Canton City Public Health
Stark County THRIVE
Fiscal Year 2020 Annual Report

OEI 2.0 Grant #7620011OE0220

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Executive Summary

Since 2013, Canton City Public Health (CCPH) has been the lead agency for the Ohio Equity Institute's (OEI) local initiative known as Stark County THRIVE (Toward Health Resiliency for Infant Vitality & Equity). Stark County THRIVE has the primary responsibility for moving the community toward reaching long-term measures in infant vitality. The use of accurate data, solid scientific analysis, and evidence-based interventions to implement programs, improve policies and implementing practice changes will move the needle to reduce Stark County's unacceptable disparity and infant mortality rates. Implementing a countywide approach, THRIVE has been working closely with our partners to identify local causes of infant mortality and executing evidence-based interventions to lower the infant mortality rates in our community and improve birth outcomes. We formed a broad-based local coalition and have made great strides since starting this effort. To date, CCPH manages over 15 sub-recipient contracts with local agencies, along with faith-based and grassroots organizations. CCPH is a grantee of the Ohio Department of Health, United Way of Greater Stark County and local foundations.

We have gained a much deeper understanding of the nature of our infant mortality problem through the use of data and evaluation and we will continue to work to reach the ultimate goal of **"All babies in Stark County will celebrate their first birthday."**

Long Term Measure: Decrease the Overall, Black, and White infant mortality rates (IMR) to less than 6.0.

Baseline: In 2016 Stark County's Overall IMR was 9.3.

Update: 2019 data shows that Stark County's Overall IMR has decreased to 5.4.

Baseline: In 2016, Stark County's Non-Hispanic/Latinx Black IMR was 15.0. Rate is considered unstable due to less than 10 deaths occurring.

Update: 2019 data shows that Stark County's Non-Hispanic/Latinx Black IMR has decreased to 7.4. Rate is considered unstable due to less than 10 deaths occurring.

Baseline: In 2016, Stark County's Non-Hispanic/Latinx White IMR was 8.3.

Update: 2019 data shows that Stark County's Non-Hispanic/Latinx White IMR has decreased to 4.2.

Long Term Measure: Decrease the disparity rate ratio (difference between Black and White IMR) to 1.0.

Baseline: In 2016, Stark County's disparity was 2.7. This means that for each White baby who died before its first birthday approximately three Black babies died before their first birthday.

Update: 2019 data shows that Stark County's disparity was 1.8. This means that Black infants were almost 2 times more likely to pass away before their one-year birthday. This rate is considered unstable due to less than 10 deaths occurred in Black infants in 2019.

The following report highlights current work, successes, challenges, and future development.

Rates are calculated by number of deaths per 1,000 live births in that population. Race/ethnicity based on race/ethnicity documented at birth.

Introduction

Since 2013, Canton City Public Health (CCPH) has been the lead agency for the Ohio Equity Institute's (OEI) local initiative known as Stark County THRIVE (Toward Health Resiliency for Infant Vitality & Equity). Stark County THRIVE has the primary responsibility for moving the community toward reaching long-term objectives in infant vitality. The use of accurate data, solid scientific analysis, and implementation of evidence-based interventions will move the needle to reduce Stark County's unacceptable disparity and infant mortality rates. Implementing a countywide approach, THRIVE has been working closely with our partners to identify local causes of infant mortality and executing evidence-based interventions to lower the infant mortality rates in our community. We formed a broad-based local coalition and have made great strides since starting this effort.

All calculations in the graphs and charts contained herein are based upon analysis of the Stark County population as a whole and Non-Hispanic/Latinx Black (NHB) and Non-Hispanic/Latinx White (NHW) unless otherwise noted. 2019 birth data is preliminary and subject to change.

Decreasing the number of preterm and very preterm births	Decreasing the number of low-weight and very-low-weight births
Preterm (less than 37 weeks gestation) Healthy People 2020 Goal: 9.4%	Low Birth Weight (<2,500 g) Healthy People 2020 Goal: 7.8%
Very Preterm (less than 32 weeks gestation) Healthy People 2020 Goal: 1.5%	Very Low Birth Weight (<1,500 g) Healthy People 2020 Goal: 1.4%

Stark County Scorecard January 2019-December 2019	Race & Ethnicity			
	Overall	NH Black	NH White	Hispanic/Latinx Any Race
Total Births	4094	540	3319	167
Births <32 weeks gestation	54 Met-1.3%	*	41 Met-1.2%	*
Births 32-33 weeks gestation	59	10	46	*
Births 34-36 weeks gestation	269	40	211	17
Total pre-term births <37 weeks gestation	382 Met-9.3%	57 Not met-10.6%	298 Met-9.0%	21 Not met-12.6%
Very low birth weight (<1,500 g)	52 Met-1.3%	*	41 Met-1.2%	*
Low birth weight (<2,500 g)	339 Not Met-8.3%	63 Not Met-11.7%	255 Met-7.7%	13 Met-7.8%
Count of infant deaths	22	4	14	1
*Count of less than 10 births recorded				

Ohio Equity Institute (OEI) Grant

The goal and purpose of Stark County's Ohio Equity Institute's funded work is to improve the equity for women giving birth in Stark County to reduce disparities in birth outcomes therefore improving infant vitality. The program is focused on both upstream and downstream changes. Health equity is achieved when all people in a community have access to affordable, inclusive and quality infrastructure and services that, despite historical and contemporary injustices, allows them to reach their full health potential. Stark County's OEI, along with 8 other OEI funded programs in Ohio, work to achieve equity in their local communities by ensuring Black pregnant women have access to services that will support healthy pregnancies, and by improving the physical and social infrastructure that impact health outcomes for Black women, children and families.

Downstream: Neighborhood Navigator identifies and connects prenatal Stark County women, with a focus on Black women, in order to link them up with clinical and social services. Connecting these women works to decrease stress and improve access to resources needed. Outreach efforts are focused on non-traditional avenues in order to reach women who are not yet connected with various services.

Upstream: OEI staff works alongside local organizations and community members in order to facilitate the development, adoption, or improvement of policies and/or practices that impact the social determinants of health (SDOH) related to preterm birth and low birth weight, which often drive the inequities in birth outcomes within the OEI counties.

Building upon the work of OE19 Stark County THRIVE has:

- Expanded locations in which information posters and hot cards are placed by the Neighborhood Navigator. To track effectiveness, all women screened by Neighborhood Navigator are asked how they found out about the program.
- Continued work with community partners and content experts to improve SDOH for residents. This includes tracking policy/program changes implemented during OE19 and identification of at least one additional policy and/or practice change during OE20.
- Improved monitoring and evaluation efforts for effective program analysis.

The Stark County THRIVE OEI SDOH teams continue to work to address areas that will improve programs and or policies that impact birth outcomes. Through a collaborative process members of the THRIVE core team and community advisory committee selected two areas of focus: Adolescent Health/Family Planning led by Jessica Boley, OEI Epidemiologist and Housing led by Dawn Miller, OEI Project Manager. The THRIVE SDOH teams meet monthly. To help facilitate this practice focus, team members include representation from managed care plans, Stark Housing Network providers, Homeless Coordinated Entry, City of Canton Department of Development, Stark County Job and Family Services, Stark County Health Department, local reproductive clinics, pediatricians, and members of the community served.

Community Context of Stark County, Ohio

Community context plays a vital role in guiding the work that the OEI team has undertaken. Every community has its own culture, assets, history of achievement, and challenges on which to build. Engagement with community partners helps us to fully recognize and understand these unique community settings, it helps direct strategies and tactics to better align with and leverage existing efforts already underway in our community.

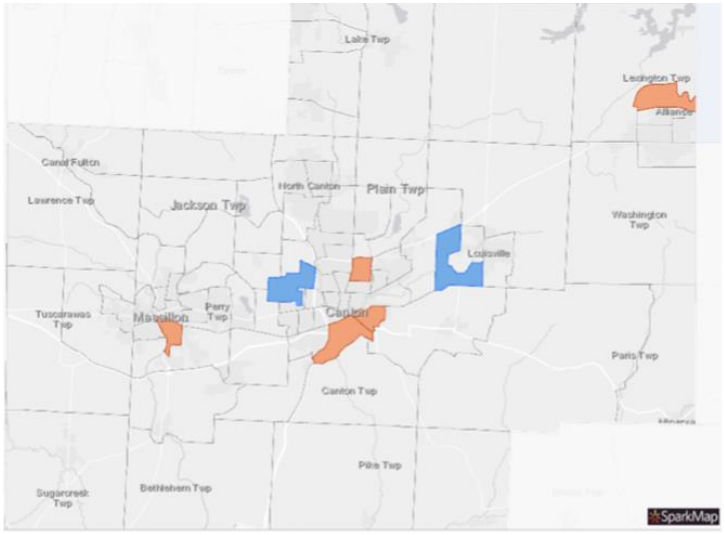
A historical review of the inequities that exist in Stark County, which contribute to poor birth outcomes can be traced back to early 1930's redlining of the Southeast Canton neighborhood and construction of the Route 30 highway.

"In the 1930s, an agency in the U.S. Government started mapping areas of the major cities for loans as part of the New Deal and so they rank them by color, so if you lived in certain areas based upon that color you would get a different rate, so some of those that were in the redlined areas, they couldn't get loans or business loans or home interest loans, so they couldn't borrow from the federal government," said Rachel Lovell, Ph.D., research assistant professor, Case Western Reserve University. Those who were redlined or denied mortgages were mostly minority groups— specifically African Americans

In the Southeast Canton neighborhood and other urban centers of Stark County previously thriving businesses such as grocery stores, manufacturing, health services, and walkable neighborhoods were soon gone creating lasting impediments to resident's health and economic vitality. As a result, people residing in these areas are disproportionately impacted by,

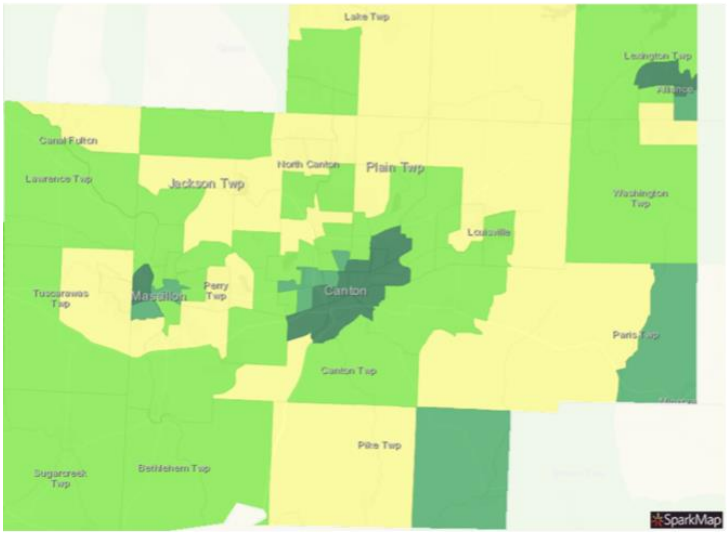
- High poverty,
- Access to fresh fruits and vegetables,
- Low educational attainment,
- Chronic health conditions,
- Infant mortality,
- Crime, and
- Unemployment.

Community Context of Stark County, Ohio



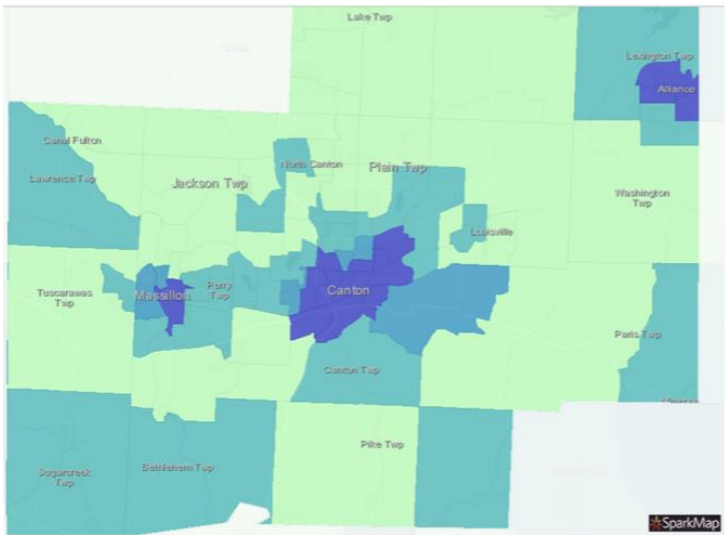
Food Desert Census Tracts, Change, 1 Mi. / 10 Mi. by Tract, FARA 2010-2015

- Food Desert - Added in 2015
- Food Desert - No Change
- Not a Food Desert - Removed in 2015
- Not a Food Desert



Unemployed Workers, Percent by Tract, ACS 2014-18

- Over 12.0%
- 8.1 - 12.0%
- 4.1 - 8.0%
- Under 4.1%
- No Data or Data Suppressed



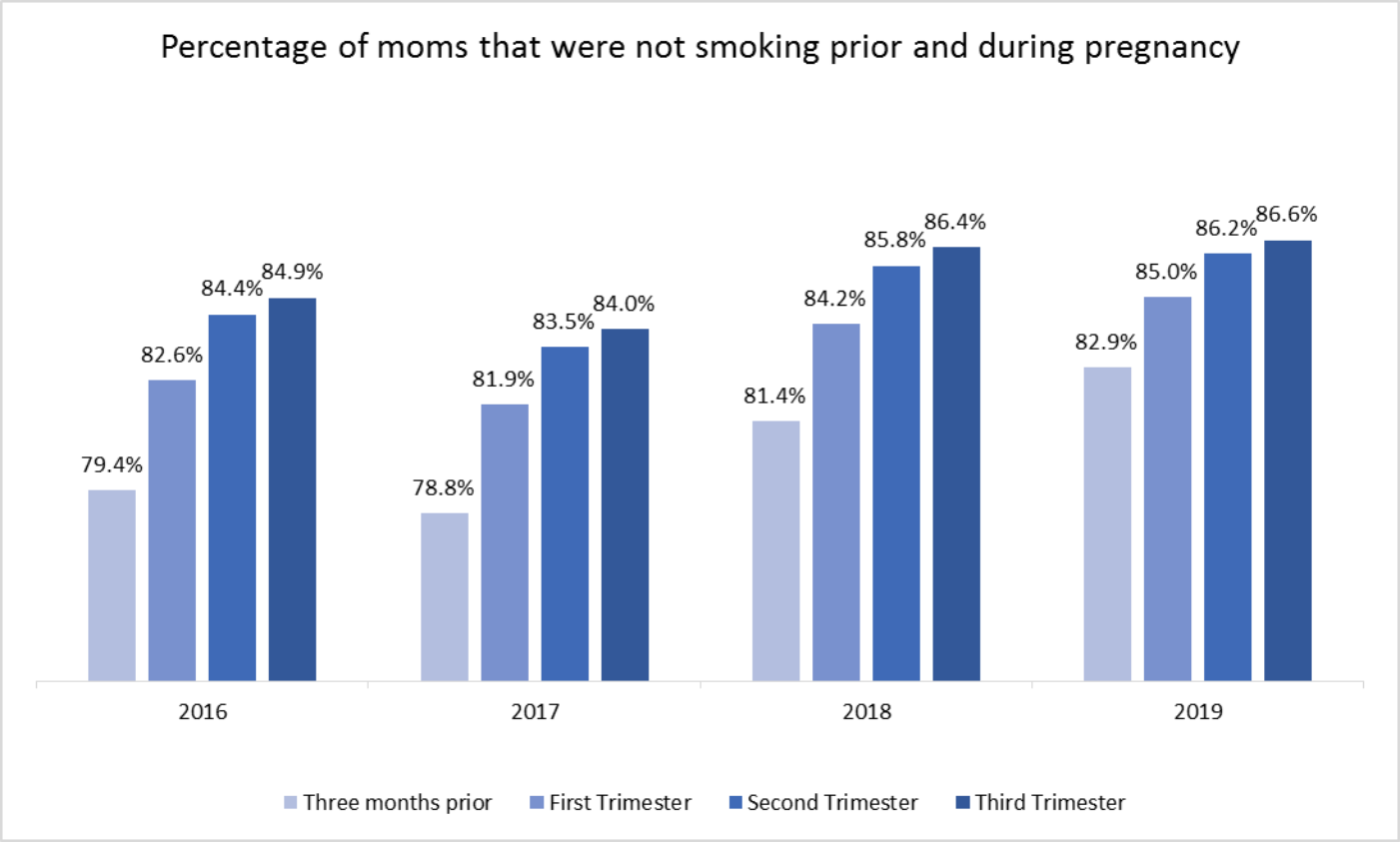
Population Below 200% Poverty Level, Percent by Tract, ACS 2014-18

- Over 50.0%
- 38.1 - 50.0%
- 26.1 - 38.0%
- Under 26.1%
- No Data or Data Suppressed

Indicators monitored: Smoking

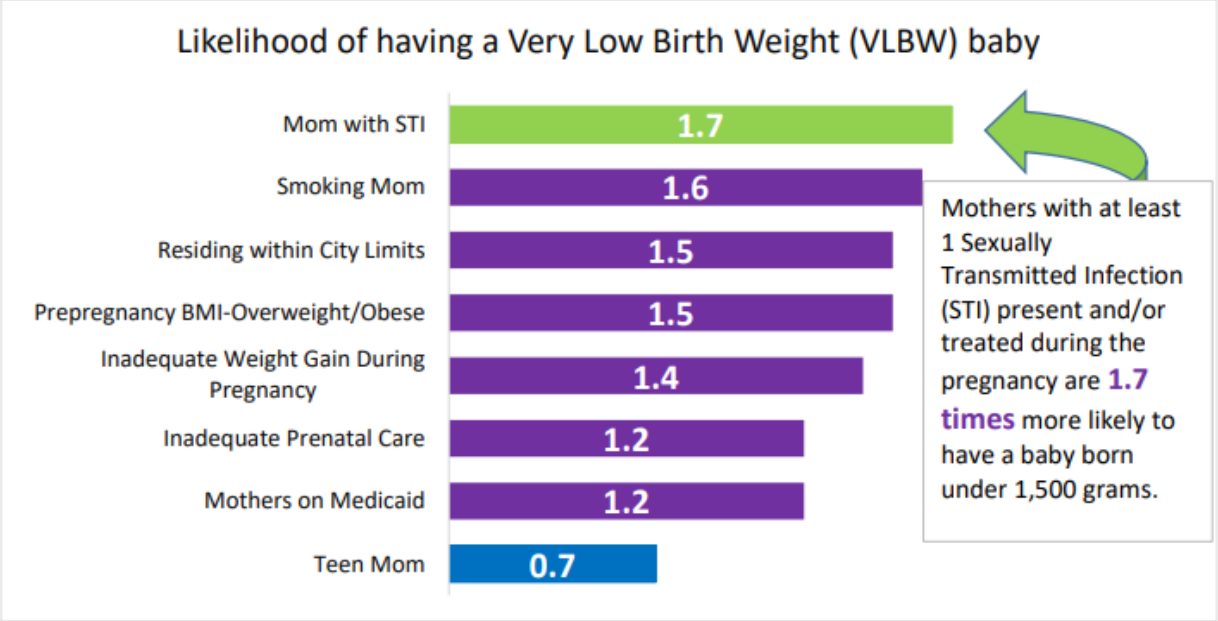
"Quitting smoking—and quitting early in pregnancy—was associated with reduced risk of preterm birth even for high-frequency cigarette smokers." (Soneji S, 2019)

Studies have shown time and time again that women who do not smoke during the pregnancy are at a decreased risk for premature and low birth weight births.(Dahlin, 2016), (Priscilla Perez da Silva Pereira, 2017) (Soneji S, 2019). In 2019, Ohio passed the "Tobacco 21" law which raised the age to purchase cigarettes and other tobacco products including nicotine alternative products from 18 to 21. (Ohio Department of Health, 2019) While it may be too early to determine if this has any effects on maternal smoking, in 2019, Stark County saw the highest percentage of mothers not smoking prior to pregnancy and during each of the pregnancy trimesters when compared to the previous 3 years.



Indicators monitored: Sexually Transmitted Infections

During the Perinatal Periods of Risk (PPOR) analysis conducted on Stark County births from 2013-2017 during OE19, it was determined that Stark County mothers who had a sexually transmitted infection (STI) during and/or treated during the pregnancy were 1.7 times more likely to have a preterm birth. Sexually transmitted infections included for analysis includes: Bacterial vaginosis, chlamydia, gonorrhea, herpes, syphilis, and trichomoniasis.



Zip Codes with Highest Percentages of STI's in Mothers Who Gave Birth				
	2016	**2017**	**2018**	**2019**
44626	9.09%	7.41%	11.76%	15.00%
44703	17.24%	13.51%	15.11%	9.09%
44704	13.11%	19.12%	19.15%	19.64%
44705	11.90%	8.01%	13.54%	11.35%
44706	9.95%	10.31%	7.73%	6.28%
44707	17.72%	13.04%	14.84%	12.37%
44708	9.35%	10.62%	13.55%	9.74%
44709	6.86%	9.78%	10.26%	5.49%
44710	14.05%	10.45%	12.78%	10.08%
44714	15.97%	16.84%	14.43%	15.08%
All of Stark County	8.68%	8.20%	9.19%	7.67%

Building upon that information, additional analysis was completed and has helped guide work being conducted by the family planning & adolescent health SDOH committee.

Looking from 2016 until 2019, the overall percentage of mothers with one or more STI's has decreased. Zip codes represented in the table have had a top 10 percentage of births with an STI present and/or treated during the pregnancy in at least 2 of the past 4 years.

Indicators monitored: Sexually Transmitted Infections

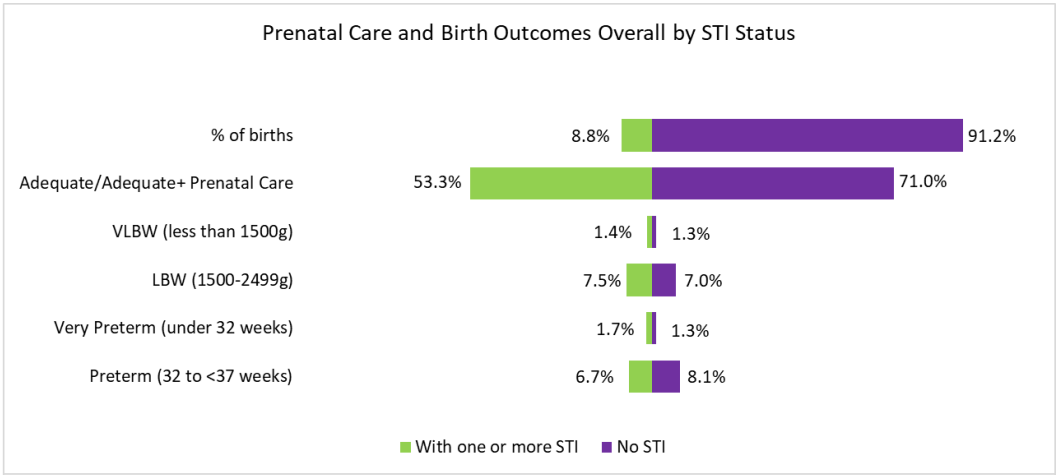
Overall in 2019, mothers with an STI were 18% less likely to receive adequate or adequate plus prenatal care as classified by the Kotelchuck Index. They were also more likely to have a very low birth weight (VLBW) or low birth weight (LBW) birth than mothers who did not have an STI. They were also more likely to have a very preterm birth.

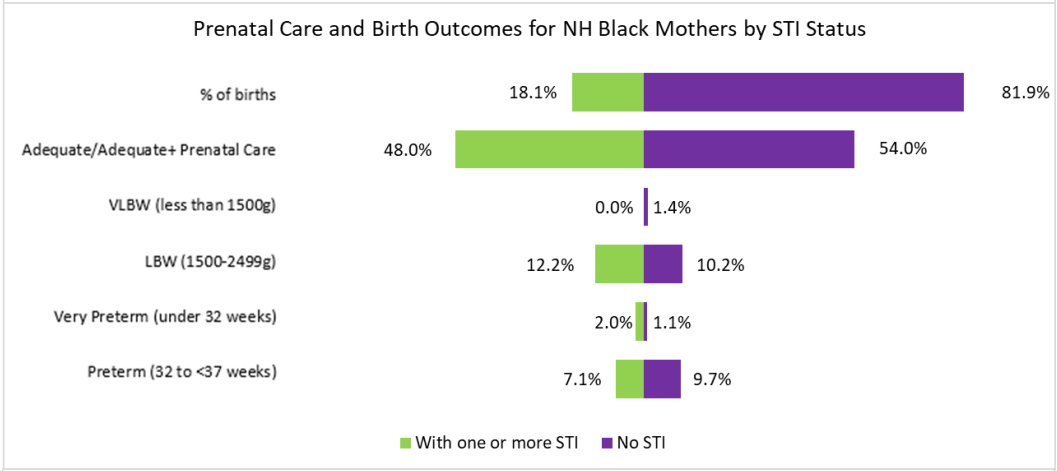
For NH Black mothers, just over 50% were likely to have adequate prenatal care, even without an STI. For mothers with an STI, less than 50% received adequate or adequate plus prenatal care. NH Black mothers with an STI were also more likely than non-STI counterparts to have a LBW birth. At 18.1% NH Black mothers were also more likely to have an STI then Stark County mothers overall.

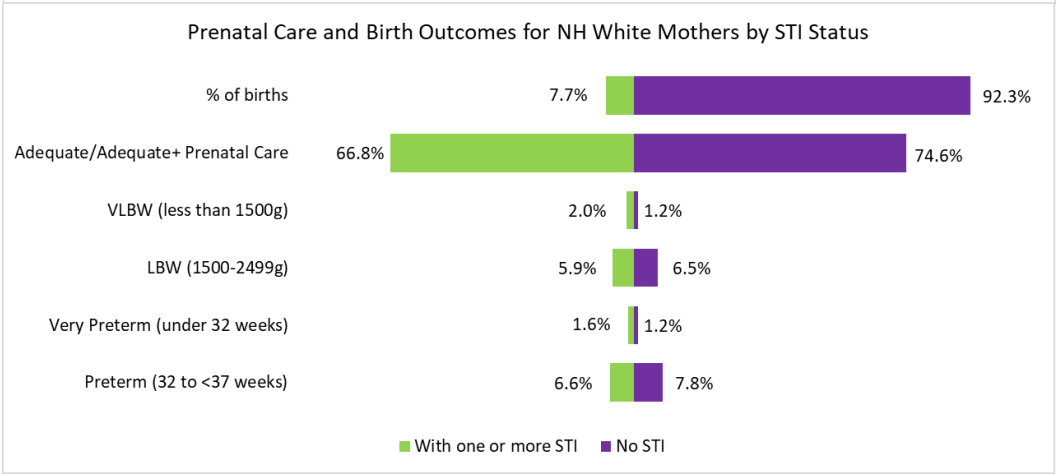
For NH White mothers, those with an STI were close to 8% less likely to receive adequate/adequate plus prenatal care. The mothers with an STI were also more likely to have a VLBW and a very preterm birth.

Overall, this raises questions regarding the adequacy of prenatal both overall but specially to mothers with STI's. Future work may want to focus on:

- Prevention of STI's prior to pregnancy
- Prevention of STI's during pregnancy
- Improving adequacy of prenatal care, especially for NH Black mothers and mothers with an STI

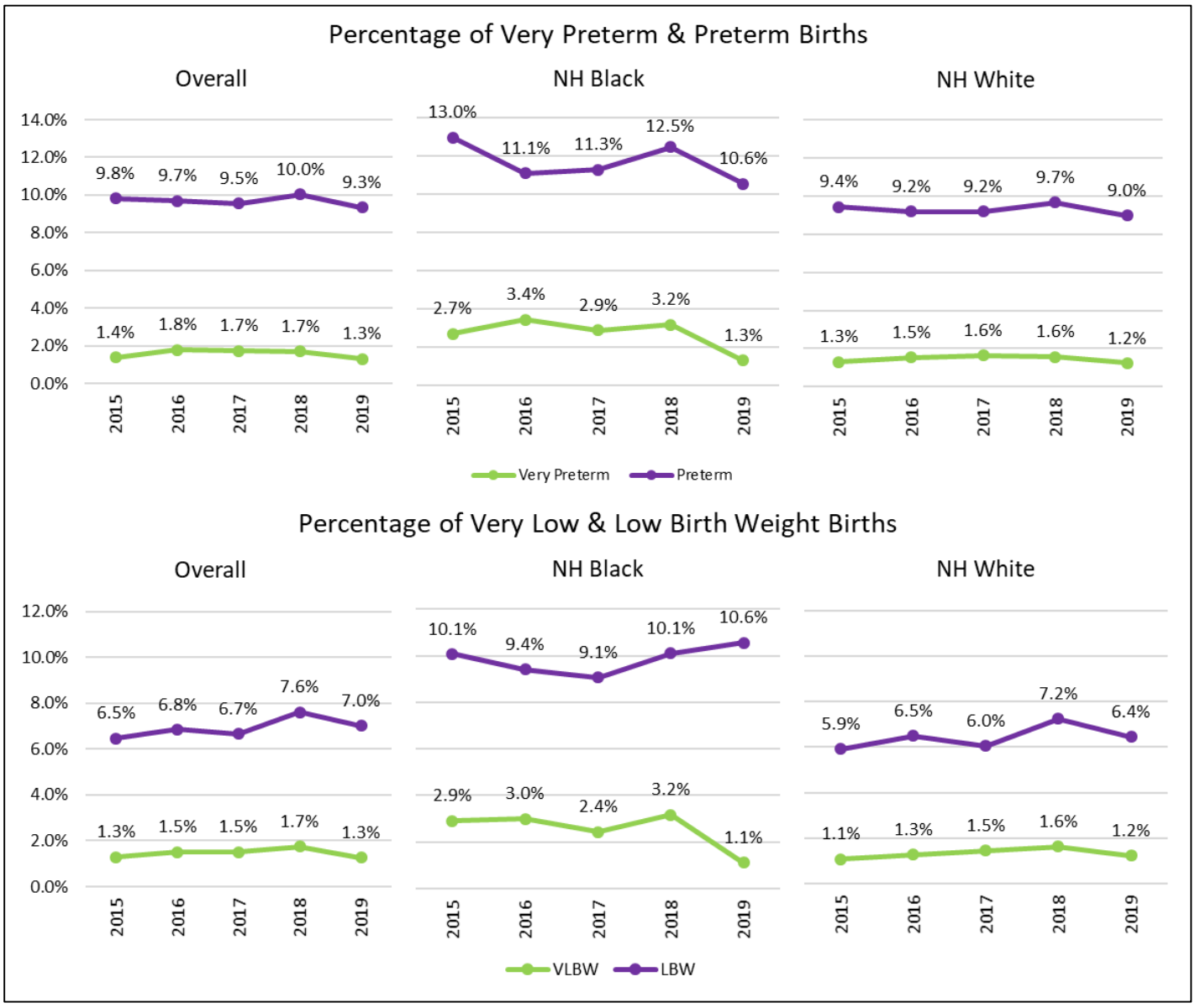






Birth Outcomes in Stark County

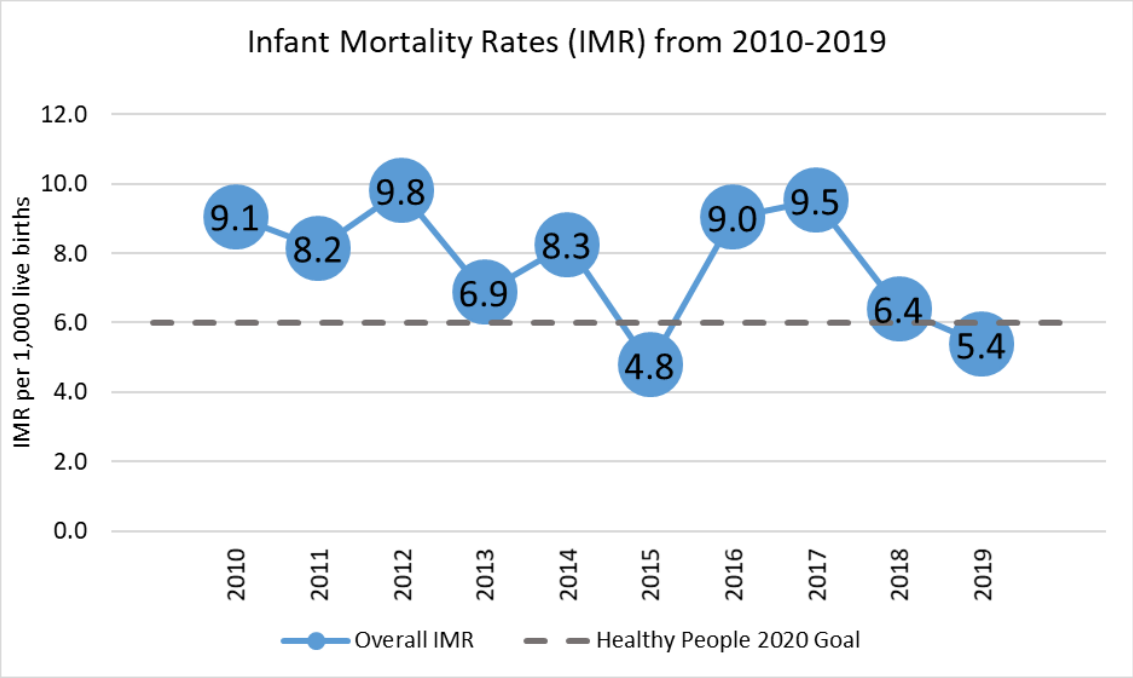
Premature and low birth weight births are common indicators monitored overall. In reviewing very preterm (<32 weeks gestation) and preterm (<37 weeks gestation, includes very preterm births), overall percentages have been relatively stable. In 2019 both NH Black and NH White infants had the best birth outcomes in the past 5 years, with a dramatic difference in NH Black percentages of premature and very premature births.



The overall percentage of very low birth weight (VLBW:less than 1,500 g) accounted for 1.3% of births in 2019, low birth weight (LBW:1,500-2,499 g) births is in line with the previous 4 years, accounting for on average 6.9% of births. While NH Black infants has seen a marked decrease in the percentage of VLBW births, they have been seeing a gradual increase in the percentage of LBW births. VLBW and LBW births for NH White infants has remained consistent over the past 5 years.

Infant Mortality in Stark County

Infant mortality rates (IMR) are calculated by the number of infant deaths divided by number of infant births, multiplied by 1,000. This calculation of rates helps to compare populations. The IMR for all of Stark County since 2010 has fluctuated between 9.8 per 1,000 births and 4.8 per 1,000 births. During this time period, Stark County was able to achieve the Healthy People 2020 Goal of an IMR below 6.0 twice, in 2015 and 2019, while coming close in 2018.

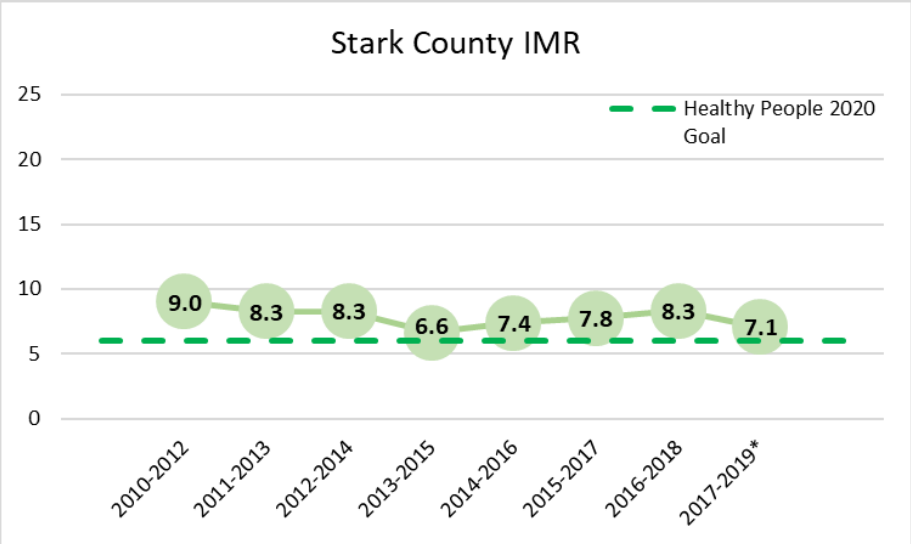


Since 2010, Stark County has seen on average 4,100 births per year. The majority of these births are to NH White mothers (average of 3,444 per year) and births to NH Black mothers is the second largest group with an average of 477 per year. These two groups make up approximately 96% of the births. In the last 10 years, births to NH White mothers have been decreasing (2010 birth rate 55.1 per 1,000 in population, 2019 birth rate 49.9 per 1,000 in population) while those to NH Black mothers have been gradually increasing (2010 birth rate 63.8 per 1,000 in population, 2019 birth rate 69.4 per 1,000 in population). Population based on females ages 15-49. Race/ethnicity of infant deaths is based on race/ethnicity documented at birth.

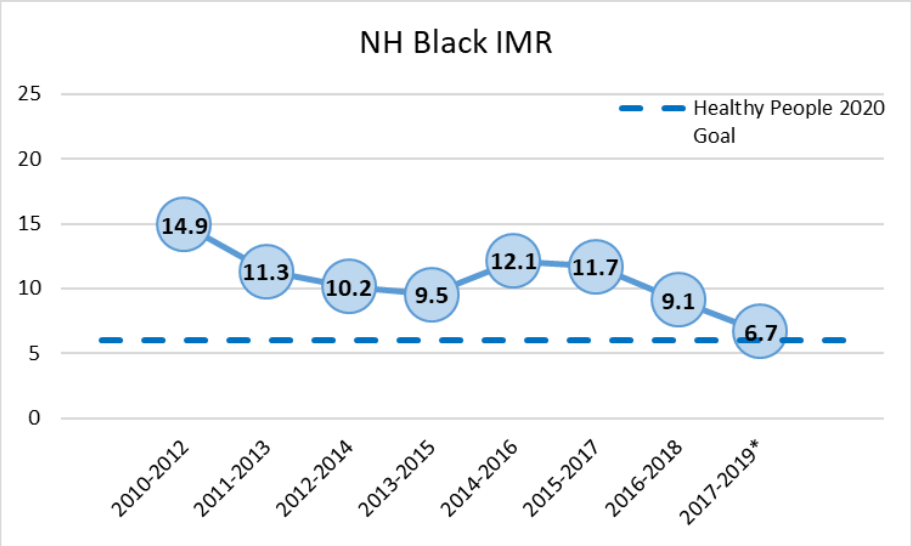
	2010	2011	2012	2013	2014	2015	2016	2017	2018	2019
NH Black Deaths	8	7	5	4	6	4	7	5	1	4
NH Black Births	462	422	455	536	485	447	468	452	505	540
NH White Deaths	26	24	32	20	24	16	29	31	24	14
NH White Births	3480	3490	3459	3498	3536	3514	3514	3310	3325	3319
Total Deaths	37	33	40	29	35	20	38	38	26	22
Total Births	4081	4047	4077	4216	4237	4180	4205	3990	4060	4094

Infant Mortality in Stark County

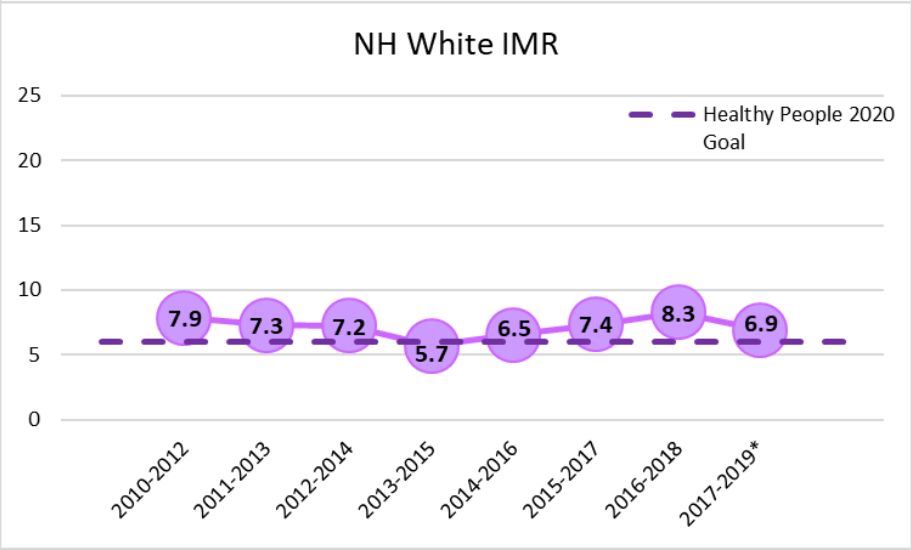
In order to look at rates based on larger and therefore more stable counts, these graphs are a combination of data from 2010-2019. Each data point encompasses 3 years' worth of data, with each consecutive data point adding a new year and dropping the oldest year. This rolling of years helps smooth out outlier years and see how Stark County is doing in the long run and allows analysis of more stable rates for all populations.



Historically, NH Black families have experienced the highest infant mortality rates in Stark County but also due to low counts annually (less than 10), calculating rates for this group is very unstable on an annual basis. The 3-year groupings help us to see the decrease in IMR for this population over the past 10 years.

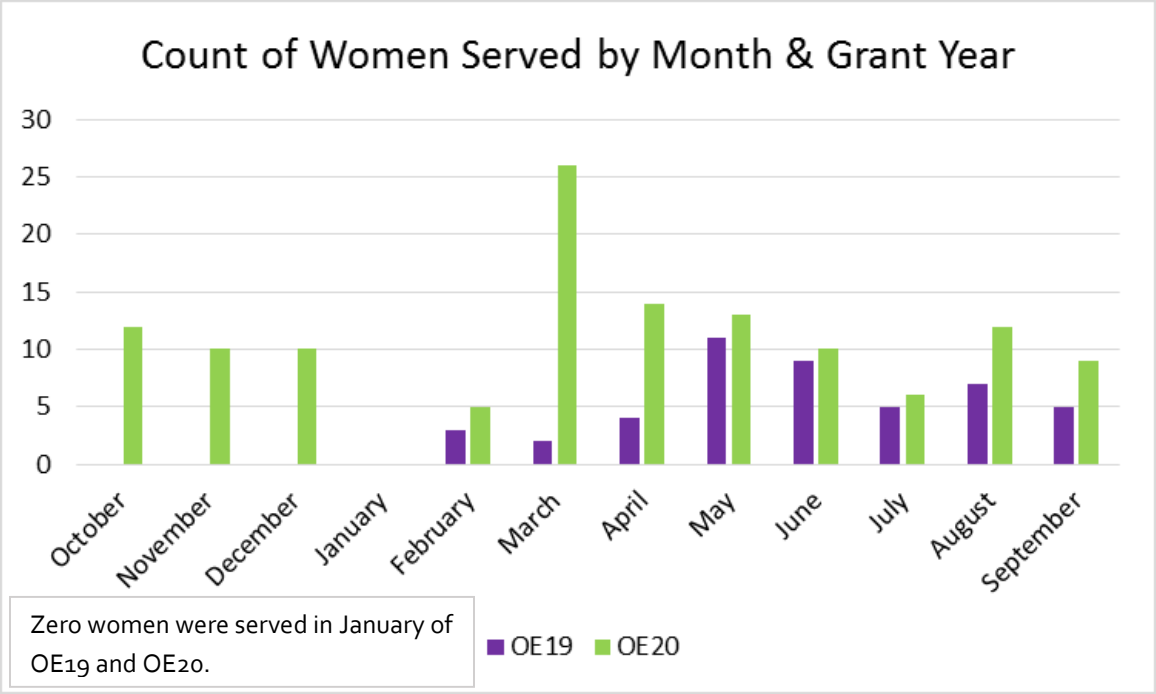


Deaths among NH White infants has been relatively consistent over the past 10 years. From 2013-2015, this population did see an IMR below the Healthy People 2020 goal of 6.0 per 1,000 births.



Neighborhood Navigator

Work completed by the Neighborhood Navigator (NN) drives downstream changes and intervention. During OE20 more focused strategies were explored and utilized for community outreach including reaching out to barber shops and beauty salons, coffee shops, laundromats, working with My Community Health Center (FQHC), working with local churches, hanging posters at gas stations and Dollar Trees and handing out and hanging hot cards (Appendix B).



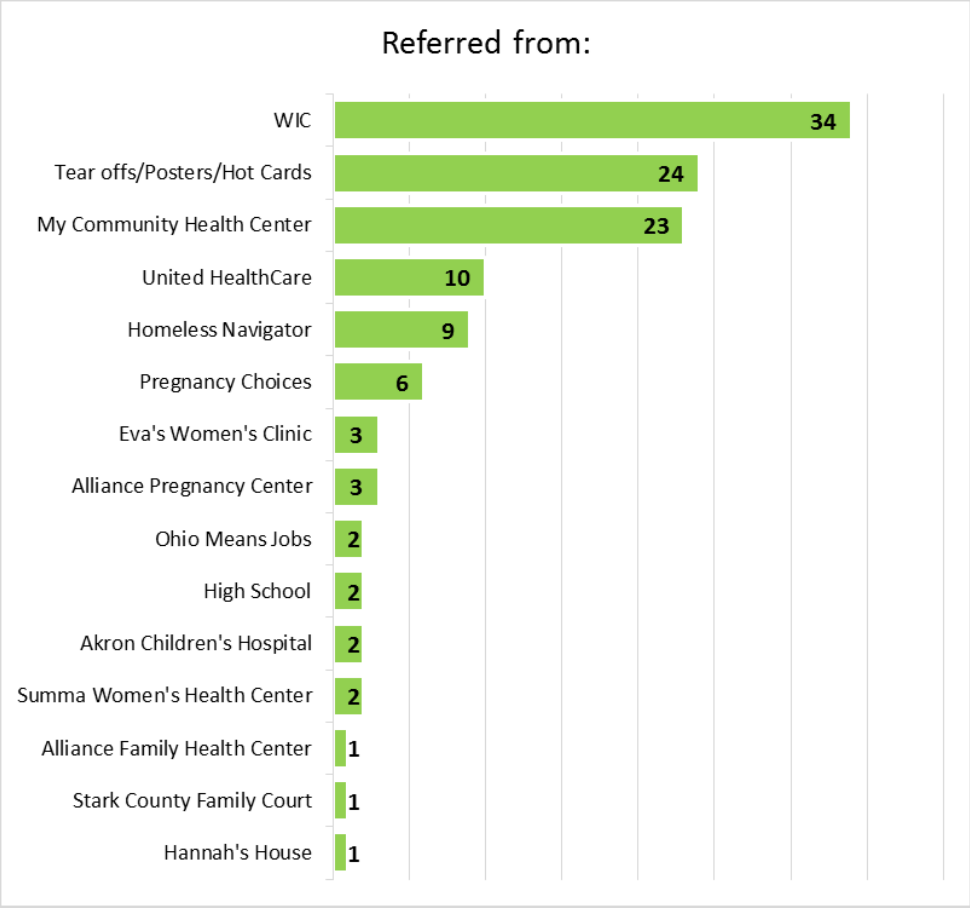
When looking back to OE19 compared with OE 20, Elonda, Stark County THRIVE Neighborhood Navigator, felt that she had more time to do screenings during the OE20 grant cycle. In OE19, she started with the program late in the first quarter of the grant and working to understand the position and determine a plan for outreach was the initial main focus. During OE20, she was able to hang tear offs posters and disperse hot cards so that more people in community were able to notice who she was and what she does as a NN. Having her photo on posters and hot cards proved to be beneficial, "one day I was at the grocery store and someone recognized me from the posters and hot cards that was in need of services. I was able to do a screening for them and got them connected to the services they needed". This additional time that Elonda had during the OE20 grant cycle proved to be beneficial. During OE19, Elonda served 46 women, 42.6% of her goal of serving 108 women. By the end of quarter 2 of the OE20, Elonda had already served 63 of the 106 needed during the grant cycle. By the end of the OE20 grant cycle, Elonda was able to successfully serve 126 women. While the goal of 80% of those women being Black wasn't met (43% of those served were Black), Elonda was able to identify 265 needs of which 265 referrals were offered to assist the mothers served.

Community partners that are involved in NN work include Pregnancy Choices, My Community Health Center, and WIC offices in Canton City and Massillon City. The majority of referrals come from WIC. While active outreach isn't being conducted, we believe it is still important to note. While these mothers aren't considered unreached, working with mothers referred from them helps to ensure that they are getting linked to all the possible programs and services that can help them have a healthy pregnancy.

Neighborhood Navigator

Of these avenues, one of the most successful was spending time at My Community Health Center. During that time, the NN was able to see and screen all different moms coming in to their appointments. From Elonda Williams, NN, "Being there was the most pregnant moms I screened in one month!" The least successful avenue was working with the churches. During OE20, NN reached out to 9 churches in Stark County. When connecting with them, she spent at least an hour with a church representative explaining her work as a Neighborhood Navigator and how she is able to help pregnant women to get the services needed to have a healthy pregnancy. When asked why this avenue hasn't been successful, Elonda responded, "I believe the reason for me not getting any referrals from churches is because it's not a lot of young pregnant women going to church". Working to improve commitment to services referred to will be focused on during OE21.

Utilizing tear off posters and hot cards was also very successful. While thinking of non-traditional and unique strategies for reaching women, it was decided that hanging posters and hot cards throughout the community, especially places where women can walk to, filled gaps in the communities where transportation is limited. These areas also are considered financially poor. When focusing on communities of color, Elonda looked to stores that Black women would be able to afford to shop with little income or no job, which pointed to dollar stores or stores that had dollar sections. By concentrating on Dollar Tree locations, which have everyday items at an affordable prices, the navigator was able to fill that gap. The navigator also reached out to pharmacies in these neighborhoods to try and reach the women who were getting their prenatal vitamins or other prescriptions, but was not allowed to hang any information.

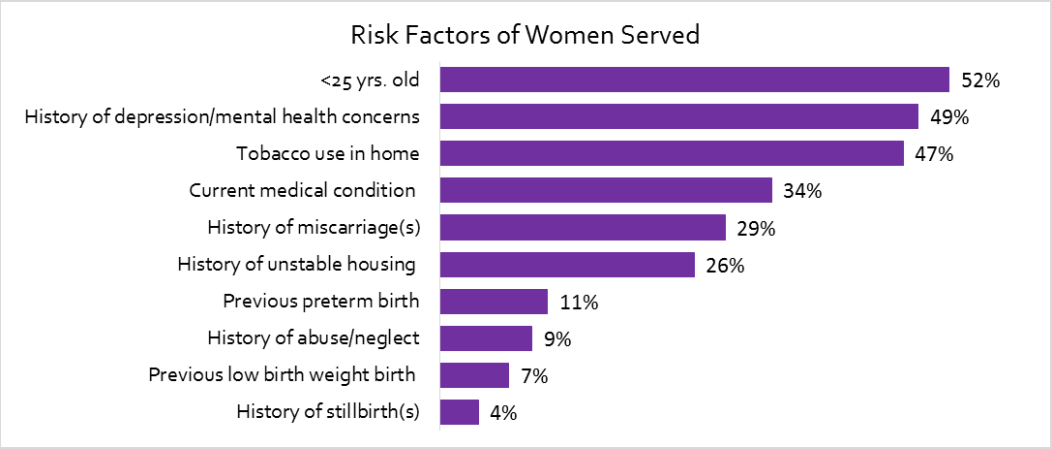


During OE21, OEI team will be working to better document which posters are most successful and determine a plan to get them in additional places to improve visibility.

Women Served by Neighborhood Navigator

During the OE 20 grant cycle, the NN served 127 women. The majority of mothers served were between the ages of 20-29. Teen mothers (less than 20 years of age) accounted for 19% of women served. Majority of women served had a high school degree or GED while 18% had additional schooling beyond high school. Eighty-five percent of mothers served were on Medicaid for their insurance and 12% were uninsured at the time of screening. Totals may not add up to 100% due to rounding.

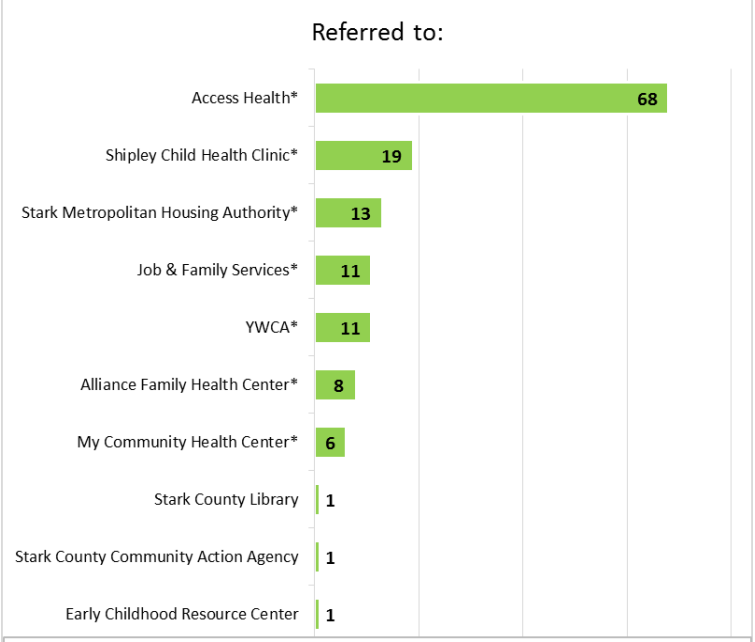
OE20	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Screened/ineligible	1	1	0	0	2
Eligible Women (n)	32	31	37	27	127
Race, Ethnicity					
White, non-Hispanic	63%	65%	46%	44%	54%
Black, non-Hispanic	38%	32%	51%	52%	43%
Other, non-Hispanic	0%	3%	3%	4%	2%
Hispanic	0%	0%	0%	0%	0%
Age					
<15 yrs.	0%	0%	3%	0%	1%
15 - 17 yrs.	6%	0%	3%	11%	5%
18 -19 yrs.	16%	16%	8%	15%	13%
20-24 yrs.	22%	19%	41%	26%	28%
25-29 yrs.	28%	42%	19%	26%	28%
30-34 yrs.	13%	16%	16%	0%	12%
35+ yrs	16%	6%	11%	22%	13%
Education					
Less than HS	22%	35%	27%	30%	28%
HS degree/GED	59%	52%	51%	52%	54%
Some college/associate's	19%	10%	19%	15%	16%
Bachelor's degree	0%	0%	3%	0%	1%
Master's Degree or more	0%	3%	0%	0%	1%
Insurance Type					
Private	3%	0%	5%	4%	3%
Medicaid	84%	87%	78%	93%	85%
Uninsured	13%	13%	16%	4%	12%



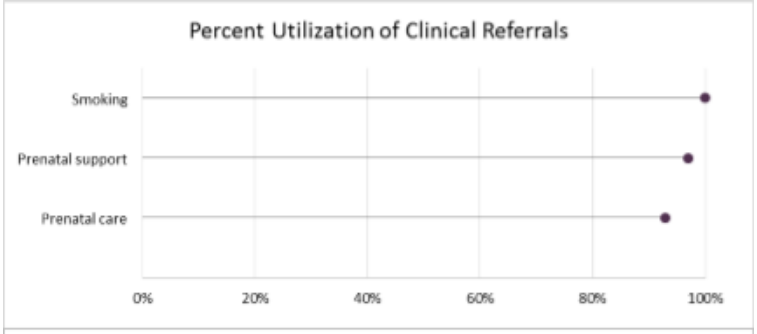
In Stark County during OE20, there was an average of 2.7 risk factors per woman served. NH Black women served have an average of 2.5 risk factors while NH White women had an average of 2.9 risk factors. While there was a slight difference in the average number of risk factors between the two groups, the highest percentage of risk factors identified for each group were the same: Under 25 years of age (53% of NH Black, 52% of NH White), history of depression/mental health concerns (44% in NH Black, 55% in NH White) and tobacco use in home (42% of NH Black, 54% of NH White).

Women Served by Neighborhood Navigator

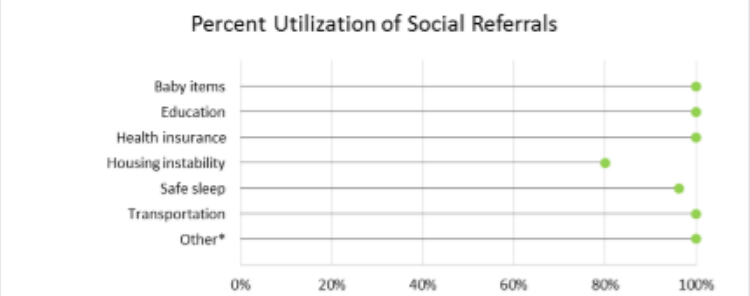
During OE20, a total of 269 needs were identified while screening clients for which the NN made 263 referrals. Mothers utilized 260 of those referrals.



*Referral locations have a community health worker (CHW) associated with the organization that the client is referred to. The CHW connects with the additional referrals.



Additional categories were not referred to during the fiscal year, these include: mental health concerns and substance abuse.



Additional categories were not referred to during the fiscal year, these include: clothing, employment, food, interpersonal violence and utilities.
*Other referrals included: car seat and identification

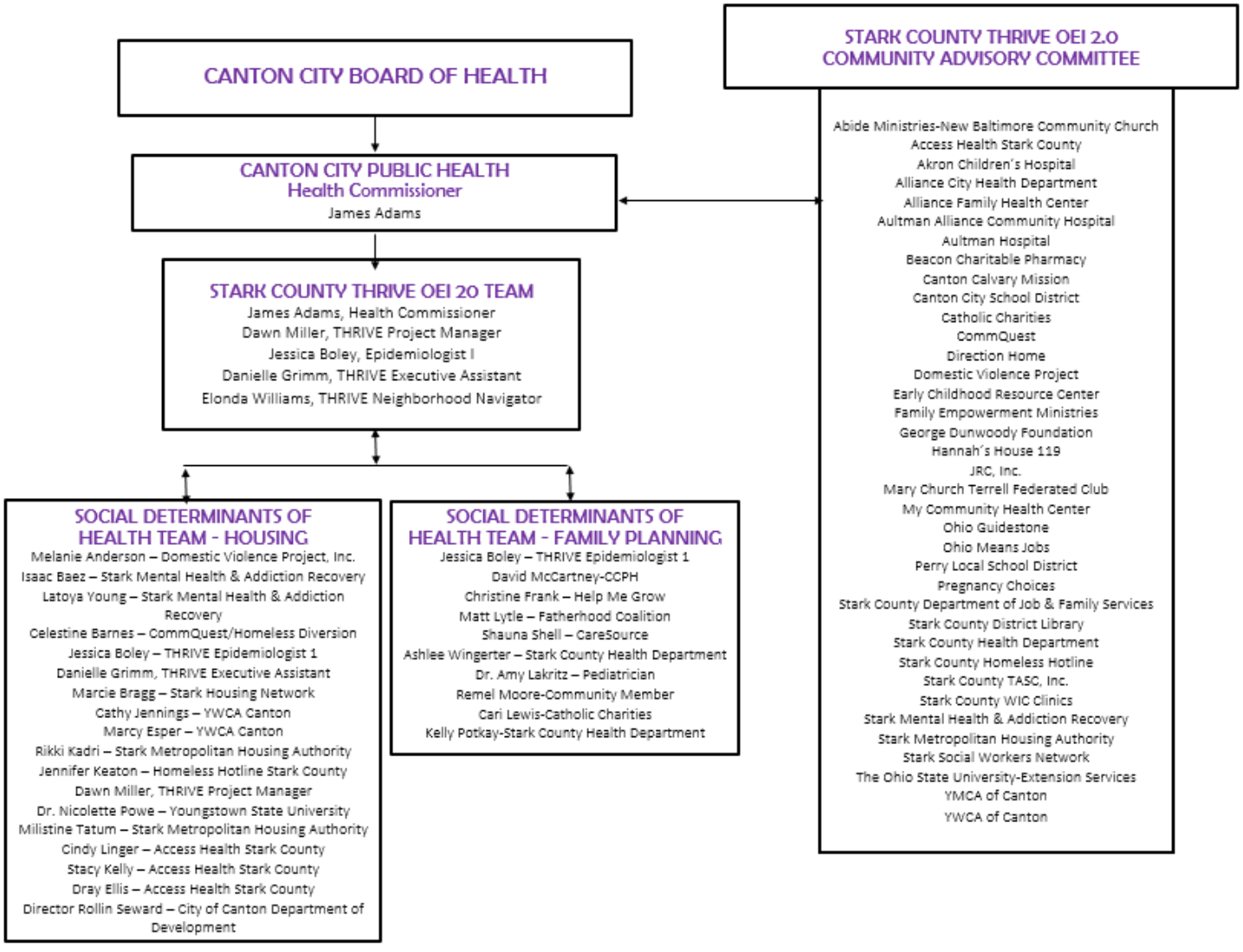
Organizations in which the clients were referred to may offer multiple needs. May referral locations have a community health worker (CHW) associated with the program. Getting clients connected to a program with a CHW allows for a longer engagement period which can identify additional needs not only through the pregnancy but until the baby is one year of age. Overall, when looking at clinical referrals, the clients were most likely to utilize referrals that accessed smoking cessation programs. Prenatal care was the least utilized clinical referral. When it came to social referrals, mothers were less likely to utilize referrals for housing and safe sleep programs. Barriers to accessing referrals included transportation problems, client miscarried, and clients moving out of service area.

When thinking of the overall successes and challenges regarding Neighborhood Navigator work, Elonda stated that, "Successes was being able to help women of all races. Challenges was not being able to keep all African American moms to commit to services." From an epidemiological perspective, successes were reaching the goal number of clients to be served and the percentages of referrals offered and utilized. Challenges were working towards consistent data entry. Dawn Miller, Project Coordinator stated a challenge regarding Neighborhood Navigator work is not being able to work with women who have a child under the age of 1 (maternal vs pregnant) and working with COVID-19 restrictions the 2nd half of the grant cycle while a success was a connection of over 100 Stark County mothers with needed services. Looking forward to OE21, a goal is to improve diversity of referred to locations to meet the client's immediate needs in case they end up not getting connected with a CHW.

Social Determinants of Health-Overview

Stark County THRIVE OEI has two areas of Social Determinants of Health (SDOH) on which it focuses; Housing and Adolescent Health/Family Planning.

The SDOH Adolescent Health/Family Planning Team is led by Jessica Boley, OEI epidemiologist and the SDOH Housing Team is led by Dawn Miller, OEI Project Manager. Both Teams (see appendix for a team charter) are comprised of local community partners and community members which meet monthly. Below is the schematic diagram showing the relationship of the THRIVE OEI and SDOH Teams, and the Community Advisory Committee



Social Determinants of Health-Housing

The policy change adopted by the Stark County THRIVE SDOH Housing team during OE19 and implemented in OE20 focused on partnering with the Stark County Homeless Hotline. This resulted in the implementation of a revised screening protocol for the Hotlines screening personnel, whereby pregnant women are referred to the THRIVE OEI Neighborhood Navigator. Homeless Navigation Director changed intake process and worked with intake staff to add the question "are you pregnant and/or have a child under age one?" as part of the initial intake forms. Intake staff fax referral form to Canton City Public Health and Neighborhood Navigator reaches out to screen individual.

As a result of this policy change, the Stark County THRIVE SDOH Housing team sought to increase: community awareness of various housing options; access to stable housing for pregnant women; identification and prioritization of expedited housing placements for pregnant women; and identification of pregnant women who would benefit from referral and connection to the THRIVE Neighborhood Navigator.

The OE20 policy/practice implementation efforts of the Social Determinants of Health Housing Team can be summarized as follows;

- Implementation of the Stark County Homeless Hotline intake procedure change resulting in nine women referred to the Neighborhood Navigator. During the COVID 19 pandemic individuals contacting the Homeless Hotline have decreased dramatically but Neighborhood Navigator is still receiving referrals. OE19 change is on track but will be revisiting the Homeless Hotline intake staff for messaging to potential clients so that we can increase our conversion %.
- Expansion of Team members to include the City of Canton Director of Development, Stark MHAR-cultural ally to the Black/African American community, Community Legal Aid, two THRIVE community health workers and supervisors,
- Secured $35,000 in HOME/Emergency Solutions funding to support the implementation of a tenant based rental assistance program for pregnant women to be managed by the YWCA Canton
- Finalized framework and criteria for the tenant based rental assistance to pregnant women. Roll out of the program was to begin in mid-April but due to the COVID-19 pandemic roll out of the program was delayed until fall 2020.
- Stark Metropolitan Housing Authority (SMHA) leadership was approached to modify their intake application to include a screening question to identify pregnant women. Unfortunately, the question could not be added.
- Continue to monitor the number of pregnant women identified by Homeless Hotline and compare to number referred and screened by Neighborhood Navigator. Document conversion rate and if it falls below 40% SDOH team will develop next steps to improve rate such as revising the script used by Homeless Hotline intake staff.

For the OE20 program year the team will continue its work on the housing needs of Stark County's pregnant women. This decision was based on the successful implementation of the Homeless intake process change, engagement with the City of Canton Department of Development and Stark Community Legal Aid. Specific policy/practice changes to be addressed include establishing relationships with court personnel (magistrate, judges, clerks, etc.) to refer pregnant women and families with child under age one who are involved in eviction proceeding to the Neighborhood Navigator.

Social Determinants of Health-Family Planning & Adolescent Health

Family Planning & Adolescent Health Team is comprised of local community partners and community members. The group has been looking at large upstream policy and practice changes. As such, the process is slow moving and an adjustment of scope may need to be adjusted in order to meet the grant deliverables of a policy/practice change adopted annually.

During OE20, the team worked to develop a survey for parents and caregivers on their beliefs and practices on adolescent reproductive health and family planning and the risks of unprotected sex. The team received Institutional Review Board (IRB) approval in January 2020 and was able to begin collection survey responses. Initially, the survey was receiving a couple completed responses daily then things stalled out. While the survey link was being posted on the Canton City Public Health Facebook page weekly, it wasn't getting the hits needed. We did a paid sponsorship on Facebook for the post in order to help it reach a larger population and a weekly reminder email was sent to our community along with the survey link and encouraged them to share it with their coworkers, clients, and partners. This allowed for close to 40 additional survey responses. We chose to close the survey in September after receiving 159 responses. Based on responses of participants who requested additional information to be sent on adolescent health, 166 education forms were distributed to 34 unique email addresses. In regards to reproductive health and risks of unprotected sex, requests for additional education information to be sent out included 17 unique email addresses to which a total of 65 educational handouts were sent. Only one email was returned as undeliverable. During the start of OE21, the group will be looking closer at the results of the initial survey. A follow-up survey will be sent to those who were sent additional education material to see if the material met their needs. The team will also be pulling together a report out to participants and stakeholders discussing the overall results of the survey.

During discussions with various OEI groups, questions arose about how COVID would affect pregnancy rates and STI rates since many clinics were either closed or reduced hours. OEI Epidemiologist brought this discussed to team, which evolved into if, when and how CHW's in the county are talking about family planning and STI's during their time with clients. The group discussed ways to improve knowledge of the CHW's on these topics.

The practice change that was able to be adopted in OE20 is improved training of CHW's on talking with their clients about family planning and STI prevention before, during and after pregnancy. During OE21 grant, with assistance from a Kent State University Graduate student, an initial knowledge assessment of the CHW's will be conducted. They will then attend a required training on the topics which will be recorded for future trainings. After the training a post assessment will be completed. In additional to training materials, the CHW's will also receive a one-page handout as a quick reference guide that reviews birth control options by the most prevalent managed care plans in Stark County. By working to improve the training and education received by the CHW's, we can work with the Stark County HUB to track how many mothers CHW's are discussing both family planning and STI prevention. For evaluation, if we are able to improve the number of mothers who get proper care and take proper precautions to prevent STI's, we hope to see the number of mothers with an STI give birth, which can help to reduce the preterm and low birth weight births, thereby improving infant vitality in Stark County.

Epidemiologist Report

During OE20, Stark County THRIVE received data requests in order to support the Stark County CHIP/CHNA work. Epidemiologist has also produced information for Stark County's Baby & Me Tobacco Free grant. The epidemiologist sends out quarterly reports on birth outcomes that is sent to the Canton City Board of Health. Sharing this data, sometimes leads to additional questions from the Board of Health which allows for additional data sharing. Along with the quarterly report that is sent to the Board of Health, the epidemiologist sends out a quarterly report to the program manager and neighborhood navigator on the OEI work that was completed during the past quarter.

Additional training that was completed during OE20 included: OSU's 21st Annual Summer Program in Population Health: Practical Implementation of Health Equity Initiatives and attendance at the 2020 CityMatCH Leadership and MCH Epidemiology Conference. Both trainings allowed for an expansion on knowledge, on health equity, mapping, disparities, monitoring and evaluation, amongst other topics.

In addition to OE20 work, the epidemiologist also supports the evaluation being completed by Kent State University on the Stark County THRIVE Pathways HUB program. As Stark County THRIVE continues its work in the community, we are seeing an increase of people who reach out with questions regarding the data and birth outcomes in Stark County and are able to answer them with confidence. Additional requests for data have come from health systems, community organizations, United Way, the philanthropic community, and have been used to develop grant proposals, presentations to Board members and the community.

Due to COVID-19, the epidemiologist also spent time releasing local reports on COVID-19 data both on a county level and city level. She worked in partnership with other local health departments to improve data collection and reduce missing information. Early county reports were released 3 times a week which decreased to twice a week as the illness progressed. City level data was released to the Canton City Public Health leadership twice a week.

Future Planning

When looking to OE21 and beyond, THRIVE continues to see areas for improvement.

In regards to NN strategies to improve outreach to NH Black women, the NN would like to be able to keep referral sources that were already established as well as going forward with new strategies to better reach Black women. The Project Coordinator is looking to increase the frequency of the touchpoint meetings held between the Neighborhood Navigator, Epidemiologist, and Project Coordinator for the purpose of improving team communication, success of outreach activities, monitoring of REDCap data and evaluating the value of each avenue in being a referral point for the Neighborhood Navigator and using that information to redesign messaging, communication, and engagement efforts. Project epidemiologist would like to see improved tracking of referral locations, including which tear-off locations are most utilized. Epidemiologist would like to begin tracking of the women who are referred to a CHW to see how many end up being successfully enrolled and improve variety of referral locations to better meet the needs of the clients screened.

The THRIVE SDOH Housing Team's local policy and practice change work can be enhanced to continue improving the physical and social environments in our communities to help reduce the inequities in birth outcomes experienced by African American women and families by,

1. Identification of African American women who have worked with Neighborhood Navigator and/or participated in the Tenant Based Rental Assistance Program to participate on the SDOH Housing Team.
2. Conduct focus groups and/or survey the target population to gather current qualitative and quantitative data, in coordination with Stark Housing Network and other community partners.

Now that the family planning & adolescent health SDOH team is getting its footing, the team hopes to continue looking at upstream changes including improving the health of women before they become pregnant by,

1. Improving adolescent well visits
2. Providing local pediatricians information on discussing reproductive health with their patients
3. Explore peer talk options to get medically sound information to adolescents on reproductive health and prevention of STI's.

Data Tables-REDCap

Neighborhood Navigator Outcomes				
	NH White	NH Black	Other	Total
# Women screened	69	55	3	127
# Eligible women	69	55	3	127
# Eligible women served	69	55	3	127
# Needs identified	146	116	7	269
# Referrals made	144	112	7	263
% Needs met	99%	97%	100%	98%
# Referral utilized	143	110	7	260
% Referrals utilized	99%	98%	100%	99%

Clinical Referrals			
	Referrals Made	Referral Utilized	% Utilized
Prenatal Care	15	14	93%
Prenatal Support	125	121	97%
Smoking	7	7	100%
Mental Health Concerns	0	0	0%
Substance Abuse	0	0	0%
Total	147	142	97%

Social Referrals			
	Referrals Made	Referral Utilized	% Utilized
Baby items	1	1	100%
Clothing	0	0	0%
Education	1	1	100%
Food	0	0	0%
Health insurance	12	12	100%
Housing	7	6	86%
Safe sleep	93	90	97%
Transportation	4	4	100%
Utilities	0	0	0%
Car Seat	1	1	100%
Total	119	115	97%

Zip Code	# of Clients Served
44705	20
44707	15
44646	14
44706	11
44709	10
44601	9
44703	9
44710	9
44704	8
44708	6
44647	5
44711	2
44714	3
44720	1
44730	1
44614	1
44641	1
44688	1
44702	1

Data Tables-Stark County Birth Data

Stark County Births					
	2015	2016	2017	2018	2019
Overall	4180	4205	3990	4060	4094
NH Black Births	447	468	452	505	540
NH White Births	3514	3514	3310	3325	3319
Very Preterm (Less than 32 weeks gestation)					
	2015	2016	2017	2018	2019
All	58	75	69	69	54
NH Black	12	16	13	16	7
NH White	46	54	54	52	41
Preterm (Less than 37 weeks gestation					
	2015	2016	2017	2018	2019
All	411	407	381	407	382
NH Black	58	52	51	63	57
NH White	331	323	304	321	298
Very Low Birth Weight (Less than 1,500 g)					
	2015	2016	2017	2018	2019
All	54	63	60	71	52
NH Black	13	14	11	16	6
NH White	38	45	48	54	41
Low Birth Weight (1,500 g-2,499 g)					
	2015	2016	2017	2018	2019
All	270	288	266	309	287
NH Black	45	44	41	51	57
NH White	208	228	200	241	214

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Dahlin, S. G. (2016). Maternal tobacco use and extremely premature birth - a population-based cohort study. *BJOG*, 1938-1946. doi:10.1111/1471-0528.14213

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Priscilla Perez da Silva Pereira, M. F. (2017, May 1). Maternal Active Smoking During Pregnancy and Low Birth Weight in the Americas: A Systematic Review and Meta-analysis. *Nicotine & Tobacco Research*, 497-505. Retrieved from https://doi.org/10.1093/ntr/ntw228

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Analysis contained within this report were conducted by Jessica Boley, RD, LD THRIVE Epidemiologist I. At the time of this release (October 2020), 2019 death data was preliminary and subject to change. Birth and death data was accessed from ODH Data Warehouse. Final access for analysis 10/7/2020. "These data were provided by the Ohio Department of Health. The Department specifically disclaims responsibility for any analyses, interpretations or conclusions" OEI data accessed from ODH REDCap System. Final access for analysis 10/7/2020. "This work is funded either in whole or in part by a grant awarded by the Ohio Department of Health, Bureau of Maternal, Child and Family Health, Ohio Equity Institute 2.0 and as a sub-award of a grant issued by the Ohio Department of Health under the Ohio Equity Institute 2.0 grant, grant award # 7620011OE0220 and CFDA number 93.994."

Appendices

A. Logic Model
B. Neighborhood Navigator Tools
C. SDOH-Housing
    a. Team Charter
    b. Action Plan
    c. Policy/Practice change adoption
D. SDOH-Family Planning & Adolescent Health
    a. Team Charter
    b. Action Plan
    c. Policy/Practice change adoption
E. Stark County THRIVE Organization Chart

Are you pregnant or have a child under age 1? Do you know someone who is?

Stark County THRIVE

Public Health
Prevent. Promote. Protect.
Canton City Public Health
Stark County THRIVE

Our ***Neighborhood Navigator*** can connect you to the free services of a ***Community Health Worker (CHW)***.

If you are pregnant or if your child is under age 1—we can help!
A CHW can assist and support you with:

- food
- housing
- transportation
- clothing
- and baby items

Call Stark County THRIVE today! ***330-575-3048***

Elonda Williams 330-575-3048
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Stark County THRIVE

Canton City Public Health

Outreach Avenues - Tracking

	Main Avenue	Avenue Type	Organization Name	Contact Name	Contact Number	Date Contacted	Method of Contact	Result of Contact	Info re: Contact	Answer/ Notes	Tracking	
											# Screens at Visit	# Referrals to CHW
1									0			
2									0			
3									0			
4									0			
5									0			
6									0			
7									0			
8									0			
9									0			
10									0			
11									0			
12									0			
13									0			
14									0			
15									0			
16									0			
17									0			
18									0			
19									0			
20									0			
21									0			
22									0			
23									0			
24									0			
25									0			

				Tracking - Subsequent Visit Results			
Follow Up Date	Result/Notes	Frequency of Office Sit Ins	Next Sit In Date Scheduled	# Screens at Visit	# Referrals to CHW	Follow Up Date	Result/Notes

OE20
GMIS #7620011OE0220
Canton City Public Health (CCPH) - Stark County THRIVE
Logic Model

Activities

PC, EPI, NN
Participate in TA

PC
Admin of OEI 2.0

EPI
Assure quality of data in REDCap

EPI
Analyze local MCH and birth outcomes data

EPI
Analyze REDCap data

SDOH Team
Strengthen local SDOH team

NN
Identify barriers of clients

NN
Collection of client qualitative & quantitative data in REDCap

NN
Identification and engagement of priority population to needed clinical and social services

Update Resource Portfolio

Outputs

PC, EPI, NN
Increased participation in learning about CE and M&E

PC
Finalized work plans, logic model, M&E plan

PC, EPI
Monthly program reports and Quarterly /Annual Data Reports

EPI
Synthesis of NN, FIMR & local MCH and birth outcomes data

EPI
Data Dissemination

SDOH team
Information for Quarterly Data Reports

SDOH team
Action plan(s)

NN
Information for Quarterly Data Reports

NN
Connection of currently unserved women to needed clinical and social services

Outcomes

Short-Term One year

Improved understanding and use of monitoring and evaluation and community engagement strategies

Increased knowledge of birth outcomes and SDOH data

Increased engagement and collaborations amongst agencies/organizations

Adoption of policy and/or practice change that can improve SDOH

Increased use of clinical and social services for pregnant women

Mid-Term 2-4 years

Implementation of policy and/or practice change

Improvement in Social Determinates of Health

Improved birth outcomes amongst women served

Long-Term 5+ Years

Decrease disparities in Birth outcomes for Stark County Residents

Decrease disparities in Infant Mortality Rates in Stark County

Decrease rate of fetal deaths in Stark County

Achieve equity in infant mortality in Stark County

Public Health
Prevent. Promote. Protect.
Canton City Public Health
Stark County THRIVE

Rev. 5/2019

Stark County THRIVE

Appendix E11

Social Determinants of Health Team Charter

Team Name: Stark County THRIVE/OEI Social Determinants of Health Team- Housing **Version Date:** March 9, 2019 **Project Start Date: March 2019 Rev. October 2019 Rev. April 2020 Rev. June 2020 September 2020** **End Date: Ongoing**			
Meeting Schedule (set standing meeting days/time)	**Day of Week (Recurring): Thursday**	**Time/Duration:** 10:00 am - 11:30 am	**Location: Canton City Public Health**

Group Agreement (Ground Rules or Group Norms)	Project Outcome The process will be considered a success if: ▪ The Stark County THRIVE/OEI Social Determinants of Health Team establishes clear, consensus-based recommendations on the best alternatives to include THRIVE Action Plan; ▪ Project decisions fit into the context of the surrounding hot spot communities and recognize and respect the unique needs of the at-risk populations; ▪ The project schedule takes the least amount of time and makes the most effective use of limited project funding; ▪ Appropriate community representatives, partners, and funders are involved throughout the process to avoid surprises that lead to delays. Terms of membership A member's position on the Stark County THRIVE/OEI Social Determinants of Health Team may be declared vacant if the member: ▪ Resigns from the Stark County THRIVE/OEI Social Determinants of Health Team (this should be in writing and forwarded to the Stark County THRIVE Project Coordinator ▪ Fails to attend more than two meetings without prior notice In a case where a member's position is declared vacant, the Stark County THRIVE Project Coordinator may appoint an alternative representative from the same interest group to fill the position. Stark County THRIVE/OEI Social Determinants of Health Team Operating Guidelines <u>Convening of Meetings</u> ▪ Meetings will be held at the time and place chosen by the Stark County THRIVE/OEI Social Determinants of Health Team in the course of their meetings.

- It is anticipated that there will be twelve meetings until the Stark County THRIVE/OEI Social Determinants of Health Team members determine that quarterly meetings are sufficient to complete the Team's objectives.
- Stark County THRIVE/OEI Social Determinants of Health Team members will be informed of meetings through email or direct mail, depending on his/her preference, at least two weeks prior to the meeting.

<u>Communication</u>

- Email: Stark County THRIVE Project Coordinator should be copied on all correspondence, and if Stark County THRIVE Project Coordinator chooses to open a dialogue via email, all Stark County THRIVE/OEI Social Determinants of Health Team members will be copied.

<u>Conduct of meetings</u>

- Meetings will be open to all Stark County THRIVE/OEI Social Determinants of Health Team members.
- Meetings will be facilitated.
- Informed alternates are acceptable and encouraged if the Stark County THRIVE/OEI Social Determinants of Health Team member cannot attend.
- All cell phones will be turned off during the meetings.
- Meetings will end with a clear understanding of expectations and assignments for next steps.
- Meetings are expected to be one to two hours and not exceed three hours. Extension of time, in 15-minute increments, will require the consent of the majority of members attending that meeting. Consensus will be indicated with a show of hands.
- The Stark County THRIVE Executive Assistant will keep a record of meeting attendees, key issues raised, and actions required. Comments from individual members will generally not be attributed and a verbatim record of the meeting will not be prepared.

- The previous meeting record and a meeting agenda will be forwarded to members of the Stark County THRIVE/OEI Social Determinants of Health Team at least one week before the next meeting. Any changes to the record of the past meetings shall be in writing and forwarded to the Stark County THRIVE Executive Assistant and Stark County THRIVE Project Coordinator prior to the next meeting.

Meeting Ground Rules

- Speak one at a time – refrain from interrupting others.
- Wait to be recognized by facilitator before speaking.
- Facilitator will call on people who have not yet spoken before calling on someone a second time for a given subject.
- Share the oxygen – ensure that all members who wish to have an opportunity to speak are afforded a chance to do so.
- Maintain a respectful stance toward towards all participants.
- Listen to other points of view and try to understand other interests.
- Share information openly, promptly, and respectfully.
- If requested to do so, hold questions to the end of each presentation.
- Remain flexible and open-minded, and actively participate in meetings.

Roles and Responsibilities

THE Stark County THRIVE/OEI Social Determinants of Health Team is an advisory group to Stark County THRIVE Project Coordinator.

Stark County THRIVE/OEI Social Determinants of Health Team members agree to:

- Provide specific local expertise, including identifying emerging local issues;
- Review project reports and comment promptly;
- Attend all meetings possible and prepare appropriately;
- Complete all necessary assignments prior to each meeting;

- Relay information to their agency/organization leadership after each meeting and gather information/feedback as practicable before each meeting;
- Articulate and reflect the interests that Stark County THRIVE/OEI Social Determinants of Health Team members bring to the table;
- Maintain a focus on solutions that benefit the Stark County community;

Stark County THRIVE Project Coordinator and the Social Determinants of Health Team agree to:

- Provide Stark County THRIVE/OEI Social Determinants of Health Team members the opportunity to collaborate with other agencies and groups on making recommendations for the project;
- Effectively manage the scope, schedule and budget;
- Keep Stark County THRIVE/OEI Social Determinants of Health Team partners informed of progress;
- Provide documentation to support recommendations;
- Provide technical expertise;
- Brief local decision makers and produce briefing materials and reports;
- Provide early notification of Stark County THRIVE/OEI Social Determinants of Health Team meetings and provide ten working days to review and comment on technical reports and other documents;
- Conduct public meetings necessary to inform and engage the community; and
- Manage logistics for meetings.

Decision Making

The Stark County THRIVE/OEI Social Determinants of Health Team is primarily advisory. In those areas where it has some decision-making authority, members will strive to reach agreement by consensus at a level that indicates that all partners are willing to "live with" the proposed action. Partners will strive to work expeditiously and try to avoid revisiting decisions once made. If

	agreement cannot be reached on a particular issue, Stark County THRIVE/OEI Project Coordinator will retain final decision-making authority. Conflict Resolution When an issue arises that cannot be easily resolved, Stark County THRIVE/OEI Social Determinants of Health Team members agree to: ▪ Determine if the issue should be resolved within or outside of the Stark County THRIVE/OEI Social Determinants of Health Team and participate however is appropriate. ▪ Ensure the appropriate decision makers are at the table to resolve the issue.

Description (Define the Problem)
Pregnant women who experience housing concerns have increased maternal stress and are at higher risk for poor birth outcomes expressed by low weight and preterm births.

Team Sponsor: Stark County THRIVE OEI 2.0	**Team Leader:** Dawn Miller	
Team Members:	**Area of Expertise:**	**Team Role:**
Celeste Barnes	Program Manager - CommQuest's Homeless Prevention and Diversion Programs offer individuals who are precariously housed, have emergent housing incidents, or at imminent risk of homelessness case management and support services.	Member
Jennifer Keaton	Program Manager - Homeless Hotline management that provides 24-hour assistance, referring callers to appropriate shelters and other programs for the homeless or those at risk of homelessness after conducting an initial assessment interview.	Member
Marcie Bragg	Executive Director, Stark Housing Network Inc. The Network manages the Homeless Continuum of Care coalition comprised of various health and human service nonprofit organizations, government entities, and community leaders committed to addressing homelessness in Stark County, Ohio. All partner agencies share a vested interest in preventing and ending homelessness given its prevalence among and impact on their respective client populations.	Member

Rikki Kadri	Resident Services Coordinator, Stark Metropolitan Housing Authority. SMHA offers a wide variety of services and activities to assist residents with obtaining the needed tools and resources to facilitate self-sufficiency, success, and an improved quality of life. SMHA collaborates with various community agencies, to focus on education, safety, and health and wellness initiatives that benefit the full spectrum of the resident population.	Member
~~Lisa Seeden~~ Milistine Tatum	Director, Resident Support Services, Stark Metropolitan Housing Authority. SMHA offers a wide variety of services and activities to assist residents with obtaining the needed tools and resources to facilitate self-sufficiency, success, and an improved quality of life. SMHA collaborates with various community agencies, to focus on education, safety, and health and wellness initiatives that benefit the full spectrum of the resident population.	Member
Dawn Fish	Financial Manager, Department of Development and Planning, City of Canton	Member
Rollin Seward	Director, Department of Development and Planning, City of Canton	Member
Aaron Wagster	Supportive Services Manager, ICAN Housing	Member
John Petit	Managing Attorney, Community Legal Aid Oversees Health, Education, Advocacy and Law Project. A partnership between Community Legal Aid and Stark County THRIVE to help patients overcome legal problems that are getting in the way of their health. A medical-legal partnership allows for a holistic look at the personal legal issues that impact a patient's or population's health. These impacts may be housing, education, employment, domestic violence, income stability, and access to care.	Member

Stacy Kelly	Supervisor, Access Health Stark County Oversees CHW who will be implementing Tenant Based Rental Assistance with clients	
Cathy Jennings	CEO, YWCA Canton Shelter and supportive housing services Oversees CHW who will be implementing Tenant Based Rental Assistance with clients	
Cindy Linger	Director, Access Health Stark County	
~~Marcy Smith~~ Position is currently vacant but once CHW is hired she will serve clients enrolled in TBRA program.	CHW, YWCA Canton CHW who will be implementing Tenant Based Rental Assistance with clients	
Draya Ellis	CHW, Access Health Stark County CHW who will be implementing Tenant Based Rental Assistance with clients	
Isaac Baez	Cultural Diversity and Inclusion Coordinator Stark MHAR	
Latoya Young	Cultural Ally – African American community Stark MHAR	
Dawn Miller	Stark County THRIVE OEI Project Coordinator	Team Leader, Monitoring and Evaluation and Reporting
~~Sandy Marinchick~~	~~Stark County THRIVE HUB Manager~~	
Danielle Grimm	Stark County THRIVE Executive Assistant	
~~Elonda Williams~~	~~Stark County THRIVE Neighborhood Navigator~~	

Baseline Data: Homeless Hotline, Stark Metropolitan Housing Authority, Rapid Rehousing Providers, Permanent Supportive Housing Providers, Emergency Shelters, Domestic Violence Shelters, Care Coordination Systems data will be gathered.

AIM Statement (Specific and Measurable Performance Improvement Goal):
(Measure of change) + (in what) + (by whom) + (by when)
Decrease the impact of housing related concerns experienced during pregnancy creating maternal stress which lead to low birth weight and preterm births by September 30, 2020.

Scope (Boundaries – Define where the process being improved starts and ends):
1. By ~~March 1,~~ July 1, 2020 the tenant-based housing support program for pregnant women will be developed and begin serving pregnant women. --- In progress and implementation date revised due to COVID 19.
September 2020 UPDATE: Finalized policy and protocol for TBRA program.

2. Ongoing: Continue to monitor the outcomes of the new homeless hotline protocol for referrals to

Neighborhood navigator and evaluate the impact of the services provided. Determine if changes should be made to improve the referrals.

3. By May 30, 2020 plans will be developed with Child Protective Services, Courts, Stark County Jail, and Community Legal Aid for identifying housing needs and referrals of pregnant women to the Neighborhood Navigator.
September 2020 UPDATE: This objective was not completed during OE20 but will be included in OE21 objectives/action plan.

Customers (primary and other/internal and external):	**Customer Needs to Be Addressed/Benefits to Them: (Consider efficiency and effectiveness benefits.)**
Pregnant women	
Women with a child under age 1	
Housing providers	
Social Service agencies	
Court System, Sheriff's Office, Police Departments and Community Legal Aid	

Available Resources:	**Additional Resources Required:**
SDOH Team members with existing relationships	Pregnant women experiencing or who have experienced housing barriers serving on the SDOH Team.

Key Milestones:		**Start Date:**	**Tools Used/Action Taken:**	**End Date:**
PLAN	Convening of SDOH Housing Team and identification of action plan targets.	3/7/2019	Community Advisory Committee meeting minutes documenting selection of SDOH focus areas.	Ongoing

Communication Plan (List how communication of changes will be made to stakeholders and how learning will be shared.)	**Who**	**How**	**When**
	Stark County THRIVE OEI	Canton City Board of Health Reports Canton City Public Health Leadership Team report Funder reports Community Advisory Committee Presentations Community and Partner Appreciation Breakfast Community Health Improvement Plan Update Media releases, radio interviews and newspaper	Quarterly and Annually
	Stark Housing Network	TBD	TBD
	Stark Metropolitan Housing Authority	TBD	TBD
	Stark MHAR	TBD	TBD
	CommQuest Services	TBD	TBD
	Stark County Sheriff's Office	TBD	TBD
	Court System	TBD	TBD
	Community Legal Aid	TBD	TBD

	Community partners e.g. businesses, neighborhood associations, churches	TBD	TBD

Appendix E12

Social Determinants of Health Action Plan Template

OEI Local Social Determinants of Health Team Action Plan
TEAM: HOUSING
The State Action Plan Template may be modified to meet your needs. (Ex. add rows and copy additional tables if you have more than 3 milestones)

UPDATED April 2020 June 2020 September 2020

Step 1: Defining Initial Strategies	
1. Describe each of your team's top 3 activities/strategies below. 2. Brainstorm the leading strengths and assets your team and larger community have to carry out each strategy. 3. List the barriers your team may encounter in carrying out these action steps. 4. Identify the "so what?" of your strategy.	
Strategy #1 Keyword(s): Flowchart of Housing Options: September: Eliminated from plan	
1-2 Sentence Description: Flowchart will define housing options and include specific questions that will guide user in accessing needed services and supports. Flowchart to be used by social service staff as guide for assessing clients "actual" housing stability status.	
Leading Strengths & Assets: Housing program staff on SDOH team.	**Major Barriers:** None at this time.
What will change as a result of this strategy? Increased community awareness of various housing options best suited for particular situation. Increased knowledge of specific questions to be asked that will increase social service staff's ability to assess their clients "actual" housing stability status and guide appropriate avenues for support. Increased access to stable housing for pregnant women reducing maternal stress and improved birth outcomes.	
Strategy #2 Keyword(s): Stark County Homeless Hotline protocol for pregnant women- Completed	
1-2 Sentence Description: Review process for intake and assessment of callers to hotline who do not move to screening phase for housing supports. At this time only those who meet criteria for housing are screened during the screening pregnancy status would be identified and a referral to Neighborhood Navigator is made.	
Leading Strengths & Assets: Housing program staff on SDOH team	**Major Barriers:** Customer/client representation on SDOH Team; Existing protocol; other social service agencies requesting additional intake questions be added to intake process; hotline capacity.
What will change as a result of this strategy? Increased identification of pregnant women who would benefit from referral to Neighborhood Navigator.	
Strategy #3 Keyword(s): Stark Metropolitan Housing Authority Intake Process – SMHA declined to change process, PC will revisit this strategy with SMHA Director February 2020 September: Removed from Plan	
1-2 Sentence Description: Revision of intake process to include proof of pregnancy to prioritize for housing placement.	
Leading Strengths & Assets: SMHA on SDOH Team	**Major Barriers:** Operational process; online intake system

What will change as a result of this strategy?
Increased identification, prioritization, and expedited housing placement of pregnant women

Strategy #4 Keyword(s): Child Protective Services, Courts, Stark County Sheriff's Office, Community Legal Aid	
1-2 Sentence Description: Prioritize pregnant women involved with CPS, Courts, Stark County Sheriff's Office, and Community Legal Aid for addressing housing needs upon re-entry into community, reunification with children, and those with previous evictions to obtain stable housing and connection to Neighborhood Navigator.	
Leading Strengths & Assets: SDOH Team members relationships with CPS, Court system, Sheriff's Office and Community Legal Aid	**Major Barriers:** Lack representation from customer/client, CPS, Court system, Sheriff's Office and Community Legal Aid on SDOH Team
What will change as a result of this strategy? Increased access to stable housing for pregnant women reducing maternal stress and improved birth outcomes. Increase court and Sheriff's Office outlet for identifying housing and social service connections to address social determinants of health needs for pregnant women while decreasing recidivism.	

Step 2: Creating an Action Plan			
List the action steps needed to carry out each identified strategy. Determine clear, realistic and measurable results from doing these action steps. Identify by when you will complete these action steps and who is responsible to assure completion.			
Strategy #1 Keyword(s) Flowchart of Housing Options			
Action Steps	**Expected Results**	**By When**	**Who is Responsible**
Develop survey questions	Survey will be created for use	March 14, 2019 Completed	SDOH Team members
Contact THRIVE community health workers and staff of WIC, Moms & Babies 1st and Help Me Grow to ascertain the questions they ask of their clients to assess housing status.	Responses will be documented	March 22, 2019 Completed	Neighborhood Navigator
Results of survey responses will be reviewed by SDOH team	Development of Flowchart and messaging prompts for use by direct care staff working with pregnant women.	April 4, 2019 Completed	SDOH Team members
Create training plan for use by social service agencies to introduce flowchart and messaging to clients.	Social service agencies will be more informed about available housing options and how to guide clients in accessing them.	~~August 1, 2019~~ ~~June 2020~~ September: Removed from plan	SDOH Team members
Develop outreach plan for connecting with social service agencies regarding Flowchart availability.	Social service agencies will be more informed about available housing options and how to guide clients in accessing them.	~~September 1, 2019~~ ~~July 2020~~ September: Removed from	SDOH Team members
Create evaluation plan to assess use of flowchart by social service agencies.	Social service agencies will be more informed about available housing options and how to guide clients in accessing them.	~~August 1, 2019~~ ~~June 2020~~ September: Removed from plan	SDOH Team members

Strategy #2 Keyword(s) Stark County Homeless Hotline protocol for pregnant women			
Action Steps	**Expected Results**	**By When**	**Who is Responsible**
Discuss with leadership of Homeless Hotline change in intake process to include question on pregnancy status.	Willingness and ability to change intake process.	May 1, 2019 Completed	Jennifer Keaton
Identify and recruit client/customer to participate on SDOH Team	Information from individual who has experienced housing barriers will inform SDOH Team next steps.	July 1, 2019 March 2020 September: Will continue in OE21	SDOH Team members
Move forward with change to intake process.	Add question about pregnancy status to intake.	September 30, 2019 Implemented	SDOH team and additional homeless hotline staff
Develop and implement training on intake process change with homeless hotline staff.	Increase identification of pregnant women and referrals to Neighborhood Navigator.	September 30, 2019 Implemented	SDOH team and additional homeless hotline staff
Monitor data to determine # women identified, # referred, and # screened by NN	Increase identification of pregnant women and referrals to Neighborhood Navigator.	Ongoing throughout grant period and into OE21	SDOH team
Strategy #3 Keyword(s) Stark Metropolitan Housing Authority Intake Process			
Action Steps	**Expected Results**	**By When**	**Who is Responsible**
Discuss with SMHA leadership the feasibility of making change to system prioritizing pregnant women.	Willingness and ability to change intake process.	April 4, 2019 Completed	SMHA Resident Services Manager
Develop and implement training on new intake process with SMHA staff.	Add question about pregnancy status to online application.	TBD based on IT availability to make change. SMHA Administration not able to make change.	SMHA Resident Services Manager
~~Collect data to establish a baseline~~	Monitor and evaluate process change in increasing housing placement of pregnant women.	September 30, 2019	SDOH Team members
Revisit opportunity to implement question on pregnancy status as part of housing application	Willingness and ability to change intake process.	July 2020 Removed from plan; SMHA not able to make change.	Project Coordinator and SMHA Housing

Strategy #4 Keyword(s) Child Protective Services, Courts, Stark County Sheriff's Office, Community Legal Aid. September: Continue into OE21 Plan.			
Action Steps	**Expected Results**	**By When**	**Who is Responsible**
Contact to CPS, Courts, Stark County Sheriff's Office and Community Legal Aid	Determine if there is interest by each agency to participate in SDOH. Increased engagement and collaboration among agencies has been increased because of increased knowledge of birth outcomes and the SDOH team's areas of focus being addressed.	May 1, 2019 Community Legal Aid joined Housing team in October 2019. 9/30/2020 Continue outreach to CPS, Courts and law enforcement	SDOH Team members
Identify and recruit client/customer to participate on SDOH Team	Information from individual who has experienced housing barriers will inform SDOH Team next steps.	July 1, 2019 June 2020 Stark MHAR Cultural Ally to the Africa American community has been invited and has accepted invitation to join Housing SDOH team.	SDOH Team members
Identify and recruit individuals from CPS, Courts, Stark County Sheriff's Office and Community Legal Aid to participate on SDOH Team	Information from agencies will inform SDOH Team next steps.	~~July 1, 2019 Community Legal Aid joined Housing team in October 2019.~~ 9/30/2020 Continue outreach to CPS, Courts and law enforcement	SDOH Team members
Collect baseline data from CPS, Courts, Sheriff's Office and Community Legal Aid	Data will inform extent of need	~~July 1, 2019~~ ~~July 1, 2020~~ Continue into OE21.	SDOH Team members
Discuss how existing processes can be improved to facilitate pregnant women being supported to obtain and maintain stable housing and connection with Neighborhood Navigator.	Increase identification of pregnant women and referrals to Neighborhood Navigator to reduce recidivism and maintain stable housing. In process: PC and CLA finalizing protocol for referrals	~~September 30, 2019~~ March 2020 COMPLETED	SDOH Team members

Create next steps for addressing needs of pregnant women involved with CPS, Courts, Sheriff's Office ~~and Community Legal Aid.~~	Increase identification of pregnant women and referrals to Neighborhood Navigator to reduce recidivism and maintain stable housing.	September 30, 2019 June 2020 September 2020: Moved into OE21.	SDOH Team members and representative from CPS, Courts, Sheriff's Office ~~and Community Legal Aid~~.

Strategy #4: Tenant based rental assistance program for pregnant women working with a THRIVE CHW			
Design program	Increase stable housing for pregnant women through tenant-based rental assistance program and support from CHW	March 2020 COMPLETE	SDOH Team & YWCA Director
Identify pregnant women working with THRIVE CHW who are precariously housed	Increase stable housing for pregnant women through tenant- based rental assistance program and support from CHW	May 2020: In process September 2020: Clients enrolled and strategy will be continued into OE21.	SDOH Team & YWCA Director, NN, and THRIVE CHW

Public Health
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Canton City Public Health
Stark County THRIVE

OEI 2.0 Stark County THRIVE Social Determinants of Health Housing Team

Program change identified
Individuals contacting the homeless hotline for services were not prescreened to determine pregnancy status or if they had a child under age 1.

Program change implemented
As of July 1, 2019 the Stark County Homeless Hotline's protocol to prescreen callers for homeless network services has been changed to ask: Are you pregnant or have a child under age 1? If caller answers yes the Intake Specialist describes the services of Stark County THRIVE and asks for verbal permission to make a referral to the Neighborhood Navigator. Once verbal consent is obtained a referral form is completed and sent to Stark County THRIVE for follow up contact by the Neighborhood Navigator.

The Stark County Homeless Hotline is a department of the Stark County Mental Health & Addiction Recovery, the Hotline operates 24 hours per day, referring callers to appropriate shelters and other programs for the homeless or those at risk of homelessness after conducting an initial assessment interview. The Hotline maintains a current listing of available shelter beds throughout Stark County and works with mental health agencies, hospitals, law enforcement, alcohol and drug treatment centers and the courts to assist clients in need of shelter, homeless prevention services or other social service supports. Stark Housing Network manages the Homeless Continuum of Care of Stark County (HCCSC). HCCSC is a coalition of various health and human service nonprofit organizations, government entities, and community leaders committed to addressing homelessness in Stark County, Ohio. All partner agencies share a vested interest in preventing and ending homelessness given its prevalence among and impact on their respective client populations.

Goal: Improve birth outcomes and infant vitality by increasing identification and referral of pregnant women and women with a child under age 1 to THRIVE Neighborhood Navigator via Stark County Homeless Hotline.

Objective: By October 31, 2019, establish baseline using data collected during July, August, and September 2019.

This program change was accepted by:

Marcie Bragg

Marcie Bragg, Executive Director
Stark Housing Network, Inc.

9/26/2019

Date

Dawn Miller

Dawn Miller, THRIVE Project Manager

10-4-19

Date

Appendix E11

Social Determinants of Health Team Charter

Team Name: Stark County THRIVE/OEI Social Determinants of Health Team-Family Planning/Adolescent Health **Version Date:** April 28, 2018 (initial) December 3, 2019 (revision) January 10, 2020 (revision) June 2020 (revision) September 2020(revision) **Project Start Date: January 1, 2019** **End Date:**			
Meeting Schedule (set standing meeting days/time)	**Day of Week (Recurring):** Third Tuesday of every month	**Time/Duration:** 9:00 am to 10:30 am	**Location:** Stark County THRIVE office

Group Agreement (Ground Rules or Group Norms)	**Project Outcome** The process will be considered a success if: The Stark County THRIVE/OEI Social Determinants of Health Team establishes clear, consensus-based recommendations on the best alternatives to include THRIVE Action Plan; • Project decisions fit into the context of the surrounding hot spot communities and recognize and respect the unique needs of the at-risk populations; • The project schedule takes the least amount of time and makes the most effective use of limited project funding; • Appropriate community representatives, partners, and funders are involved throughout the process to avoid surprises that lead to delays. **Terms of membership** A member's position on the Stark County THRIVE/OEI Social Determinants of Health Team may be declared vacant if the member: • Resigns from the Stark County THRIVE/OEI Social Determinants of Health Team (this should be in writing and forwarded to the Stark County THRIVE Project Coordinator) • Fails to attend more than two meetings without prior notice In a case where a member's position is declared vacant, the Stark County THRIVE Project Coordinator may appoint an alternative representative from the same interest group to fill the position. **Stark County THRIVE/OEI Social Determinants of Health Team Operating Guidelines** **<u>Convening of Meetings</u>** • Meetings will be held at the time and place chosen by the Stark County THRIVE/OEI Social Determinants of Health Team in the course of their meetings. • It is anticipated that there will be twelve meetings until the Stark County THRIVE/OEI Social Determinants of Health Team members determine that quarterly meetings are sufficient to complete the Team's objectives. • Stark County THRIVE/OEI Social Determinants of Health Team members will be informed of meetings through email or direct mail, depending on his/her preference, at least two weeks prior to the meeting. **<u>Communication</u>** • Email: Stark County THRIVE Project Coordinator should be copied on all correspondence, and if Stark County THRIVE Project Coordinator chooses to open a dialogue via email, all Stark County THRIVE/OEI Social Determinants of Health Team members will be copied.

Conduct of meetings

- Meetings will be open to all Stark County THRIVE/OEI Social Determinants of Health Team members.
- Meetings will be facilitated.
- Informed alternates are acceptable and encouraged if the Stark County THRIVE/OEI Social Determinants of Health Team member cannot attend.
- Meetings will end with a clear understanding of expectations and assignments for next steps.
- Meetings are expected to be one to two hours and not exceed three hours. Extension of time, in 15 minute increments, will require the consent of the majority of members attending that meeting. Consensus will be indicated with a show of hands.
- The Stark County THRIVE Executive Assistant will keep a record of meeting attendees, key issues raised, and actions required. Comments from individual members will generally not be attributed and a verbatim record of the meeting will not be prepared.
- The previous meeting record and a meeting agenda will be forwarded to members of the Stark County THRIVE/OEI Social Determinants of Health Team at least one week before the next meeting. Any changes to the record of the past meetings shall be in writing and forwarded to the Stark County THRIVE Executive Assistant and Stark County THRIVE Project Coordinator prior to the next meeting.

Meeting Ground Rules

- Speak one at a time – refrain from interrupting others.
- Share the oxygen – ensure that all members who wish to have an opportunity to speak are afforded a chance to do so.
- Maintain a respectful stance toward towards all participants.
- Listen to other points of view and try to understand other interests.
- Share information openly, promptly, and respectfully.
- If requested to do so, hold questions to the end of each presentation.
- Remain flexible and open-minded, and actively participate in meetings.

Roles and Responsibilities

The Stark County THRIVE/OEI Social Determinants of Health Team is an advisory group to Stark County THRIVE Project Coordinator.

Stark County THRIVE/OEI Social Determinants of Health Team members agree to:

- Provide specific local expertise, including identifying emerging local issues;
- Review project reports and comment promptly;
- Attend all meetings possible and prepare appropriately;
- Complete all necessary assignments prior to each meeting;
- Relay information to their agency/organization leadership after each meeting and gather information/feedback as practicable before each meeting;
- Articulate and reflect the interests that Stark County THRIVE/OEI Social Determinants of Health Team members bring to the table;
- Maintain a focus on solutions that benefit the Stark County community.

Stark County THRIVE Project Coordinator and the Social Determinants of Health Team agree to:

- Provide Stark County THRIVE/OEI Social Determinants of Health Team members the opportunity to collaborate with other agencies and groups on making recommendations for the project;
- Effectively manage the scope, schedule and budget;
- Keep Stark County THRIVE/OEI Social Determinants of Health Team partners informed of progress;
- Provide documentation to support recommendations;
- Provide technical expertise;
- Brief local decision makers and produce briefing materials and reports;
- Provide early notification of Stark County THRIVE/OEI Social Determinants of Health Team meetings and provide ten working days to review and comment on technical reports and other documents;
- Conduct public meetings necessary to inform and engage the community;
- Manage logistics for meetings.

Decision Making

- The Stark County THRIVE/OEI Social Determinants of Health Team is primarily advisory. In those areas where it has some decision-making authority, members will strive to reach agreement by consensus at a level that indicates that all partners are willing to "live with" the proposed action. Partners will strive to work expeditiously and try to avoid revisiting decisions once made. If agreement cannot be reached on a particular issue, Stark County THRIVE/OEI Project Coordinator will retain final decision-making authority.

Conflict Resolution

When an issue arises that cannot be easily resolved, Stark County THRIVE/OEI Social Determinants of Health Team members agree to:

- Determine if the issue should be resolved within or outside of the Stark County THRIVE/OEI Social Determinants of Health Team and participate however is appropriate.
- Ensure the appropriate decision makers are at the table to resolve the issue

Description (Define the Problem) Mothers who have an STI during pregnancy are at an increased risk of delivering a low birth weight baby/premature baby.

Team Sponsor: Stark County THRIVE OEI 2.0	**Team Leader:** Jessica Boley	
Team Members:	**Area of Expertise:**	**Team Role:**
1. Matthew Lytle	Fatherhood Coalition, Job & Family Services	Member
2. Shauna Shell	Managed Care plans	Member
3. Christine Frank	Early childhood development	Member
4. Ashlee Wingerter	Staff nurse, Stark County Health Department	Member
5. Dr. Amy Lakritz	Pediatrics	Member
6. Remel Moore	Community partner	Member
7. Cari Lewis	Catholic Charities, non-profit	Member
8. Courtney Wright	Dietitian, Stark County Health	Member
9. Kelly Potkay	Health Educator, Stark County Health Department	Member
10. David McCartney	Early Intervention Specialist/HIV Prevention Team, CCPH	Member
11. Amanda Archer	Epidemiologist II	Epi support
12. Dawn Miller	Program management	Project Coordinator
13. Sarah Thomas	MPH Student	Intern

Baseline Data: In Stark County, there were 4091 births to residents in 2019. Of these, 738 (18%) had at least 1 STI present and/or treated during the pregnancy. Mothers who worked with a Pathways HUB CHW accounted for 148 of the overall births with 22 (15%) having an STI. In the first 6 months of 2020, of the 1863 births, 336 (18%) had at least 1 STI present and/or treated during the pregnancy. Mothers who worked with a Pathways HUB CHW accounted for 77 of the overall births, of which 15 (20%) had an STI. Nationally per YRBSS, in 2017 39.5% of youths between 9th-12th grade have ever had sexual intercourse, with 3.4% having sex before the age of 13. The percentage of those who used a condom during their last sexual encounter has been decreasing since 2005 to 53.8%. In Ohio, from 2013, 42.7% of youths between 9th-12th grade have ever had sexual intercourse, with 3.7% having sex before the age of 13. The percentage of Ohio youths who did not use a condom during their last sexual encounter is 49.2%. 2013 is the most recent Ohio data available.

Nationally per HP2030, 78.7% of adolescents aged 12-17 received 1 or more preventative health care visits in the past 12 months (2016-2017) while the target is 82.6%. Nested within this goal is to increase the proportion of adolescents who speak privately with a physician or other health care provider during a preventative medical visit. Baseline data 38.4% of adolescents aged 12-17 spoke privately with a physician or other health care provider with a target of 43.3%.

AIM Statement (Specific and Measurable Performance Improvement Goal):
(Measure of change) + (in what) + (by whom) + (by when)
Decrease in the percentage of births to mothers with an STI present and/or treated during the pregnancy in mothers who work with a Pathways HUB CHW to 13% by October 1, 2021.

Scope (Boundaries – Define where the process being improved starts and ends):
Process begins by gathering local data to identify gaps. Process ends when programs/policies are in place to overcome gaps identified.

Customers (primary and other/internal and external):	**Customer Needs to Be Addressed/Benefits to Them: (Consider efficiency and effectiveness benefits.)**
Pathways HUB Community Health Workers	Improved knowledge on family planning, birth control & STI topics.
Adolescents and youths in Stark County	Improved curriculum and dialogue between parents/caregivers on adolescent health topics
Available Resources: Partners for a Healthy Baby Curriculum National YRBS data from 2017	**Additional Resources Required:** Quarterly reporting of education data from Pathways HUB

Key Milestones:		**Start Date:**	**Tools Used/Action Taken:**	**End Date:**
PLAN	Adoption of policy/practice change for CHW's working with in the Pathways HUB	6/2020	Used VS data and pathways HUB data. Formal adoption of a policy/practice change.	9/30/2020
	Implementation of policy/practice change for CHW's	10/1/2020	Survey results, CHW curriculum	12/31/2020
	Begin monitoring data on a quarterly basis	1/1/2021		continuous
	Identify a policy/practice change focused on adolescent health	12/31/2020		TBD
	Adopt a policy/practice change focused on adolescent health	TBD		TBD

Communication Plan (List how communication of changes will be made to stakeholders and how learning will be shared.)	**Who**	**How**	**When**
	SDOH team	Quarterly one pager with monitoring data	Quarterly
	ODH	Monthly & Quarterly Reporting	As required
	THRIVE Advisory Board	Quarterly one pager with monitoring data	Quarterly

Appendix E12

Social Determinants of Health Action Plan Template

OEI Local Social Determinants of Health Team Action Plan TEAM:
Family Planning

The State Action Plan Template may be modified to meet your needs. (Ex. add rows and copy additional tables if you have more than 3 milestones)

Step 1: Defining Initial Strategies	
1. Describe each of your team's top 3 activities/strategies below. 2. Brainstorm the leading strengths and assets your team and larger community have to carry out each strategy. 3. List the barriers your team may encounter in carrying out these action steps. 4. Identify the "so what?" of your strategy.	
Strategy #1 Keyword(s): Surveying parents on AH/FP	
1-2 Sentence Description: Surveying the public to see when/what/if they are talking about topics associated with reproductive health and family planning/risks of unprotected sex	
Leading Strengths & Assets: Epi/research support from Amanda A. and David M.	**Major Barriers:** Nothing has been done like this before.
What will change as a result of this strategy? Better understanding of what is being discussed by assessing where Stark County is currently, we can then look at evidence-based programs that can help to fill that gap.	
Strategy #2 Keyword(s): Improve CHW's knowledge of family planning/STI services provided by managed care plans	
1-2 Sentence Description: Creation of a handout that contains a table of the common managed care plans our clients are enrolled with to show what family planning/STI prevention services they offer.	
Leading Strengths & Assets: Representation from the managed care plans on various THRIVE committees	**Major Barriers:** Will need to get buy in from CHW's and those training CHW's.
What will change as a result of this strategy? Improved understanding of services by CHW's and improved communication of those topics by CHW's.	
Strategy #3 Keyword(s): Improve discussion of birth control and STI prevention before, during and after pregnancy by CHW's.	
1-2 Sentence Description: Survey CHW's to see if they are talking about birth control and STI prevention before, during and after pregnancy. By determining what is being discussed and when, additional education and training can be provided.	
Leading Strengths & Assets: Access to CHW's and trainers	**Major Barriers:** Will need to get buy in from CHW's and those training CHW's.
What will change as a result of this strategy? Improved discussion and documentation of education regarding these topics for clients who work with a CHW.	

Strategy #4 Keyword(s):	
1-2 Sentence Description:	
Leading Strengths & Assets:	**Major Barriers:**
What will change as a result of this strategy?	

Step 2: Creating an Action Plan			
1. List the action steps needed to carry out each identified strategy. 2. Determine clear, realistic and measurable results from doing these action steps. 3. Identify by when you will complete these action steps and who is responsible to assure completion.			
Strategy #1 Keyword(s) Surveying parents on AH/FP			
Action Steps	**Expected Results**	**By When**	**Who is Responsible**
1. Creation of a survey	A starting number for comparison	6/12/2019	Team input
2. Finalization of survey	Have committee test out survey on forms	8/14/2019	Team
3. Submit IRB Application	Approved IRB to continue process	1/14/2020	Jessica Boley Amanda Archer David McCartney
4. Execute survey	Allow for responses	2/2020	Jessica Boley
5. Outreach for better exposure of survey	Increase the number of potential respondents	2/2020-3/2020	Team
6. Analyze results	Better understanding and a report to stakeholders and public	8/2020	Jessica Boley Amanda Archer David McCartney
7. Identification of gaps in community	Will show what area we can look to for a program implementation	8/2020	Team
Strategy #2 Keyword(s) Improve CHW's knowledge of family planning/STI services provided by managed care plans			
Action Steps	**Expected Results**	**By When**	**Who is Responsible**
1. Discuss plan with HUB manager and/or HUB coordinator	Get agreement to execute intervention	8/5/2020	Jessica Boley
2. Determine top 3-4 managed care plans utilized by CHW clients	Guidance for which plan should be included on the table	8/10/2020	Jessica Boley

3. Determine what common family planning/STI prevention services are provided by the managed care plans	Guidance for what services should be included on the table	8/15/2020	Jessica Boley Shauna Shell
4. Pull together a complete table to be reviewed by managed care plans	A cohesive quick reference guide	8/31/2020	Jessica Boley
5. Have managed care plans present to CHW's at a training	Better understanding of services provided	9/30/2020	Sandy Marinchick
6. Share the handout with CHW's & get a signed agreement that they will utilize the sheet for all clients they work with	Measurable agreement for utilization of sheet	10/30/2020	Sandy Marinchick Jessica Boley
7. Make the sheet part of the training process for new CHW's	Will get new CHW's on the right foot of using it as a reference guide	As needed	Sandy Marinchick
8. Review sheet annually for changes in coverage.	Will ensure the handout is up to date and correct information is given	Annually	TBD
Strategy #3 Keyword(s) Improve discussion of birth control and STI prevention before, during and after pregnancy by CHW's.			
Action Steps	**Expected Results**	**By When**	**Who is Responsible**
1. Discuss plan with HUB coordinator	Get agreement to execute intervention	8/5/2020	Jessica Boley
2. Draft an initial survey to survey CHW's on what topics they discuss and when	A quick survey to get a baseline on what topics need to be focused on	8/15/2020	David McCartney, Sarah Thomas (Intern)
3. Execute survey	Completed survey results by CHW's	8/31/2020	Jessica Boley, Sarah Thomas (Intern)
4. Analyze results from survey to determine focus	An understanding of gaps in education provided to clients	9/15/2020	Jessica Boley Sarah Thomas (Intern)
5. Review CHW curriculum to pull out education on topics that aren't being discussed	Pinpoint where in the curriculum the information is discussed	9/30/2020	Sarah Thomas (Intern)
6. Reinforce education curriculum that fills the gaps on birth control and STI prevention topics	Increase in education documentation on topics by CHW's	10/30/2020	Jessica Boley CHW trainer
7. Track changes in number of educations provided on birth control and STI prevention by CHW's	Improved understanding by CHW's and clients served on importance of birth control and STI prevention	FY21 grant cycle	Jessica Boley Pathways HUB staff
Strategy #4 Keyword(s)			
Action Steps	**Expected Results**	**By When**	**Who is Responsible**

Public Health
Prevent Promote Protect

Canton City Public Health
Stark County THRIVE

OEI 2.0 Stark County THRIVE Social Determinants of Health-
Family Planning & Adolescent Health Committee

Problem identified:
In Stark County, mothers who have at least one sexually transmitted infection (STI) present and/or treated during the pregnancy are 1.7 times more likely to have a baby born under 1,500 grams (data from ODH secure data warehouse, 2013-2017 data included in Perinatal Periods of Risk analysis).

Adoption:
From Fall 2016-April 2020, Community Health Workers (CHW's) funded through Stark County THRIVE Pathways HUB served 341 Black mothers during their pregnancy. Stark County THRIVE-OEI will work with the Pathways HUB to assess current knowledge of the CHW's on family planning, birth control, STI's and utilize qualitative data to understand barriers to discussing these topics with their clients. OEI will work to develop additional training to fill gaps and reinforce knowledge. After the training, a post-assessment will be conducted to see if knowledge improved. OEI will continue to work with the Pathways HUB to determine if there is an increase in education of these topics by the CHW's with the clients served.

Goal:
Improved training and knowledge of CHW's on family planning, birth control options, and STI's in order to allow them to become more comfortable in discussing these topics with mothers they are working with. By increasing knowledge and improving discussions on these topics with mothers (pregnant or maternal), we would hope to see a decrease in number of STI's in the population served and an increase in education provided to clients on these topics. This will allow moms who are currently pregnant to better protect themselves against an STI during the pregnancy and allow mothers who are not currently pregnant to make sound choices to protect themselves.

Monitoring:
Phase 1: Documentation of the number of CHW's trained. Analysis of pre/post assessment data.
Phase 2: Quarterly monitoring of education provided by CHW's on topics discussed in training.

This program change was accepted by:

Sandy Marinchick 9/30/20	Dawn Miller 9/29/2020	RDLD 9/29/2020
Sandy Marinchick Date	Dawn Miller, MBA Date	Jessica Beley, RD, LD Date
THRIVE Pathways HUB Manager	THRIVE Project Manager	THRIVE Epidemiologist

420 Market Ave. N., Canton, OH 44702
Phone 234-410-3087 Fax 330-489-3335 www.CantonHealth.org/THRIVE

FUNDERS

City of Canton, Department of Community Development
HealthPath Foundation
Ohio Department of Health
Ohio Department of Medicaid
Ohio Health Plans: Buckeye, CareSource, Molina, Paramount, UnitedHealthcare
Sisters of Charity Foundation of Canton
Stark Community Foundation
United Way of Greater Stark County

COMMUNITY PARTNERS / REFERRING AGENCIES

2-1-1 United Way of Greater Stark County
Abide Ministries-New Baltimore Community Church
Access Health Stark County
Akron Children's Hospital
Alliance City Health Department
Alliance Family Health Center
Alliance Pregnancy Center
Aultman Alliance Community Hospital
Aultman Hospital
Beacon Charitable Pharmacy
Buckeye Health Plan
Canton Calvary Mission
Canton City School District
CareSource
Catholic Charities
CommQuest
Community Legal Aid
Direction Home
Domestic Violence Project
Early Childhood Education Alliance
Early Childhood Resource Center
Eva Women's Clinic
Family Empowerment Ministries
George Dunwoody Foundation
Hannah's House 119
JRC, Inc.
Mary Church Terrell Federated Club
Massillon City Health Department
My Community Health Center
Ohio Guidestone
Ohio Means Jobs
Paramount Health Care
Perry Local School District
Pregnancy Choices
Salvation Army
Stark Community Support Network
Stark County Community Legal Aid
Stark County Department of Job and Family Services
Stark County District Library
Stark County Health Department
Stark County Homeless Hotline
Stark County TASC, Inc.
Stark County WIC Clinics
Stark Mental Health & Addiction Recovery
Stark Metropolitan Housing Authority
The Ohio State University – Extension Services
UnitedHealthCare
YMCA of Canton
YWCA of Canton

STARK COUNTY FATHERHOOD PROGRAMS

Stark County Department of Job and Family Services
Stark County Fatherhood Coalition
Parenting Time Order Assistance
Early Childhood Resource Center
Dr. Dad, 24/7 Dad, On My Shoulders, Parent Cafés
Stark County Community Legal Aid
Parenting Time Assistance

CANTON CITY BOARD OF HEALTH

CANTON CITY PUBLIC HEALTH
Jim Adams, Health Commissioner

STARK COUNTY THRIVE COUNTY-WIDE COLLABORATIVE

STARK COUNTY THRIVE OEI TEAM
James Adams, Health Commissioner
Dawn Miller, THRIVE Project Manager
Jessica Boley, Epidemiologist I
Danielle Grimm, THRIVE Executive Assistant
Elonda Williams, Neighborhood Navigator

STARK COUNTY THRIVE OEI COMMUNITY ADVISORY COMMITTEE

STARK COUNTY THRIVE
Social Determinants of Health Team
ADOLESCENT HEALTH/FAMILY PLANNING

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Jessica Boley
Katherine DeMuesy
Christine Frank
Dr. Amy Lakritz
Matt Lytle
Remel Moore
Shauna Shell
Ashlee Wingerter

STARK COUNTY THRIVE
Social Determinants of Health Team - HOUSING

Melanie Anderson
Isaac Baez
Celestine Barnes
Marcie Bragg
Marie Curry
Draya Ellis
Cathy Jennings
Rikki Kadri
Jennifer Keaton
Stacy Kelly
Cindy Linger
Sandy Marinchick
Dawn Miller
John Petit
Dr. Nicollette Powe
Rollin Seward
Marcy Smith
Aaron Wagster
LaToya Young

STARK COUNTY THRIVE PATHWAYS HUB
Sandy Marinchick, HUB Manager
Danielle Grimm, Executive Assistant
Marcy Esper, HUB Coordinator

STARK COUNTY THRIVE PATHWAYS HUB EVALUATION & QUALITY IMPROVEMENT COMMITTEE

Kent State University Evaluators:
Stephanie Abbruzzese
Dr. Bethany Lanese
Dr. Abby Eng
Dr. Peter Leahy

Jim Adams
Jessica Boley
Joni Close
Julie Elkins
Sharon Faiello
Dan Gichevski
Chelsea Griffith
Danielle Grimm
Dr. John Humphrey
Stacy Kelly
Amelia Kocher
Cindy Linger
Matt Lytle
Dr. Anju Mader
Sandy Marinchick
Dawn Miller
Robin Mingo-Miles
Kirkland Norris
Rob Pierson
Terry Regula
Sherry Smith
Morgan White
Patricia Williams

CARE COORDINATING AGENCIES

ACCESS HEALTH STARK COUNTY
Cindy Linger, Executive Director
Supervisor
- Stacy Kelly

9 CHWs

ALLIANCE FAMILY HEALTH CENTER
HRSA Certified
FQHC Look-Alike
Amelia Kocher, Executive Director
Supervisor
- Morgan White

2 CHWs

COMMQUEST
Keith Hochadel, Executive Director
Supervisor
- Patricia Sartor

1 CHW

MARGARET B. SHIPLEY CHILD HEALTH CLINIC
Laurie Inskeep, Executive Director
Supervisor
- Alanna Riesen

1 CHW

MY COMMUNITY HEALTH CENTER
HRSA Certified
FQHC Look-Alike
Terry Regula, Chief Executive Officer
Supervisor
- Sharon Faiello

2 CHWs

STARK COMMUNITY SUPPORT NETWORK
Shawnta Forester, Chief Executive Officer
Supervisor
- Shawnta Forester

1 CHW

STARK COUNTY DEPARTMENT OF JOB AND FAMILY SERVICES
Deb Forkas, Executive Director
Supervisor
- Matt Lytle

1 CHW

STARK COUNTY HEALTH DEPARTMENT
Kirkland Norris, Health Commissioner
Supervisor
- Amanda Uhler

1 CHW

STARK METROPOLITAN HOUSING AUTHORITY
Herman Hill, Executive Director
Supervisor
- Milistine Tatum

1 CHW

YWCA of Canton
Cathy Jennings, Executive Director
Supervisor
- Cathy Jennings

1 CHW