress among the top health concerns for adults, along with drug and alcohol abuse.
- For youth, depression was also identified among the leading health concerns, reinforcing the importance of school-based prevention, screening, and early support.

Vulnerable Populations Impacted by CHIP: Youth and families; individuals experiencing mental health or substance use concerns; residents at risk of overdose or suicide; and residents who face barriers to behavioral health services.

**Sources: 2024 Allen County Community Health Survey; 2025 Allen County CHIP baseline data. CDC PLACES. Allen County Community Health Improvement Plan 2026–2029*

Priority 3: Supports for Healthy Living

Healthy choices are strongly influenced by the environments in which people live, work, learn, and play. Access to nutritious food, opportunities for physical activity, tobacco-free environments, and preventive services can help residents maintain health and reduce the risk of chronic disease.

The 2026-2029 CHIP will build on existing community efforts to expand healthy food access, support active transportation, promote tobacco-free living, strengthen food pantry practices, and advance chronic disease prevention. The goal is to make healthy choices easier and more accessible for residents across Allen County.

Why it's important in Allen County:

- In 2023, 40.6% of Allen County adults were obese and 34.3% reported high blood pressure, highlighting significant chronic disease prevention needs.
- In 2023, 12.9% of Allen County adults had diagnosed diabetes, reinforcing the need for prevention, screening, and healthy-living supports.

- In 2025, 473 residents participated in Green Rx, connecting residents with opportunities to increase access to healthy foods and wellness resources.
- In 2025, 94 customers used SNAP/EBT at farmers markets, supporting the CHIP goal of increasing access to affordable, nutritious foods.
- The 2024 Allen County Community Health Survey identified not getting enough exercise among the leading health concerns for adults; among lower-income households, access to healthy food was also a leading concern.

Vulnerable Populations Impacted by CHIP: Residents experiencing food insecurity; low-income households; residents with or at risk for chronic disease; children and youth; and residents with limited access to safe opportunities for physical activity.

**Sources: 2024 Allen County Community Health Survey; CDC PLACES, 2023; 2025 Allen County CHIP baseline data.*

Priority 4: Maternal, Infant and Child Health

A healthy start in life provides a strong foundation for lifelong health and well-being. Breastfeeding support, safe sleep, developmental services, immunizations, lead testing, and regular well-child care help children grow and develop while supporting families during critical stages of life.

The 2026-2029 CHIP will strengthen supports for families by increasing breastfeeding and safe-sleep resources, improving developmental and preventive services, expanding immunization and lead testing, and gathering community input to better understand maternal, infant, and child health needs.

Why it's important in Allen County:

- In 2025, 70% of infants were breastfeeding at hospital discharge, with the CHIP goal of increasing breastfeeding by 4%.
- In 2025, 229 safe-sleep cribs were distributed, including 30 in targeted census tracts, providing families with resources to create safer sleep environments.
- Only 82.9% of kindergarten students met immunization requirements at baseline; the CHIP target is to increase coverage to 88%.
- In 2025, 1,085 lead tests were completed, with a CHIP goal of increasing testing by 10% to identify lead exposure earlier.
- In 2025, 16% of children receiving Early Intervention services were meeting developmental milestones, highlighting an opportunity to strengthen early identification and developmental support.
- Help Me Grow capacity was 80% at baseline, with a target of maintaining at least 85% capacity to connect families with needed services.

Vulnerable Populations Impacted by CHIP: Pregnant women; infants and young children; families with limited resources; children at risk for developmental delay or lead exposure; and families who experience barriers to preventive or supportive services.

**Sources: 2025 Allen County CHIP baseline data and program reports.*

Next Steps and Call to Action

The Allen County Community Health Improvement Plan (CHIP) 2026-2029 is intended to be a living plan that grows and changes with the needs of the community. Progress toward the goals and objectives will be monitored at least quarterly throughout the three-year implementation period. The work plans located in Appendix C identify the community partners responsible for supporting and implementing each objective.

The CHIP Collaborative will collect regular updates from responsible partners to assess progress, identify successes and challenges, and ensure that strategies remain on track. Goals, objectives, and strategies may be adjusted as needed based on new data, community needs, available resources, and emerging opportunities. These updates will help maintain transparency, accountability, and community engagement throughout the implementation period.

This CHIP represents the commitment and collaboration of community organizations, agencies, leaders, and residents working together to improve the well-being of Allen County. Community health improvement is a shared responsibility, and everyone has a role to play. Organizations and individuals interested in participating in CHIP initiatives, supporting a work plan, or becoming involved in community health improvement efforts are encouraged to connect with the CHIP Collaborative.

For more information or to become involved:

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Appendix A: List of Key Terms

The following terms are used throughout the Allen County Community Health Improvement Plan (CHIP) 2026-2029. Definitions are provided to promote consistent understanding among community partners, organizations, and residents involved in implementing the plan.

Baseline – The starting measurement used to compare progress toward a CHIP objective or target.

CHA – Community Health Assessment – A systematic process of collecting and analyzing information about the health of a community and the conditions that influence health.

CHIP – Community Health Improvement Plan – A community-driven plan identifying health priorities, strategies, and actions to improve health and quality of life.

Community Co-Ownership – Shared involvement of residents, organizations, agencies, and partners in identifying needs, developing solutions, implementing strategies, and evaluating progress.

Community Health Survey – A survey that gathers information directly from residents about health concerns, community conditions, experiences, and priorities.

Objective – A specific, measurable result that a CHIP strategy is intended to achieve.

ODH – Ohio Department of Health.

Priority Area – A major health or community issue identified through assessment, data, community input, and collaborative planning as an area requiring focused action.

SHIP – State Health Improvement Plan – A statewide plan that identifies health priorities, strategies, and actions to improve health across Ohio.

SNAP – Supplemental Nutrition Assistance Program, a federal nutrition assistance program helping eligible individuals and families purchase food.

Strategy – A collection of coordinated actions that has a reasoned chance of improving results. Strategies reflect the best available thinking about what works and require contributions from multiple partners; no single organization can create all of the improvements needed in a community.

Target – The desired level of improvement established for a CHIP objective during the implementation period.

Appendix B: List of Community Partners

Kayla Monfort Chad Welker	Director Associate Director	Activate Allen County
Dre White Ashlin Magrum Stefanie Motter Leann Unverferth	VP, Community Living Services Population Health Director Director of Aging and Disability Services Mobility Manager	Allen County Agency on Aging
Rachael Staley	Director of Early Intervention Program	Allen County Board of DD
Sofia Clifton	Programs Coordinator	Allen County Commissioners
Brandon Fischer Dustin Holcomb Sarah Misiakiewicz Lori Nester Tami Gough	Health Commissioner Project DAWN Coordinator & Population Health Epidemiologist Health Educator & Creating Healthy Communities WIC Certifying Health Professional Director Prevention & Health Promotion Services & Every Baby Sleeps Safe	Allen County Public Health
Brian Wildermuth	Director	Allen County RTA
Craig Kupferberg	Superintendent	Allen County Schools
Reba Wall	Administrative Assistant	Allen Metropolitan Housing Authority
Jennifer Sexton	Executive Director	American Red Cross
Chris Jackson	Executive Director	Bradfield Community Center
Samuel White	Communications Advisor	Cenovus Energy Lima
Sharetta Smith Shane Coleman Carmilla Zion	Mayor Chief of Staff Deputy Director of Housing and Neighborhoods	City of Lima
Margaret Lawrence Andrea Ankney	Chief Officer Director, Community Services	Coleman Professional Services

Erin Burkholder Carla Thompson	Director of Outreach and Prevention Violence Prevention Educator/ Neighborhood Resource Navigator	Crime Victim Services Crime Victim Services
Josh Unterbrink	President	Lima Allen County Chamber of Commerce
Jed Metzger	President	Lima Allen County Chamber Foundation
Rebecca Phillips Megan Kinnear	Executive Director Public Outreach and Community Program Planner	Lima Allen County Regional Planning Commission
Andre Rudolph Kate Morman	Superintendent Director of Health Services	Lima City Schools
Jeff Utz Amy Schmidt	Executive Director, Lima Memorial Physicians Director Primary Care and Specialty Services	Lima Memorial Health Systems
Tammie Colon Dan Faraglia	Executive Director Crisis Infrastructure Specialist	Mental Health and Recovery Services Board of Allen, Auglaize and Hardin Counties
Beth Keehn Tyler Smith Cat Lusky Jennifer Kiene Dawn Mansfield	Director, Government and Community Affairs Director, Community Health Manager, Community Health Director, Help Me Grow Program Director, Behavioral Services	Mercy Health, St. Rita's Medical Center
Bethan Miller	Executive Director	Prevention Awareness Support Services (PASS)
Erin Hardesty Beca Sheidler	President Chief Operation Officer	United Way of Greater Lima
Tommie Harner Dena Hedrick	Director Program/Compliance Manager	West Ohio Food Bank

Priority Area 1: Thriving Communities

Key measures: Community education; Household safety; Lead remediation; Gun-related incidents; RTA ridership; UPLIFT ridership; FACTS membership

Community Resilience and Knowledge

1. Increase community education opportunities.
2. Provide home repair, financial, and health literacy education.

Household Safety

1. Increase access to lock boxes and safety resources.
2. Continue Store It Safe education.

Lead-Safe Housing

1. Increase lead hazard removal in eligible homes.

Community Violence Prevention

1. Decrease gun-related violence through community partnerships and community policing.

Access to Transportation

1. Increase RTA ridership by 1% annually.
2. Increase UPLIFT ridership by 3% annually.

Transportation Coordination

1. Increase FACTS Coalition membership by 1% annually.

Priority Area 2: Mental Health and Well-Being

Key measures: 988/Hopeline; Mental health training; Employee Assistance Programs; Overdose deaths; Suicide deaths; Naloxone; School screenings; Behavioral health services

Crisis Services and Awareness

1. Increase use of 988 and the Hopeline.
2. Increase enrollment in mental health text alerts.

Employee Mental Health

1. Increase Employee Assistance Program utilization.

Mental Health Education

1. Increase adult mental health training.
2. Increase youth mental health training.

Prevent Overdose and Suicide Deaths

1. Decrease overdose deaths.
2. Decrease suicide deaths.

Naloxone Access

1. Increase naloxone vending units, distribution, and education.

Universal School Mental Health Screenings

1. Increase school participation in universal mental health screenings.

Behavioral Health Access

1. Open a partial hospitalization unit to support area youth and families.

Priority Area 3: Supports for Healthy Living

Key measures: Age-Friendly Community; Green Rx; SNAP/EBT; Active transportation; Healthy food access; Nutrition assistance; Tobacco/vaping; Food pantries; Hypertension; Obesity; Diabetes

Age-Friendly Communities

1. Develop an Age-Friendly Community work group and plan.

Increase Access to Healthy Food

1. Increase Green Rx participation.
2. Increase SNAP/EBT use at farmers markets.
3. Establish three blessing boxes.
4. Increase nutrition assistance enrollment.

Support Walk and Bike Friendly Communities

1. Implement Transportation strategies.

Support Tobacco-Free Living

1. Provide youth tobacco and vaping prevention.
2. Conduct youth-led anti-vaping media campaigns.

Healthy Food Pantries

1. Increase food pantry sites using HER nutrition guidelines.

Chronic Disease Prevention

1. Decrease hypertension.
2. Decrease obesity.
3. Decrease diagnosed diabetes.

Priority Area 4: Maternal, Infant and Child Health

Key measures: Breastfeeding; Safe sleep; Community survey; Well-child visits; Early Intervention; Help Me Grow; Immunizations; Lead testing

Support Breastfeeding

1. Increase breastfeeding at hospital discharge.

Ensure Safe Sleep for Infants

1. Increase access to safe sleep environments for infants.

Community Input

1. Conduct one maternal, infant, and child health community survey.

Ensure Children Have a Healthy Start

1. Increase well-child visits.
2. Increase Early Intervention children meeting developmental milestones.
3. Maintain Help Me Grow capacity at 85%.
4. Increase kindergarten immunization coverage.
5. Increase lead testing.

Implementation: Detailed baselines, targets, coordinators, partners, and action steps are provided in Appendix C work plans.

Appendix C: Work Plans

Priority #1: Thriving Communities

Key Measures: Community education participation; Household safety item distribution; Residential lead hazard remediation; Gun-related incidents; RTA ridership; UPLIFT ridership; FACTS membership

1.1 Community Resilience and Knowledge

Strategy: Host community education on topics to improve community resilience and knowledge.

Priority Group: Allen County residents

Partners: Allen County Public Health, Apollo Career Center, Allen County Job & Family Services, OSU Extension, community organizations

Community Co-ownership: Community partners will assist with identifying educational topics, hosting workshops, and promoting educational opportunities throughout Allen County.

Evidence for this strategy: Community education can improve residents' ability to maintain safe homes, increase financial and health literacy, and strengthen community resilience.

Objective	Baseline	Target	Coordinator
Educate residents through community education opportunities	0	100 residents	City of Lima

Action Steps:

1. Identify educational topics.
2. Partner with Apollo Career Center and community organizations.
3. Promote workshops.
4. Evaluate participation annually.

1.2 Household Safety

Strategy: Increase availability of lock boxes, safety-related items, and Store It Safe education.

Priority Group: Allen County residents

Partners: Allen County Public Health, healthcare providers, pharmacies

Community Co-ownership: Community partners will assist with distributing safety items.

Evidence for this strategy: Safe storage education reduces accidental poisonings and medication misuse.

Objective	Baseline	Target	Coordinator
Safety items distributed	0	100 items	FCFC
Store It Safe education	PSA initiated	Ongoing	FCFC

Action Steps:

5. Continue Store It Safe PSA.
6. Distribute lock boxes.
7. Provide education at community events.

1.3 Residential Lead Hazard Reduction

Strategy: Provide lead hazard removal to homes in the City of Lima.

Priority Group: City of Lima residents

Partners: City of Lima

Community Co-ownership: Partners will identify eligible homes.

Evidence for this strategy: Lead remediation reduces childhood lead exposure.

Objective	Baseline	Target	Coordinator
Homes receiving lead hazard removal	31 homes (2025)	40 homes	City of Lima

Action Steps:

8. Identify eligible homes.
9. Coordinate remediation.
10. Promote funding opportunities.

1.4 Community Violence Prevention

Strategy: Decrease gun-related violence with help of COP Precincts and Lima Citizens Police Academy.

Priority Group: Allen County residents

Partners: Allen County Public Health, Lima Police Department, LCPA

Community Co-ownership: Residents participate in community policing initiatives.

Evidence for this strategy: Community partnerships support violence prevention.

Objective	Baseline	Target	Coordinator
Gun-related incidents	46 (2025)	Decrease from baseline	City of Lima

Action Steps:

11. Promote LCPA.
12. Support COP precincts.
13. Monitor incidents annually.

1.5 Public Transportation

Strategy: Increase RTA ridership to the general community by 1% each year.

Priority Group: Allen County residents

Partners: Allen County RTA

Community Co-ownership: Community partners promote transportation.

Evidence for this strategy: Transportation improves access to services.

Objective	Baseline	Target	Coordinator
RTA riders	214,791 (2025)	Increase 1% annually	RTA

Action Steps:

14. Promote services.
15. Community outreach.
16. Monitor ridership.

1.6 UPLIFT Transportation

Strategy: Increase RTA utilization of UPLIFT routes by priority groups by 3% each year.

Priority Group: Priority populations

Partners: Allen County RTA

Community Co-ownership: Partners promote UPLIFT.

Evidence for this strategy: Transportation improves access.

Objective	Baseline	Target	Coordinator
UPLIFT riders	49,406 (2025)	Increase 3% annually	RTA

Action Steps:

17. Promote UPLIFT.
18. Target outreach.
19. Monitor ridership.

1.7 Transportation Coordination

Strategy: Improve transportation coordination by increasing FACTS membership.

Priority Group: Transportation providers

Partners: FACTS Coalition, Allen County RTA

Community Co-ownership: Partners collaborate on transportation.

Evidence for this strategy: Coordination improves service access.

Objective	Baseline	Target	Coordinator
FACTS members	62 (2025)	Increase 1% annually	Area Agency on Aging

Action Steps:

20. Recruit members.

21. Hold meetings.

22. Identify gaps.

Priority #2: Maternal, Infant and Child Health

Key Measures: Breastfeeding at hospital discharge; Safe sleep environments; Community survey completion; Well-child visit rate; Early Intervention milestone achievement; Help Me Grow program capacity; Kindergarten immunization rate; Childhood lead testing rate.

2.1 Breastfeeding

Strategy: Increase the rate of women breastfeeding at hospital discharge by 4%

Priority Group: Pregnant women, infants, children and families

Partners: ACPH, hospitals, providers, community partners

Community Co-ownership: Partners assist with outreach and education.

Evidence for this strategy: Improved access and education improves maternal and child health outcomes.

Objective	Baseline	Target	Coordinator
Increase the rate of women breastfeeding at hospital discharge by 4%	2025: 70%	4% increase	ACPH

Actions Steps:

Promote breastfeeding education through prenatal classes, hospital partnerships, provider education, and community outreach to increase breastfeeding at hospital discharge.

2.2 Safe Sleep

Strategy: Ensure families with the highest need have safe sleep environments for infants

Priority Group: Pregnant women, infants, children and families

Partners: ACPH, hospitals, providers, community partners

Community Co-ownership: Partners assist with outreach and education.

Evidence for this strategy: Improved access and education improves maternal and child health outcomes.

Objective	Baseline	Target	Coordinator
Ensure families with the highest need have safe sleep environments for infants	2025: 229 cribs (30 in CTs)	7% increase	ACPH

Actions Steps:

Distribute cribs and safe sleep education to eligible families, provide caregiver education, and partner with birthing hospitals and community organizations to improve infant safe sleep environments.

2.3 Community Survey

Strategy: Conduct 1 community survey

Priority Group: Pregnant women, infants, children and families

Partners: ACPH, hospitals, providers, community partners

Community Co-ownership: Partners assist with outreach and education.

Evidence for this strategy: Improved access and education improves maternal and child health outcomes.

Objective	Baseline	Target	Coordinator
Conduct 1 community survey	0	Survey completed?	ACPH

Action Steps:

Develop, distribute, and analyze a countywide maternal and child health community survey to identify needs, barriers, and opportunities for program improvement.

2.4 Well Child Visits

Strategy: Increase the percentage of children 15 months and younger who get 1 well child visit by 6%

Priority Group: Pregnant women, infants, children and families

Partners: ACPH, hospitals, providers, community partners

Community Co-ownership: Partners assist with outreach and education.

Evidence for this strategy: Improved access and education improves maternal and child health outcomes.

Objective	Baseline	Target	Coordinator
Increase well-child visits by 6%	Baseline pending	6% increase	Memorial and Mercy Health

Action Steps:

Promote well-child visits through provider partnerships, reminder systems, community education, and referral efforts to improve preventive care utilization.

2.5 Early Intervention

Strategy: Increase the percentage of EI children who exit services through meeting milestones by age 3

Priority Group: Pregnant women, infants, children and families

Partners: ACPH, hospitals, providers, community partners

Community Co-ownership: Partners assist with outreach and education.

Evidence for this strategy: Improved access and education improves maternal and child health outcomes.

Objective	Baseline	Target	Coordinator
Increase EI children meeting milestones	2025:16%	5% increase	EI

Action Steps:

Collaborate with Help Me Grow and referral partners to increase timely referrals, family engagement, and developmental milestone achievement among children enrolled in Early Intervention.

2.6 Help Me Grow

Strategy: Maintain 85% capacity for families enrolled in Help Me Grow (with total served)

Priority Group: Pregnant women, infants, children and families

Partners: ACPH, hospitals, providers, community partners

Community Co-ownership: Partners assist with outreach and education.

Evidence for this strategy: Improved access and education improves maternal and child health outcomes.

Objective	Baseline	Target	Coordinator
Maintain 85% capacity	80%	85%	HMG

Action Steps:

Maintain enrollment capacity through outreach, referral coordination, and ongoing family support services while monitoring program utilization.

2.7 Immunizations

Strategy: Increase the percent of Allen County children who enter Kindergarten with all required immunizations to 88%

Priority Group: Pregnant women, infants, children and families

Partners: ACPH, hospitals, providers, community partners

Community Co-ownership: Partners assist with outreach and education.

Evidence for this strategy: Improved access and education improves maternal and child health outcomes.

Objective	Baseline	Target	Coordinator
Increase kindergarten immunizations	82.9%	88%	ACPH

Action Steps:

Increase kindergarten immunization rates through school partnerships, immunization clinics, parent education, and reminder/recall efforts.

2.8 Lead Testing

Strategy: Increase the number of Allen County children 0-6 years old tested for lead by 10%

Priority Group: Pregnant women, infants, children and families

Partners: ACPH, hospitals, providers, community partners

Community Co-ownership: Partners assist with outreach and education.

Evidence for this strategy: Improved access and education improves maternal and child health outcomes.

Objective	Baseline	Target	Coordinator
Increase lead testing	2025:1085	10% increase	ACPH

Action Steps:

Increase childhood lead screening by educating providers and families, promoting routine testing, and coordinating follow-up for children with elevated blood lead levels.

Priority #3: Mental Health and Well-Being

Key Measures: 988 & Hopeline utilization; Community text alert enrollment; Employee Assistance Program utilization; Adult and youth mental health training; Overdose deaths; Suicide deaths; Naloxone distribution; Universal school screenings; Partial hospitalization services

3.1 988 & Hopeline

Strategy: Increase the number of adults utilizing 988 and the Hopeline to seek treatment services.

Priority Group: Allen County residents

Partners: Mental Health & Recovery Services Board, Allen County Public Health, healthcare providers, schools, PASS, CVS, community partners

Community Co-ownership: Community partners will assist with outreach, education, referrals, and implementation.

Evidence for this strategy: Improving awareness, prevention, and access to behavioral health services supports better mental health outcomes.

Objective	Indicator	Baseline	Target	Coordinator
Increase the number of adults utilizing 988 and the Hopeline to seek treatment services.	# of calls	2025 baseline (988: 1,152/1,232; Hopeline: 15,659)	Increase 5% each year	MHR SB

Action Steps:

23. Promote community awareness and education.
24. Coordinate activities with partner organizations.
25. Monitor baseline and annual progress.
26. Report outcomes through the CHIP evaluation process.

3.2 Community Text Alert System

Strategy: Increase enrollment in the community (MH Board-led) text alert system.

Priority Group: Allen County residents

Partners: Mental Health & Recovery Services Board, Allen County Public Health, healthcare providers, schools, PASS, CVS, community partners

Community Co-ownership: Community partners will assist with outreach, education, referrals, and implementation.

Evidence for this strategy: Improving awareness, prevention, and access to behavioral health services supports better mental health outcomes.

Objective	Indicator	Baseline	Target	Coordinator
Increase enrollment in the community (MH Board-led) text alert system.	# of enrollees	309 (June 2026)	Increase 10% each year	MHR SB

Action Steps:

27. Promote community awareness and education.
28. Coordinate activities with partner organizations.
29. Monitor baseline and annual progress.
30. Report outcomes through the CHIP evaluation process.

3.3 Employee Assistance Program

Strategy: Increase the number of employees successfully utilizing the Employee Assistance Program by 3%.

Priority Group: Allen County residents

Partners: Mental Health & Recovery Services Board, Allen County Public Health, healthcare providers, schools, PASS, CVS, community partners

Community Co-ownership: Community partners will assist with outreach, education, referrals, and implementation.

Evidence for this strategy: Improving awareness, prevention, and access to behavioral health services supports better mental health outcomes.

Objective	Indicator	Baseline	Target	Coordinator
Increase the number of employees successfully utilizing the Employee Assistance Program by 3%.	% of usage	25.96% (2025)	Increase 3% each year	MHR SB

Action Steps:

31. Promote community awareness and education.
32. Coordinate activities with partner organizations.
33. Monitor baseline and annual progress.
34. Report outcomes through the CHIP evaluation process.

3.4 Adult Mental Health Training

Strategy: Increase the number of Allen County adults participating in mental health training and education.

Priority Group: Allen County residents

Partners: Mental Health & Recovery Services Board, Allen County Public Health, healthcare providers, schools, PASS, CVS, community partners

Community Co-ownership: Community partners will assist with outreach, education, referrals, and implementation.

Evidence for this strategy: Improving awareness, prevention, and access to behavioral health services supports better mental health outcomes.

Objective	Indicator	Baseline	Target	Coordinator
Increase the number of Allen County adults participating in mental health training and education.	# people / certificates	478 (FY26)	Increase 3% each year	PASS and CVS

Action Steps:

35. Promote community awareness and education.
36. Coordinate activities with partner organizations.
37. Monitor baseline and annual progress.
38. Report outcomes through the CHIP evaluation process.

3.5 Youth Mental Health Training

Strategy: Increase the number of Allen County youth participating in mental health training and education.

Priority Group: Allen County residents

Partners: Mental Health & Recovery Services Board, Allen County Public Health, healthcare providers, schools, PASS, CVS, community partners

Community Co-ownership: Community partners will assist with outreach, education, referrals, and implementation.

Evidence for this strategy: Improving awareness, prevention, and access to behavioral health services supports better mental health outcomes.

Objective	Indicator	Baseline	Target	Coordinator
Increase the number of Allen County youth participating in mental health training and education.	# sessions / youth	483 sessions / 4,862 youth	Increase 5% each year	PASS and CVS

Action Steps:

39. Promote community awareness and education.
40. Coordinate activities with partner organizations.
41. Monitor baseline and annual progress.
42. Report outcomes through the CHIP evaluation process.

3.6 Overdose Deaths

Strategy: Decrease the number of Allen County residents who die as a result of an overdose.

Priority Group: Allen County residents

Partners: Mental Health & Recovery Services Board, Allen County Public Health, healthcare providers, schools, PASS, CVS, community partners

Community Co-ownership: Community partners will assist with outreach, education, referrals, and implementation.

Evidence for this strategy: Improving awareness, prevention, and access to behavioral health services supports better mental health outcomes.

Objective	Indicator	Baseline	Target	Coordinator
Decrease the number of Allen County residents who	Overdose deaths	17 (2025)	5% decrease	MHR SB and ACPH

die as a result of an overdose.				
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Action Steps:

- 43. Promote community awareness and education.
- 44. Coordinate activities with partner organizations.
- 45. Monitor baseline and annual progress.
- 46. Report outcomes through the CHIP evaluation process.

3.7 Suicide Deaths

Strategy: Decrease the number of Allen County residents who die as a result of suicide.

Priority Group: Allen County residents

Partners: Mental Health & Recovery Services Board, Allen County Public Health, healthcare providers, schools, PASS, CVS, community partners

Community Co-ownership: Community partners will assist with outreach, education, referrals, and implementation.

Evidence for this strategy: Improving awareness, prevention, and access to behavioral health services supports better mental health outcomes.

Objective	Indicator	Baseline	Target	Coordinator
Decrease the number of Allen County residents who die as a result of suicide.	Suicide deaths	20 (2025)	3% decrease	MHR SB and ACPH

Action Steps:

- 47. Promote community awareness and education.
- 48. Coordinate activities with partner organizations.
- 49. Monitor baseline and annual progress.
- 50. Report outcomes through the CHIP evaluation process.

3.8 Naloxone Access

Strategy: Increase naloxone vending units, distribution, and education.

Priority Group: Allen County residents

Partners: Mental Health & Recovery Services Board, Allen County Public Health, healthcare providers, schools, PASS, CVS, community partners

Community Co-ownership: Community partners will assist with outreach, education, referrals, and implementation.

Evidence for this strategy: Improving awareness, prevention, and access to behavioral health services supports better mental health outcomes.

Objective	Indicator	Baseline	Target	Coordinator
Increase naloxone vending units, distribution, and education.	# distributed / vending units	7 units / 2,850 distributed	Add 2 units and increase distribution 3% annually	ACPH

Action Steps:

51. Promote community awareness and education.
52. Coordinate activities with partner organizations.
53. Monitor baseline and annual progress.
54. Report outcomes through the CHIP evaluation process.

3.9 Universal Screenings

Strategy: Increase the number of Allen County schools participating in universal screenings.

Priority Group: Allen County residents

Partners: Mental Health & Recovery Services Board, Allen County Public Health, healthcare providers, schools, PASS, CVS, community partners

Community Co-ownership: Community partners will assist with outreach, education, referrals, and implementation.

Evidence for this strategy: Improving awareness, prevention, and access to behavioral health services supports better mental health outcomes.

Objective	Indicator	Baseline	Target	Coordinator
Increase the number of Allen County schools participating in universal screenings.	# of schools	4 schools	Increase by 2 schools each year	MHR SB, FRC, and SAFY

Action Steps:

55. Promote community awareness and education.
56. Coordinate activities with partner organizations.

57. Monitor baseline and annual progress.
58. Report outcomes through the CHIP evaluation process.

3.10 Partial Hospitalization Unit

Strategy: Open a partial inpatient hospitalization unit to support area youth and families.

Priority Group: Allen County residents

Partners: Mental Health & Recovery Services Board, Allen County Public Health, healthcare providers, schools, PASS, CVS, community partners

Community Co-ownership: Community partners will assist with outreach, education, referrals, and implementation.

Evidence for this strategy: Improving awareness, prevention, and access to behavioral health services supports better mental health outcomes.

Objective	Indicator	Baseline	Target	Coordinator
Open a partial inpatient hospitalization unit to support area youth and families.	Unit opened	No Unit	Unit Opened	Mercy St. Rita's

Action Steps:

59. Promote community awareness and education.
60. Coordinate activities with partner organizations.
61. Monitor baseline and annual progress.
62. Report outcomes through the CHIP evaluation process.

Priority #4: Supports for Healthy Living

Key Measures: Age-Friendly Community implementation; Green Rx participation; SNAP/EBT utilization; Active transportation; Food access; Nutrition assistance enrollment; Tobacco and vaping prevention; Healthy food pantry sites; Hypertension; Obesity; Diabetes

4.1 Age-Friendly Community

Strategy: Create a new work group to lead the Age-Friendly Community application.

Priority Group: Allen County residents

Partners: Allen County Public Health, hospitals, schools, community organizations, local partners

Community Co-ownership: Community partners will assist with outreach, implementation, and evaluation.

Evidence for this strategy: Community partnerships and prevention initiatives improve healthy living outcomes.

Objective	Indicator	Baseline	Target	Coordinator
Create a new work group to lead the Age-Friendly Community application.	Application completed	0	Implementation plan completed	Area Agency on Aging 3

Action Steps:

- 63. Coordinate with community partners.
- 64. Promote community awareness and participation.
- 65. Monitor annual progress.
- 66. Report outcomes through the CHIP evaluation process.

4.2 Green Rx

Strategy: Increase the number of patients served through Green Rx at LMH and Mercy.

Priority Group: Allen County residents

Partners: Allen County Public Health, hospitals, schools, community organizations, local partners

Community Co-ownership: Community partners will assist with outreach, implementation, and evaluation.

Evidence for this strategy: Community partnerships and prevention initiatives improve healthy living outcomes.

Objective	Indicator	Baseline	Target	Coordinator
Increase the number of patients served through Green Rx at LMH and Mercy.	# residents served	473	Increase 3% annually	LMH and Mercy Health

Action Steps:

- 67. Coordinate with community partners.

- 68. Promote community awareness and participation.
- 69. Monitor annual progress.
- 70. Report outcomes through the CHIP evaluation process.

4.3 SNAP/EBT at Farmers Markets

Strategy: Increase community residents utilizing SNAP/EBT at local farmers markets.

Priority Group: Allen County residents

Partners: Allen County Public Health, hospitals, schools, community organizations, local partners

Community Co-ownership: Community partners will assist with outreach, implementation, and evaluation.

Evidence for this strategy: Community partnerships and prevention initiatives improve healthy living outcomes.

Objective	Indicator	Baseline	Target	Coordinator
Increase community residents utilizing SNAP/EBT at local farmers markets.	# SNAP customers	94 (2025)	Increase 5% annually	Limas Farmer Market Committee

Action Steps:

- 71. Coordinate with community partners.
- 72. Promote community awareness and participation.
- 73. Monitor annual progress.
- 74. Report outcomes through the CHIP evaluation process.

4.4 Active Transportation

Strategy: Implement recommended strategies in the Allen County Active Transportation Plan.

Priority Group: Allen County residents

Partners: Allen County Public Health, hospitals, schools, community organizations, local partners

Community Co-ownership: Community partners will assist with outreach, implementation, and evaluation.

Evidence for this strategy: Community partnerships and prevention initiatives improve healthy living outcomes.

Objective	Indicator	Baseline	Target	Coordinator
Implement recommended strategies in the Allen County Active Transportation Plan.	Implementation changes	Ongoing	Implement 5 strategies	Pike and Pedestrian Task Force

Action Steps:

- 75. Coordinate with community partners.
- 76. Promote community awareness and participation.
- 77. Monitor annual progress.
- 78. Report outcomes through the CHIP evaluation process.

4.5 Healthy Food Access

Strategy: Create a new community resource to increase healthy food access.

Priority Group: Allen County residents

Partners: Allen County Public Health, hospitals, schools, community organizations, local partners

Community Co-ownership: Community partners will assist with outreach, implementation, and evaluation.

Evidence for this strategy: Community partnerships and prevention initiatives improve healthy living outcomes.

Objective	Indicator	Baseline	Target	Coordinator
Create a new community resource to increase healthy food access.	# blessing boxes	0	3 blessing boxes	ACPH

Action Steps:

- 79. Coordinate with community partners.
- 80. Promote community awareness and participation.
- 81. Monitor annual progress.
- 82. Report outcomes through the CHIP evaluation process.

4.6 Nutrition Assistance

Strategy: Increase enrollment in local and state nutrition programs.

Priority Group: Allen County residents

Partners: Allen County Public Health, hospitals, schools, community organizations, local partners

Community Co-ownership: Community partners will assist with outreach, implementation, and evaluation.

Evidence for this strategy: Community partnerships and prevention initiatives improve healthy living outcomes.

Objective	Indicator	Baseline	Target	Coordinator
Increase enrollment in local and state sensation programs.	# residents enrolled	Local: 203 / State: 70 (2025)	Increase 2%	Mercy Health

Action Steps:

- 83. Coordinate with community partners.
- 84. Promote community awareness and participation.
- 85. Monitor annual progress.
- 86. Report outcomes through the CHIP evaluation process.

4.7 Tobacco & Vaping Prevention

Strategy: Conduct 10 middle school tobacco/vaping education sessions.

Priority Group: Allen County residents

Partners: Allen County Public Health, hospitals, schools, community organizations, local partners

Community Co-ownership: Community partners will assist with outreach, implementation, and evaluation.

Evidence for this strategy: Community partnerships and prevention initiatives improve healthy living outcomes.

Objective	Indicator	Baseline	Target	Coordinator
Conduct 10 middle school tobacco/vaping education sessions.	# sessions	13 sessions / 34 students (FY26)	10 sessions	PASS and Crime Victim Services

Action Steps:

- 87. Coordinate with community partners.
- 88. Promote community awareness and participation.
- 89. Monitor annual progress.

90. Report outcomes through the CHIP evaluation process.

4.8 Youth Media Campaigns

Strategy: Conduct at least 2 youth-led media campaigns discouraging vaping.

Priority Group: Allen County residents

Partners: Allen County Public Health, hospitals, schools, community organizations, local partners

Community Co-ownership: Community partners will assist with outreach, implementation, and evaluation.

Evidence for this strategy: Community partnerships and prevention initiatives improve healthy living outcomes.

Objective	Indicator	Baseline	Target	Coordinator
Conduct at least 2 youth-led media campaigns discouraging vaping.	# campaigns	0	2 campaigns	Activate Allen County and Mercy Health

Action Steps:

91. Coordinate with community partners.
92. Promote community awareness and participation.
93. Monitor annual progress.
94. Report outcomes through the CHIP evaluation process.

4.9 Healthy Food Pantries

Strategy: Increase food pantry sites encouraging HER nutrition guidelines.

Priority Group: Allen County residents

Partners: Allen County Public Health, hospitals, schools, community organizations, local partners

Community Co-ownership: Community partners will assist with outreach, implementation, and evaluation.

Evidence for this strategy: Community partnerships and prevention initiatives improve healthy living outcomes.

Objective	Indicator	Baseline	Target	Coordinator
Increase food pantry sites	# sites	0	7 sites	West Ohio Food Bank

encouraging HER nutrition guidelines.				
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Action Steps:

- 95. Coordinate with community partners.
- 96. Promote community awareness and participation.
- 97. Monitor annual progress.
- 98. Report outcomes through the CHIP evaluation process.

4.10 Hypertension

Strategy: Decrease percentage of adults with hypertension.

Priority Group: Allen County residents

Partners: Allen County Public Health, hospitals, schools, community organizations, local partners

Community Co-ownership: Community partners will assist with outreach, implementation, and evaluation.

Evidence for this strategy: Community partnerships and prevention initiatives improve healthy living outcomes.

Objective	Indicator	Baseline	Target	Coordinator
Decrease percentage of adults with hypertension.	% residents	34.3% (2023)	Decrease by 2%	ACPH and Health Atlas

Action Steps:

- 99. Coordinate with community partners.
- 100. Promote community awareness and participation.
- 101. Monitor annual progress.
- 102. Report outcomes through the CHIP evaluation process.

4.11 Obesity

Strategy: Decrease percentage of adults with obesity (BMI >30).

Priority Group: Allen County residents

Partners: Allen County Public Health, hospitals, schools, community organizations, local partners

Community Co-ownership: Community partners will assist with outreach, implementation, and evaluation.

Evidence for this strategy: Community partnerships and prevention initiatives improve healthy living outcomes.

Objective	Indicator	Baseline	Target	Coordinator
Decrease percentage of adults with obesity (BMI >30).	% residents	40.6% (2023)	Decrease by 2%	ACPH and Health Atlas

Action Steps:

- 103. Coordinate with community partners.
- 104. Promote community awareness and participation.
- 105. Monitor annual progress.
- 106. Report outcomes through the CHIP evaluation process.

4.12 Diabetes

Strategy: Decrease percentage of adults with diagnosed diabetes.

Priority Group: Allen County residents

Partners: Allen County Public Health, hospitals, schools, community organizations, local partners

Community Co-ownership: Community partners will assist with outreach, implementation, and evaluation.

Evidence for this strategy: Community partnerships and prevention initiatives improve healthy living outcomes.

Objective	Indicator	Baseline	Target	Coordinator
Decrease percentage of adults with diagnosed diabetes.	% residents	12.9% (2023)	Decrease by 1%	ACPH and Health Atlas

Action Steps:

- 107. Coordinate with community partners.
- 108. Promote community awareness and participation.
- 109. Monitor annual progress.
- 110. Report outcomes through the CHIP evaluation process.

Allen County CHIP 2026–2029

Work Plan & Annual Reporting Form

Priority Area	Strategy / Goal	Coordinator	Reporting Period
[Priority # / Name]	[Strategy or Goal]	[Lead / Coordinator]	[Year / Date]
Strategy / Objective: <i>[Brief description of the strategy and objective.]</i>			
Community Co-ownership: <i>[How residents, partners, or community organizations participate in implementation.]</i>			
Evidence for this Strategy: <i>[Brief evidence, rationale, or data supporting the strategy. Include source if applicable.]</i>			

Performance Measures

Objective / Deliverable	Indicator	Baseline	Target	Coordinator
[Objective]	[Measure]	[Baseline]	[Target]	[Coordinator]
[Objective]	[Measure]	[Baseline]	[Target]	[Coordinator]
[Objective]	[Measure]	[Baseline]	[Target]	[Coordinator]
[Objective]	[Measure]	[Baseline]	[Target]	[Coordinator]

Action Steps

Action Step	Status / Notes
1. [Action step]	[Update]
2. [Action step]	[Update]
4. [Action step]	[Update]

Annual Report Status	Date	Update / Progress
[On Track / Needs Attention / Complete]	[Date]	[Progress, barriers, successes, or changes]
[On Track / Needs Attention / Complete]	[Date]	[Progress, barriers, successes, or changes]
[On Track / Needs Attention / Complete]	[Date]	[Progress, barriers, successes, or changes]

Additional Notes / Data Sources: *[Add sources, links, context, or notes as needed.]*

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