Canton City Public Health
Stark County THRIVE

Fiscal Year 2021
Annual Report

OEI 2.0 Grant #7620011OE0221

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

Stark County
THRIVE

Ohio
Department of Health

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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 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. To date, CCPH manages over 15 sub-recipient contracts with local agencies, along with faith-based and grassroots organizations. Stark County THRIVE 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=number of infant deaths/ number of infant births)*1000) to less than 6.0 per 1,000 live births to the population.

Baseline: In 2017 Stark County's Overall IMR was 9.3. (2017 Births: 3990, Deaths: 37)

Update: Preliminary 2021 data shows that Stark County's Overall IMR has decreased to 5.4. (2021 Births: 3913, Deaths: 21)

Baseline: From 2016-2017, Stark County's Non-Hispanic/Latine Black IMR was 13.0. Due to counts under 10 each year, multiple years are utilized. (2016-2017 Births: 920, Deaths: 12)

Update: From 2020-2021 preliminary data shows that Stark County's Non-Hispanic/Latine Black IMR has increased to 17.6. Due to counts under 10 each year, multiple years are utilized. (2020-2021 Births: 1022, Deaths: 18)

Baseline: In 2017, Stark County's Non-Hispanic/Latine White IMR was 9.1. (2017 Births: 3310, Deaths: 30)

Update: Preliminary 2021 data shows that Stark County's Non-Hispanic/Latine White IMR has decreased from 2017 to 3.5. (2021 Births: 3176, Deaths: 11)

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

Baseline: Utilizing data from 2016-2017, the disparity rate ratio was 1.5. This means that for each White baby who died before its first birthday close to two Black babies died before their first birthday. (2016-2017 NH Black Births: 920, Deaths: 12, IMR: 13.0, 2016-2017 NH White Births: 6824, Deaths: 60, IMR: 8.8)

Update: From 2020-2021**,** data shows that Stark County's disparity was 2.9. This means that for each White baby who died before its first birthday, three Black babies died before their first birthday. (2020-2021 NH Black Births: 1022, Deaths: 18, IMR: 17.6, 2020-2021 NH White Births: 6366, Deaths: 38, IMR: 6.3)

The following report highlights current work, successes, challenges, and future development. Birth and death data from 2020 and 2021 is considered preliminary and subject to change.

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/Latine Black (NHB) and Non-Hispanic/Latine White (NHW) unless otherwise noted. 2021 birth and death 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 2021-December 2021	**Race & Ethnicity**			
	Overall	**NH Black**	**NH White**	**Hispanic/Latine Any Race**
Total Births	3913	522	3176	166
Very Preterm Births <32 weeks gestation	56 Met 1.4%	12 Not Met 2.3%	38 Met 1.2%	*
Total pre-term births <37 weeks gestation (includes very preterm)	368 Met 9.4%	68 Not Met 13.0%	276 Met 8.7%	17 Not Met 10.2%
Very low birth weight <1,500 g	46 Met 1.2%	10 Not Met 2.0%	31 Met 1.0%	*
Low birth weight <2,500 g (includes very low birth weight)	313 Not Met 8.0%	70 Not Met 13.4%	227 Not Met 7.1%	10 Met 6.0%
Count of infant deaths	21	9	10	2
*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 health equity for birthing persons 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.

Downstream: Neighborhood Navigator identifies and connects with pregnant Stark County residents, with a focus on Black/African American, in order to link them up with clinical and social services. Making these connections works to decrease stress and improve access to resources needed. Outreach efforts are focused on non-traditional avenues in order to reach those 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) that can influence poor birth outcomes which often drive the inequities within the OEI counties.

Building upon the work of OE20 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 OE20 and identification of at least one additional policy and/or practice change during OE21.
- 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 OEI Epidemiologist and Housing led by OEI Project Manager. To help facilitate this practice focus, team members include representation from a variety of stakeholders including but not limited to: managed care plans, local housing programs, City of Canton Department of Development, 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, low educational attainment, chronic health conditions, and unemployment.

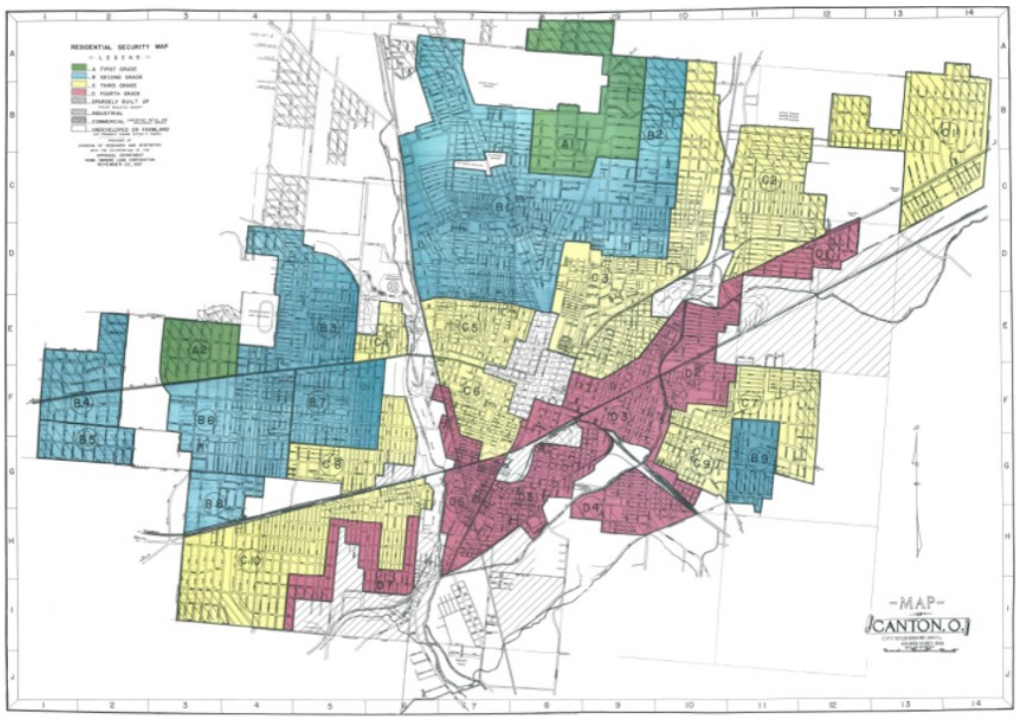
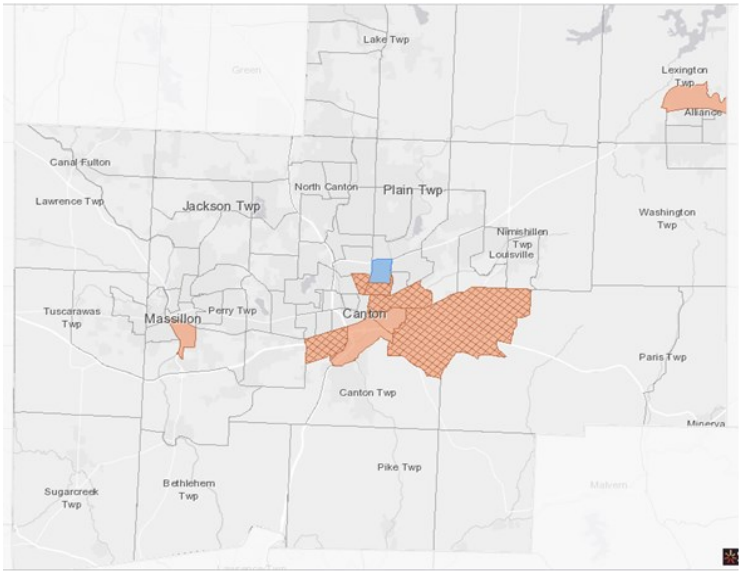


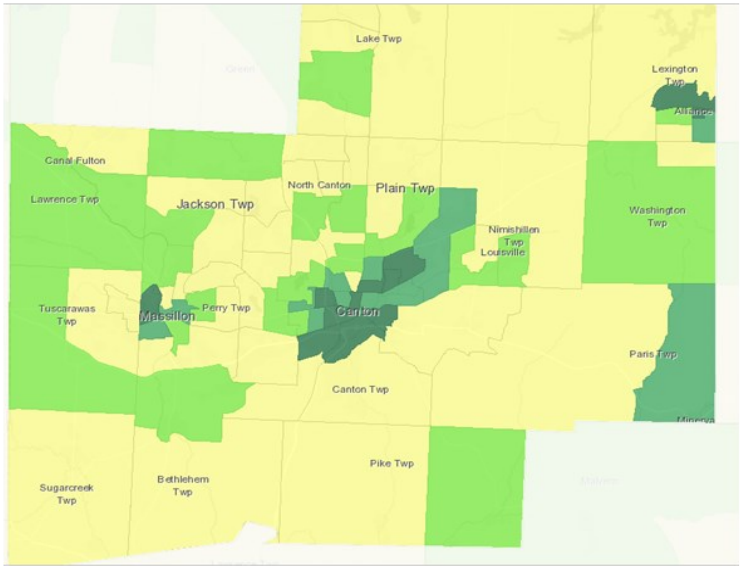
Image from: https://guides.osu.edu/maps/redlining

Community Context of Stark County, Ohio



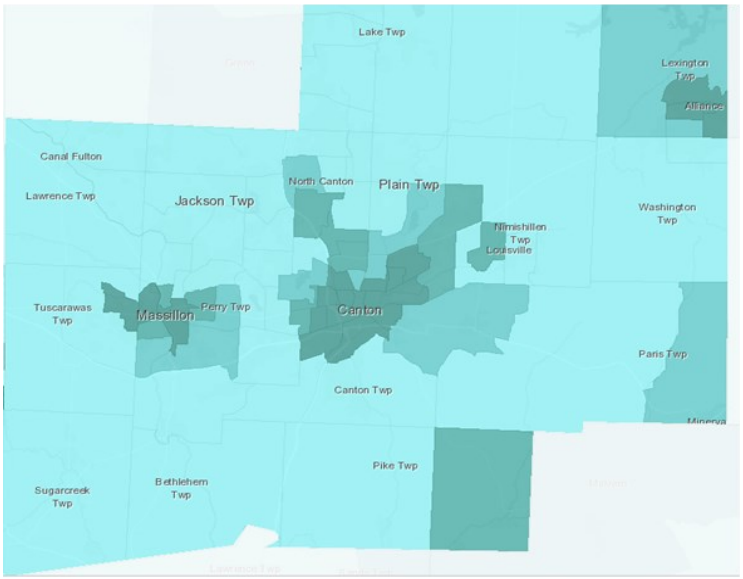
Food Desert Census Tracts, Change, 1 Mi. / 10 Mi. by Tract, USDA - FARA 2015-2019

- Food Desert - Added in 2019
- Food Desert - No Change
- Not a Food Desert - Removed in 2019
- Not a Food Desert



Unemployed Workers, Percent by County, ACS 2015-19

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

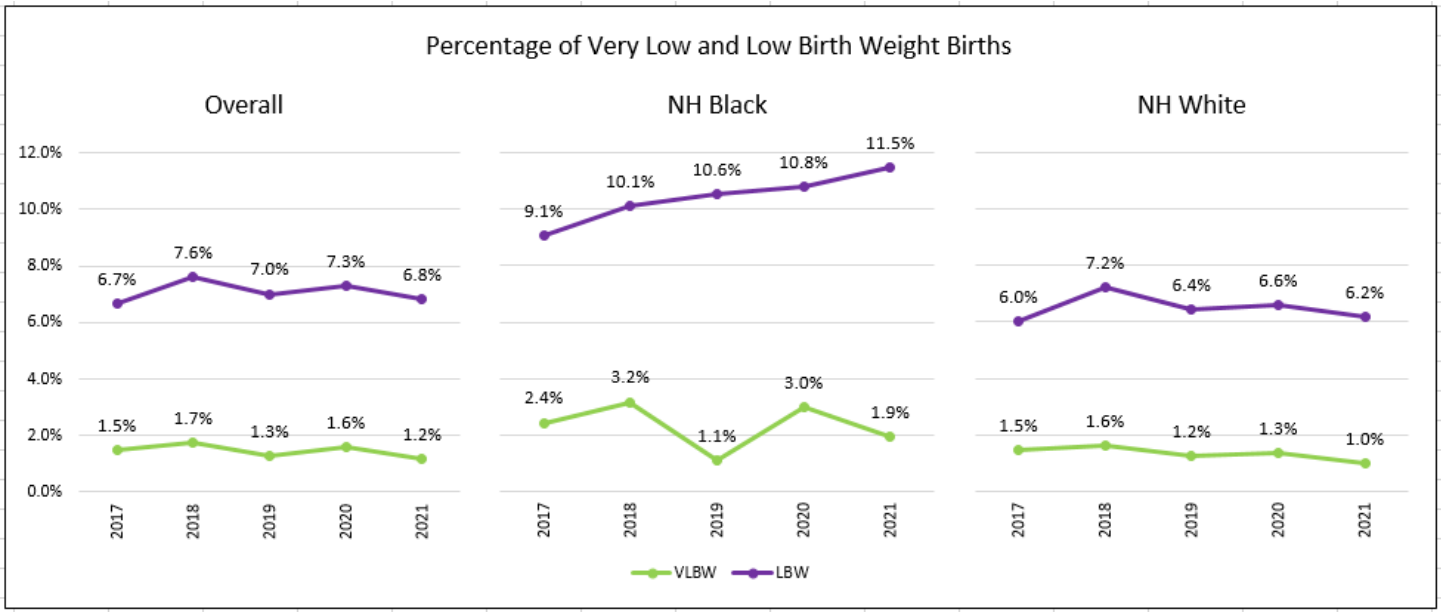


Population Below the Poverty Level, Percent by Tract, ACS 2015-19

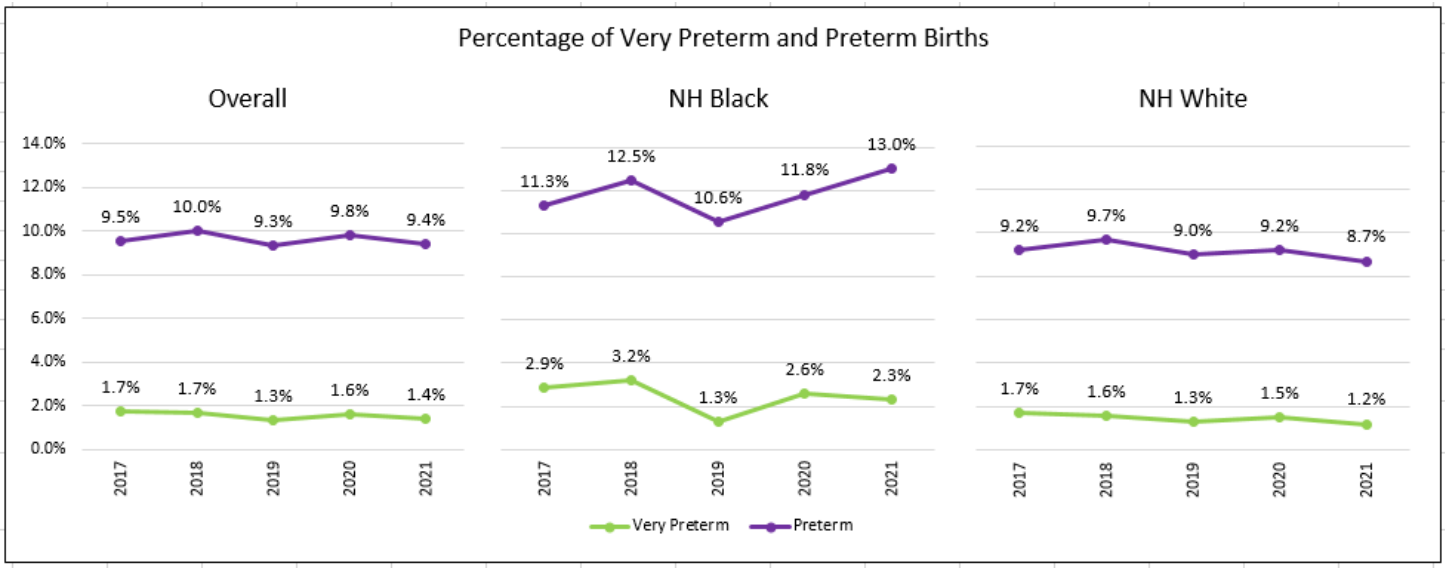
- Over 20.0%
- 15.1 - 20.0%
- 10.1 - 15.0%
- Under 10.1%
- No Data or Data Suppressed

Birth Outcomes in Stark County

Premature and low birth weight births are common indicators monitored overall. In 2021, the percentage of very low birth weight (VLBW=less than 1,500g) accounted for 1.2% of births overall, low birth weight (LBW=1,500-2,499g) births is in line with the past 5 years of accounting for 6.8% of births. While NH Black infants saw a dramatic decrease in the percentage of VLBW births in 2019, that may be an anomaly year if the trend doesn't continue. The percentage of low birth weight births has been increasing for this group since 2017. VLBW and LBW births for NH White infants has remained consistent over the past 5 years.

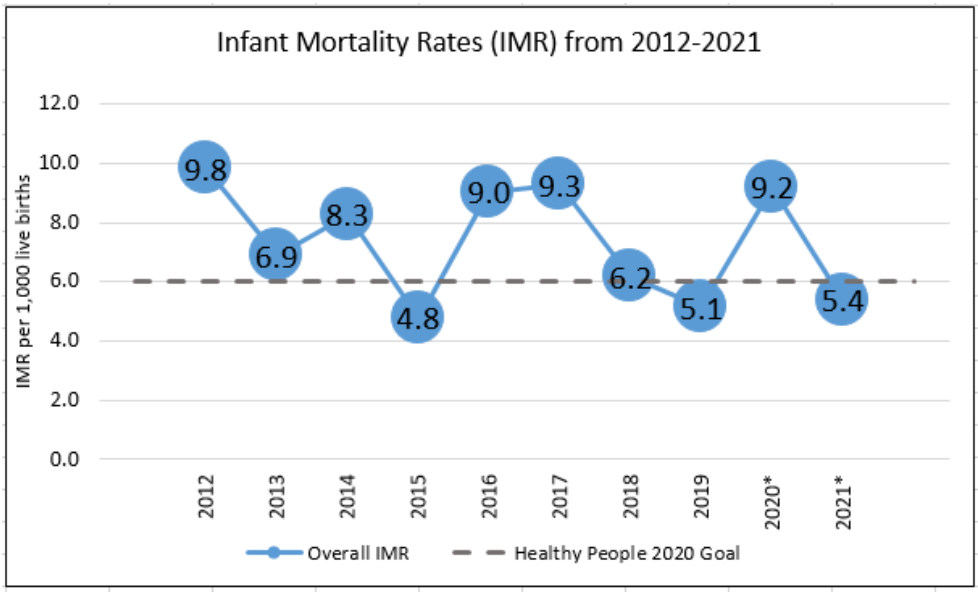


In reviewing very preterm (<32 weeks gestation) and preterm (<37 weeks gestation, includes very preterm births), Stark County overall has not seen much changes in these percentages over the past 5 years. NH Black infants have seen gradual improvements in very preterm births for the past 5 years but have also been seeing an increase in preterm births.



Infant Mortality in Stark County

Infant mortality rates 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. Infant mortality rates (IMR) in Stark County since 2012 have 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 three times, in 2015, 2019 and 2021. Despite these achievements, Stark County still has a lot of work to continue to improve upon these numbers as Healthy People 2030 has established the goal of achieving an IMR of 5.0.



Since 2011, Stark County has seen on average 4,000 births per year. The majority (on average 87%) of these births are to NH White birthing parents and births to NH Black birthing parents is the second largest group with just over 12% of births on average. Race/ethnicity of infant deaths is based on race/ethnicity documented at birth. The 10-year IMR from 2012-2021 was 7.4 per 1,000 live births (40,940 births, 304 deaths).

Counts of births & infant deaths in Stark County Residents since 2012						
	Overall Births	Overall Deaths	NH Black Births	NH Black Deaths	NH White Births	NH White Deaths
2012	4084	40	457	9	3510	30
2013	4216	29	542	6	3578	22
2014	4244	35	493	10	3599	24
2015	4197	20	454	5	3578	15
2016	4229	38	476	9	3614	29
2017	3990	38	452	8	3310	29
2018	4060	26	505	3	3325	23
2019	4094	21	540	4	3319	14
2020*	3913	36	500	9	3190	27
2021*	3913	21	522	9	3176	11

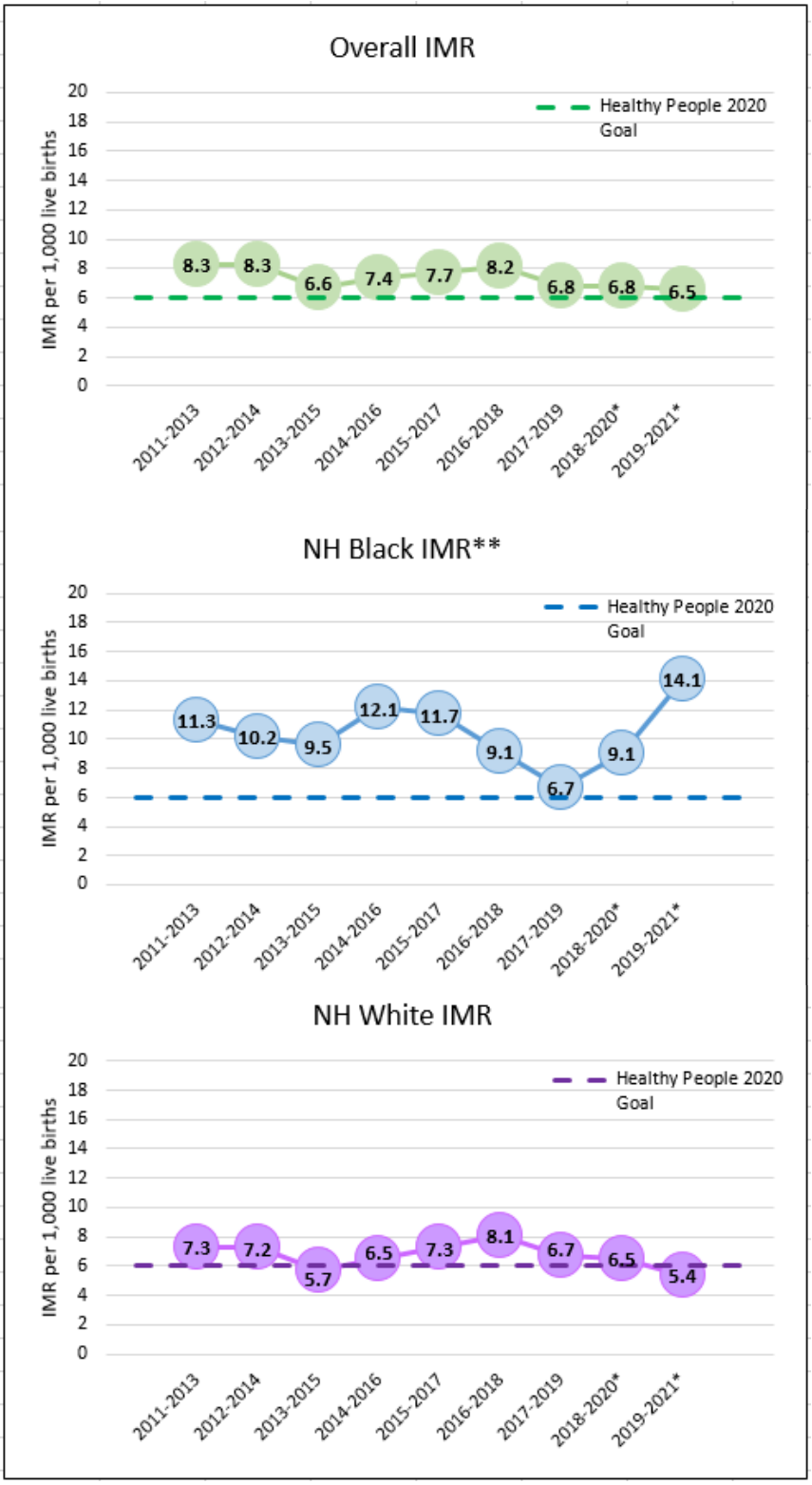
Infant Mortality in Stark County

In order to help minimize fluctuations in infant mortality rates over time, Stark County OEI also reviews 3 year groupings. Each data point in the graph shows a combination of 3 years of births and deaths to each group. When a new year is added, the oldest year is dropped off to keep the grouping at 3 years. Using this method allows OEI to look at larger and therefore more stable counts.

Race/ethnicity at birth is based on birthing parents reported race/ethnicity in Vital Statistics data as infants race is not identified. Since race is self-reported at death, it may be different than how the birth was categorized. To ensure OEI is using the correct denominator in calculating infant mortality rates, the death is counted as a death in race category in which the infant was born since that was the grouping that the birth was originally counted in.

Since 2016, the 3-year IMR for NH Black infants had stayed below 10.0 per 1,000 live births. Unfortunately, this trend did not continue as we saw an IMR of 14.1 in 2019-2021. While this is an improvement from the point of 2009-2011 in which the IMR was above 18.0 per 1,000 live births, it is still above the overall IMR in Stark County and above the Healthy People 2020 IMR goal of less than 6.0 per 1,000 live births. If NH Black infants were able to experience the same IMR as Stark County overall, it would have resulted in over 20 additional infants celebrating their first birthday with their families since 2011.

Healthy People 2030 has set the target of achieving an IMR of 5.0 per 1,000 live births.



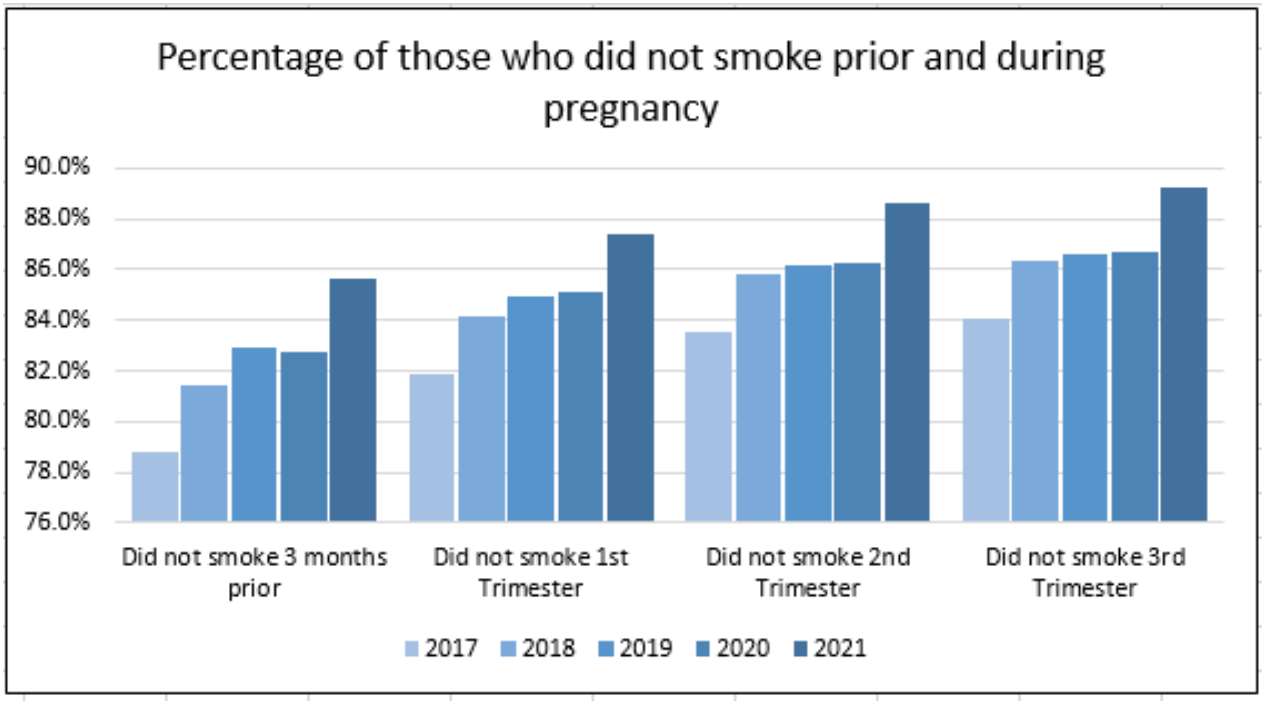
*2020/2021 data is considered preliminary

**An error in calculation was discovered since the OE20 report resulting in incorrect IMR's being reported for NH Black. These have been corrected.

Indicator 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)

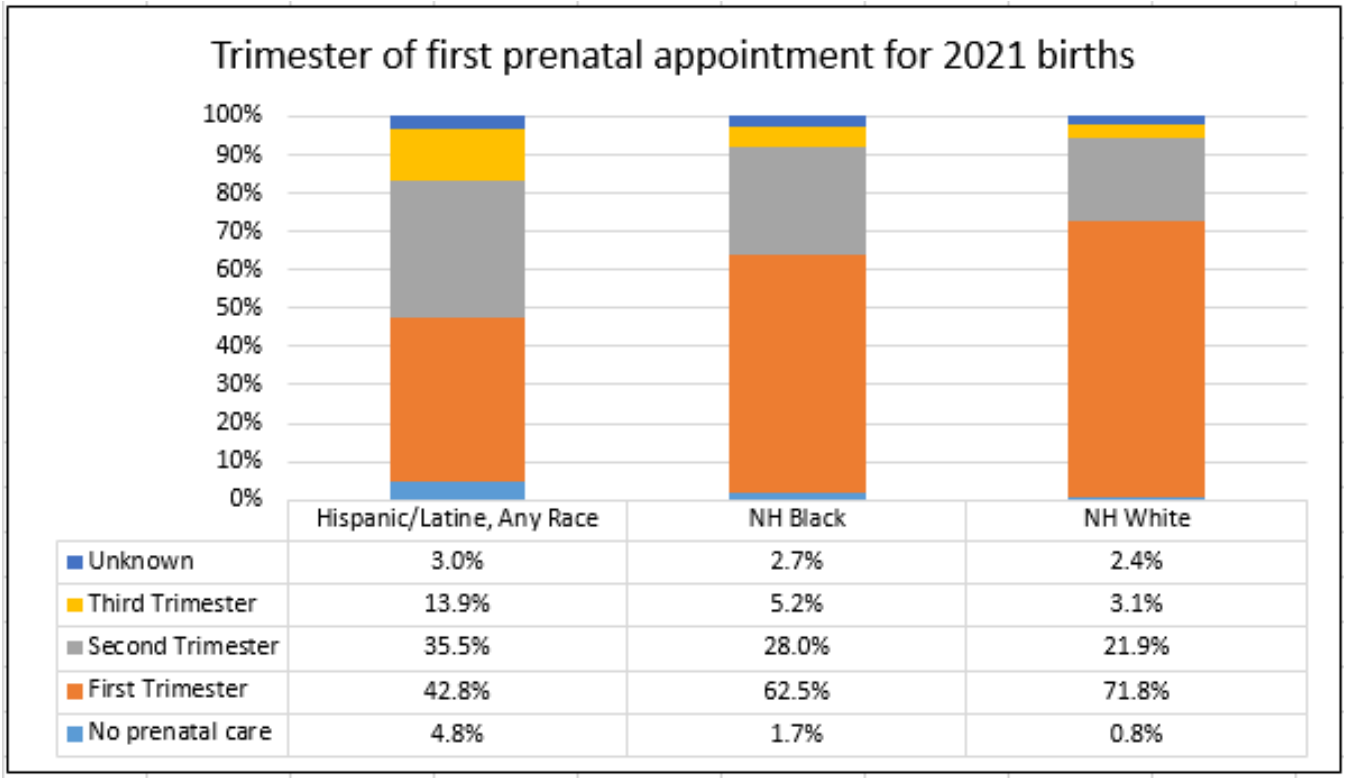
Studies have shown time and time again that women who do not smoke during the pregnancy are at a decreased risk for premature and low birth weight births.(Dahlin, 2016), (Priscilla Perez da Silva Pereira, 2017) (Soneji S, 2019). In 2019, Ohio passed the "Tobacco 21" law which raised the age to purchase 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, Stark County continues to see a high percentage of birthing parents who do not smoke prior to pregnancy and an increase in those who stop smoking during the pregnancy. In 2021, Stark County experienced the highest percentage of pregnant persons who did not smoke prior to pregnancy in the past five years in adddition to close to 90% not smoking in their third trimester.



Indicator monitored: Entry into prenatal care

Women who receive early and regular prenatal care are more likely to have healthy infants. Prenatal care includes a process of ongoing risk identification and assessment in order to develop appropriate care plans. This plan of care should take into consideration the medical, nutritional, psychosocial, cultural, and educations needs of the patient, and it should be periodically reevaluated and revised in accordance with the progress of the pregnancy. (Guidelines for Perinatal Care, 2017)

In 2021 overall, close to 70% of birthing parents began their prenatal care appointments in the first trimester. Those who identified as Hispanic/Latine, any race were less likely to seek prenatal care in the first trimester with just over 40% also this group also had the highest percentage of no prenatal care when compared with NH Black and NH White. Over 60% of NH Black birthing parents and over 70% of NH White birthing parents entered prenatal care in their first trimester. On average since 2016, 1% of birthing parents did not receive any prenatal care.



	Hispanic/Latine, Any Race	NH Black	NH White
Unknown	3.0%	2.7%	2.4%
Third Trimester	13.9%	5.2%	3.1%
Second Trimester	35.5%	28.0%	21.9%
First Trimester	42.8%	62.5%	71.8%
No prenatal care	4.8%	1.7%	0.8%

Ohio Equity Institute (OEI) Team Member Reports

Neighborhood Navigator

Currently Vacant

Initially, OE21 had the goal for the neighborhood navigator (NN) to serve 118 unique women with a target of 75% of those identifying as Black/African American. The grant was extended an additional quarter in which the goal was updated to 148 unique women. While in past grant cycles, the referral source was not a focus, this changed in OE21 when there was a transition to look more into non-traditional referral sources. These non-traditional avenues are likely to support outreach and identification of pregnant women where existing systems and programs do not currently reach.

The change in this strategy was designed to provide OEI teams flexibility and capacity to plan and tailor outreach efforts to identify moms, particularly Black moms, in ways that other partners do not have and help answer the question "If OEI teams are better positioned to effectively reach Black moms in your priority communities, and get her connected to services that have a base of evidence for improving birth outcomes—could we see a change in birth outcomes?" While there are programs are out there to help women and in turn improve birth outcomes, overall birth outcomes and disparity rates won't change if we aren't connecting the programs with women who need their services the most. The goal of the NN is to identify these unconnected Black women and to serve as an entry point to existing settings where services are provided.

The table below is a highlight of some of the avenues of outreach were utilized to assist in identifying the target population during the OE21 grant cycle. In 2021, downtown Canton saw the opening of the Akron Canton Regional Food Bank Stark County campus. Located on the campus is the Aultman Health Foundation Resource Room, which provides local organizations with space to provide onsite support. As part of her outreach, the NN was on location twice a month to help connect people to additional resources.

Success Story

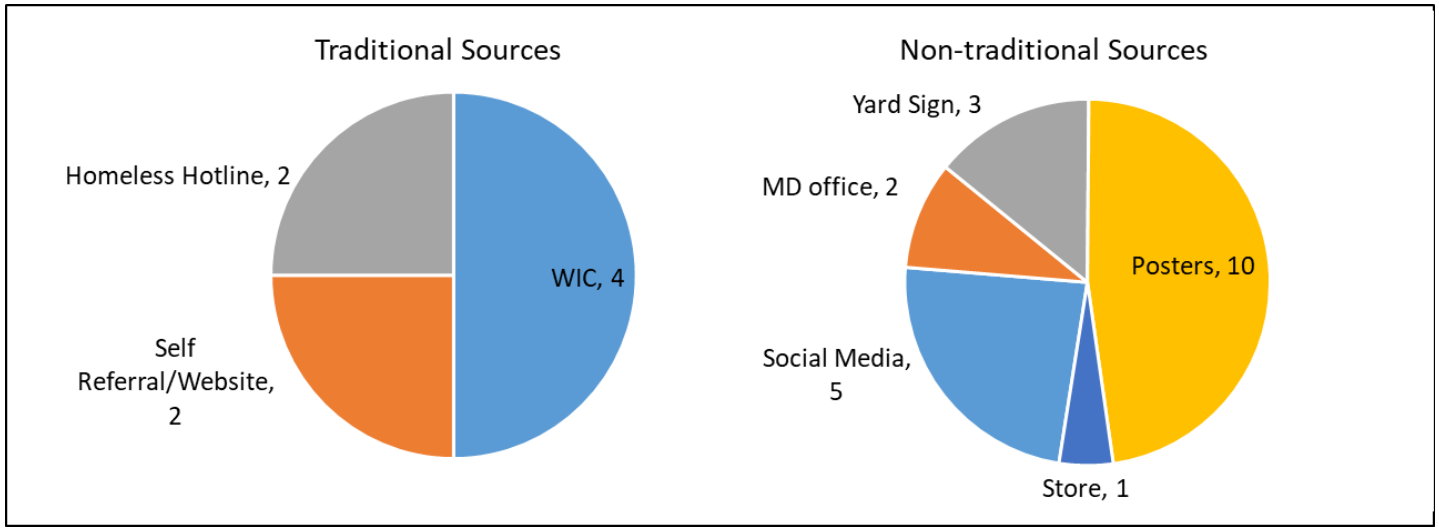
Including the NN photo on posters proved to be a win when a client approached the NN while shopping. They had recognized her from the posters and asked for more detail about the work that she did. She was able to screen the client to connected the family to needed resources in the area.

Event Participation	Posters/Tear off sheets	Posters/Tear off sheets
Akron Canton Foodbank	Housing complexes	Burger King
Juneteenth Celebration	Library (various branches)	Laundromats
Vax on the Spot events	Walmart	Church Food Pantries
Back to school events	Marc's	Arby's
Massillon Public Library Story Time & Teddy Bear Clinic	McDonalds	

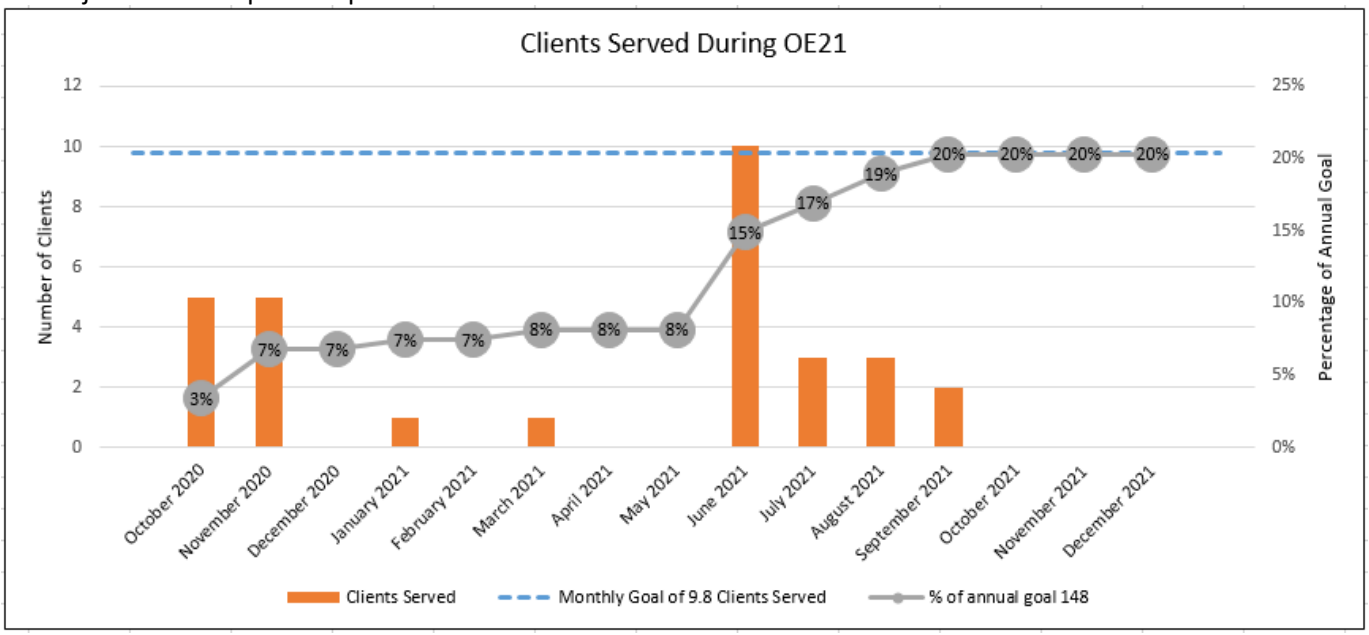
Neighborhood Navigator

Work completed by the neighborhood navigator (NN) is what drives downstream changes and intervention. OE21 continued to see challenges brought forth by COVID-19 and restrictions on many public gatherings. In September 2021, Stark County's OEI NN submitted her letter of resignation and the position was not reposted by the end of the grant cycle. While on staff, the NN did see success in receiving referrals from non-traditional sources. She affixed posters in various sites throughout the county including stores and parks. Posters had her photo along with information about services provided and tear-offs with her contact information.

New during OE21 was the placing of yard signs throughout the county with a focus on priority census tracts. While this did not yield a large number of referrals, it did account for 10% of referrals overall. The NN also saw some success with the utilization of social media postings on Facebook & Instagram. The NN spent a significant amount time working on outreach to local medical providers and food banks. While these avenues did not prove fruitful during the grant cycle, it is a strategy that should be again explored in future grant cycles.



During OE21, 20% of the annual goal of 148 unique persons served was met. The monthly quota to meet the overall goal was just under 10 persons per month in which was met in June 2021.

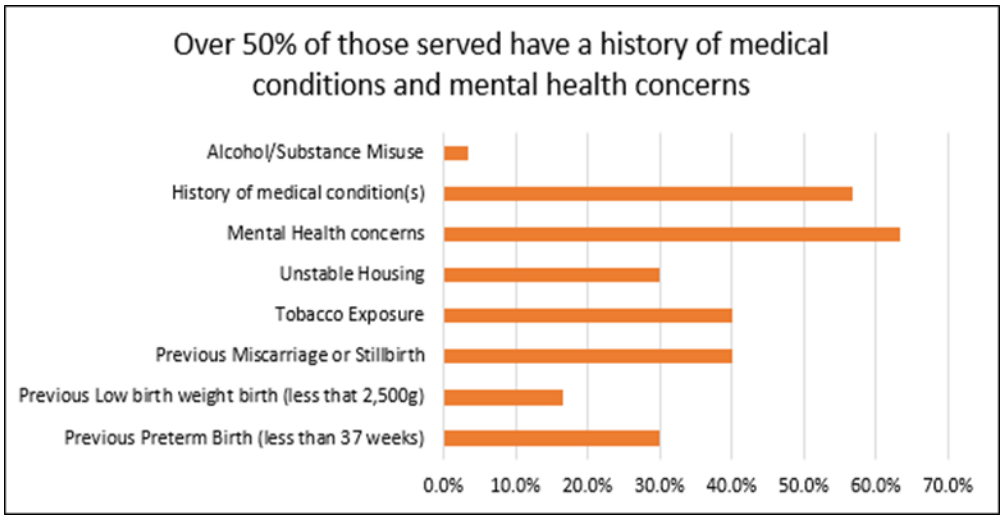


Clients served by Neighborhood Navigator

Overall during OE21, the NN served more NH Black clients than NH White but did not meet the goal of 75% of those served identifying as NH Black/African American. The majority of those served were between the ages of 20-29. Teen mothers (less than 20 years of age) accounted for 17% of clients served. Majority of clients served had a high school diploma or GED while 20% had additional schooling beyond high school. Ninety-seven percent of clients served were on Medicaid for their insurance.

OE21	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Quarter 5	Total
Eligible Women (n)	10	2	10	8	0	30
Race, Ethnicity						
White, non-Hispanic/Latine	50%	0%	30%	25%	0%	33%
Black, non-Hispanic/Latine	40%	100%	70%	75%	0%	63%
Hispanic/Latine Any Race	10%	0%	0%	0%	0%	3%
Age						
18 -19 yrs.	20%	0%	0%	38%	0%	17%
20-24 yrs.	30%	50%	30%	25%	0%	30%
25-29 yrs.	20%	0%	30%	13%	0%	20%
30-34 yrs.	20%	0%	30%	13%	0%	20%
35+ yrs	10%	50%	10%	13%	0%	13%
Education						
Less than HS	20%	50%	10%	25%	0%	20%
HS diploma/GED	50%	50%	60%	63%	0%	50%
Some college, no degree	10%	0%	30%	13%	0%	17%
Associate Degree	20%	0%	0%	25%	0%	10%
Doctorate or Professional Degree	0%	0%	0%	0%	0%	3%
Insurance Type						
Medicaid	90%	100%	100%	100%	0%	97%
Uninsured	10%	0%	0%	0%	0%	3%

During the screening process, the NN will ask about topics, which may be categorized as risk factors, that may affect outcomes in the current pregnancy. Some clients may answer yes to multiple topics. Over 50% of those served identified that they had a history of doctor diagnosed medical conditions and over 60% reported that they had mental health concerns (includes depression). Forty percent of those served had a history of fetal loss, either a miscarriage or a stillbirth. On average, clients reported 2.8 risk factors during the screening process by the NN.



Clients served by Neighborhood Navigator

During OE21, a total of 50 needs were identified while screening clients for which the NN made 50 (100%) referrals. Clients utilized all (100%) of those referrals. The majority of clinic referrals identified were for prenatal support while safe sleep topped the social referral needs. On average each client had just under 2 needs identified.

Clinical Referrals	
Prenatal Care	3
Prenatal Support	25

Social Referrals	
Baby Items	2
Clothing	1
Education	1
Housing	1
Safe Sleep	11
Transportation	5
Utilities	1

Stark County has the benefit of having over a dozen community health workers (CHW) that work with pregnant, maternal, and chronic health clients. Their work covers a wide variety of focuses. As such, they are where the majority of clients that are screened by the NN get referred. THE CHWs also provide safe sleep trainings, which when completed by the client entitles them to a free Graco Pack N' Play. Three clients were referred to WIC. One referral was also made to the following sources: Calvary Missions, HEAP, My Community Health Center, OB/Gyn. office, Midwife/Doula services and managed care plan.

This data suggests that there is continued need for overall support during the pregnancy and continued funding of safe sleep initiatives.

Ohio Equity Institute (OEI) Team Member Reports

Epidemiologist

Jessica Boley, RD, LD

While COVID-19 work occupied much of 2021, OEI Epidemiologist, Jessica Boley worked to put out data in a more useful manner. She completed reports for each of the 4 Stark County Health jurisdictions, Alliance City, Canton City, Massillon City and Stark County along with a countywide report, utilizing data from 2015-2019. These reports were largely tables of data that can be used for additional analysis. The full Stark County report is attached as Appendix B.

She also provided data to the supplement the Community Health Needs Assessment monitoring work, and to inform a presentation for the Northeast Prevention Council. She was invited to speak to junior nursing students at Malone University about infant mortality including statistics for Stark County and the overall purpose and work of THRIVE alongside Andrea Ramsey of the Mary Church Terrell Club of Canton.

In support of the OEI work, Jessica collaborated with NAACP and ODH to apply to a CityMatCH learning collaborative working to align state Title V funding with what is happening at the local level. The Alignment for Action Learning Collaborative (AAC) goal is to work to influence and improve one of the state Title V priority areas of interest in which we are focused on infant vitality and improving health lifestyles/health behaviors during this 3 year project.

During 2021, she was accepted as a student for the 2021 Training Course in Maternal Child Health Epidemiology presented by CityMatCH and completed this course in addition to completion of the OSU Summer Course in Population Health. During OE21, Jessica also participated in the Leadership Stark County Spotlight Program for Young Professionals.

In addition to OE21 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.

Social Determinants of Health (SDOH) Policy & Practice Change

Background

During the end of 2018, the THRIVE OEI Core Team met to discuss how upstream policy and practice changes in regards to SDOH can have downstream effects on infant mortality. This team came up with a list of seven priority areas: Adolescent Health, Family Planning, Female Incarceration/Courts, Food, Housing, Tobacco Use, and Other.

These areas were then brought to the THRIVE community advisory committee during their quarterly meeting in January 2019. Dawn Miller, Jessica Boley, and Amanda Archer presented information on policy/practice change and an overview of the priority areas as determined by the Core Team. This committee was then charged with looking at each priority area and provided input and additional ideas on:

1) Who was working in that area and what they were doing,
2) What would an ideal policy look like in that area,
3) Gaps evident in that area.

Mary Dunbar, formerly of Sisters of Charity Foundation of Canton Senior Program Officer/Special Projects, facilitated approximately 40 members of the THRIVE community advisory committee in a group dialogue based on the World Café model to prioritize the seven proposed SDOH areas. After looking at those three prompts for the seven areas, the committee had an opportunity to rank the priority areas from most important to least important and willingness to serve on a SDOH committee.

The committee selected Housing as #1 and Adolescent Health and Family Planning tied for 2nd based on local and state level data and feedback provided by committee members working in those spaces.

Feedback on housing gaps and possible policy/program changes from January 2019 Committee Meeting

Assisted living programs, but clients are allowed only 1 year on program; individuals aging out of foster care are often homeless. Public policy that guides how landlords rent to at-risk populations; Fathers with criminal history not allowed on premises which negatively impacts family support and relationship with child; SMHA no longer ask for proof of pregnancy for prioritizing for housing placement; develop a plan to support pregnant women in transitioning from shelter to stable housing; tenant based rental assistance for pregnant women and pre-eviction planning if hardship/ unexpected illness occurs. Quality of housing and affordability; Identify landlords' who would partner with THRIVE to support pregnant women by reducing rental payments if they are working with a THRIVE CHW, Help Me Grow or Moms & Babies First home visitor.

SDOH Policy & Practice Change

Housing Workgroup

Housing Workgroup Structure

STARK COUNTY THRIVE OEI 2.0 CORE TEAM

STARK COUNTY THRIVE OEI 2.0
COMMUNITY ADVISORY COMMITTEE

STARK COUNTY THRIVE
Social Determinants of Health Team: Housing
Dawn Miller, Team Leader

COMMITTEE MEMBERS

Domestic Violence Project Inc. Melanie Anderson, Victim Advocate Supervisor	**Stark Mental Health & Addiction Recovery** Donna Edwards, System of Care Jennifer Keaton, Program Manager/ Partner Solutions	**Stark Metropolitan Housing Authority** Millistine Tatum, Director, Resident Services and Community Affairs	**Stark Housing Network, Inc.** Marci Bragg, Executive Director	**Community Legal Aid Services, Inc.** Josh Hinkel, Staff Attorney Marie Curry, Managing Attorney	**ICAN Housing Inc.** Aaron Wagster, Supportive Services Resource Manager
Access Health Stark County Draya Ellis, CHW Jeannine Fogle, CHW Yenis Hernandez CHW Stacy Kelly, CHW Supervisor Cindy Linger, Executive Director	**Alliance for Children and Families** Shirene Starn Tapyrik, Executive Director Dionna Stokes-Ellis, Director of Housing Natatia Peterson, Health and Wellness Program Coordinator	**YWCA Canton** Tempestt Moore, CHW Kristin Hooten, Assistant Director of Housing and Supportive Services Shana Smith, Executive Director	**CommQuest** Celestine Barnes, Homeless Prevention and Diversion Programs Patricia Sartor, Coordinator, Mom & Me Recovery and CHW Supervisor	**City of Canton – Department of Development** Rollin Seward, Director Tammy Hajdu, Program/ Project Coordinator	**Dr. Nicolette Powe,** Assistant Professor, Youngstown State University

SDOH Policy & Practice Change

Housing Workgroup

Adopted Policy/Practice Change

- Stark County Homeless Hotline screening and referral protocol.

Implementation the policy/practice change

As of July 1, 2019, the Stark County Homeless Hotline's protocol for caller prescreen for homeless network services has been changed to ask callers: "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 and/or THRIVE Community Health Worker.

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.

Goal

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

Community Partners

- Stark Metropolitan Housing Authority
- City of Canton Development
- Stark Housing Network
- Stark Mental Health & Addiction Recovery-Homeless Hotline
- CommQuest-Homeless Prevention and Diversion Program
- ICAN Housing
- Canton YWCA
- Community Legal Aid

Barriers and challenges/opportunities for improvement

Canton is one of the top 10 cities in the United States for open and filed evictions. An unfortunate situation is created when an eviction is filed then the tenant catches up and pays rent over and over again. The filing stays on the client's court record even though they paid in full, resulting in difficulty finding housing.

SDOH Policy & Practice Change

Housing Workgroup

Additional Policy/Practice changes adopted

- Stark Metropolitan Housing Authority: ability to prioritize pregnant women for processing housing placement. NOTE: Stark Metropolitan Housing Authority was unable to change its process for prioritizing pregnant persons for housing.

- THRIVE Community Health Workers: expand on the questions asked to clients about housing status/ needs to be more probative to support opening of Housing Pathway especially identification of women who may be precariously housed.

- Coordination with city and county development directors to identify funds to be used for tenant based rental assistance for pregnant women.

OE20 adoption/OE21 implementation

1) THRIVE Community Health Workers: education on additional questions to be asked of clients to identify those who may be precariously housed.

2) Coordination with city and county development directors to identify funds to be used for tenant based rental assistance for pregnant women. Development and implementation of the THRIVE Tenant Based Rental Assistance Program (TBRA) was achieved.

Housing Workgroup	**Totals**
# of meetings held	5
# of Agencies Represented	12
Average percentage of members attending	90%
# of policy/practice changes recommended	3
# of policy/practice changes implemented	2

OE20 Practice Implementation	**What did we do? How well did we do it?**
# of pregnant individuals referred by Homeless Navigation	23 were referred from Homeless Navigation and enrolled with a Community Health Worker
# of pregnant individuals referred to housing services by NN	1 client was referred for housing needs and connected to a Community Health Worker

SDOH Policy & Practice Change

Housing Workgroup

OE21 Progress

January–November 2021: families with 172 children and 161 pregnant persons called into Homeless Navigation (Homeless Hotline) for assistance. Seven individuals/families with children were referred and enrolled and 23 pregnant persons were referred and enrolled. Of the 30 referrals, 50% of those self-identified as African American/Black/Multi-racial. With the client's consent, Homeless Navigation makes referrals to TBRA if they are not eligible for other program available in the County such as Rapid Rehousing through Neighborhood Navigator and/or THRIVE Community Health Worker.

Community partners provide multiple workforce, budgeting and financial stability, and parenting skills options for clients enrolled in the THRIVE Tenant Based Rental Assistance Program (as well as other Stark County residents).

- Stark County Urban League has the Stark County Workforce Support Program called *LaunchPoint*. The program provides support for resume writing and job placement, and for those clients with an interest in working that they are offered choices like Prosperity Center at Ohio Means Jobs through United Way.

- Alliance for Children and Families has the STAMP Parenting Class a hands-on, 8-week participatory course developed by the American Psychological Association that can be done online or in person.

- Homeless Navigation assists clients identify programs for which they are eligible, if not eligible for programs offered through Homeless Navigation which includes Homeless Prevention and Rapid Rehousing programs for residents in Canton City limits only.

- Community Legal Aid receives referrals from Neighborhood Navigator and THRIVE Community Health Workers using an agency specific form. If there is an eviction or problem with the landlord, CLA will review the situation and decide the direction and eligibility.

- YWCA Canton (TBRA grant administrator) processes TBRA applications and payment to landlord/utility company. A letter is sent to the landlord, client, and CLA, informing that payment has been issued; YWCA maintains a copy as well.

SDOH Policy & Practice Change

Adolescent Health/Family Planning Workgroup

Feedback on Adolescent Health gaps and possible policy/program changes from January 2019 Committee Meeting

Gaps include: Sexual education with coach/mentors; College level education places: direction programs on campus; Non-traditional schooling/community organizations; Department of Youth Services systems; Parents; Mental health talks; Involvement (parent, father); Insurance (shouldn't be); Employment

Ideal policies would be: 6th-7th grades: Decision making, Relationships, Health Planning Skills, Protection, Childbirth; Parent Seminars Conference; Whole Child Model; Age Appropriate Health Education; Kids 1st/Babies 1st; Abstinence/ Avoidance/Life planning; Health managers in schools

Feedback on Family Planning gaps and possible policy/program changes from January 2019 Committee Meeting

Gaps include: Move towards churches and outside the normal circle; Is family planning or prevention in schools for youth?; Include family planning more in father's conversation; People are not aware of programs

Ideal policies would be: Education in non-traditional places: handouts; After delivery (right at the hospital): a class that talks about family planning; Billboards and signs (awareness material); Partner with sports organizations to talk to athletes (boys) about family planning; Class about ethics that is on family structure (to gain insight on the why).

Adolescent Health/Family Planning Workgroup Structure

STARK COUNTY THRIVE OEI 2.0 CORE TEAM

STARK COUNTY THRIVE OEI 2.0
COMMUNITY ADVISORY COMMITTEE

STARK COUNTY THRIVE
Social Determinants of Health Team: Adolescent Health/Family Planning
Jessica Boley, Team Leader

COMMITTEE MEMBERS

MentorStark Laurie Moline	**CareSource** Shauna Shell	**Stark ESC** Patti Fetzer	**Canton City Public Health** David McCartney
Stark County Help Me Grow Christine Frank	**Stark MHAR** Remel Moore	**Community Partners** Dr. Amy Lakritz Tracy Herstich	**Stark County Health Department** Ashlee Wingerter Angie Shapiro Kelly Potkay Amanda Kelly

SDOH Policy & Practice Change

Adolescent Health/Family Planning Workgroup

OE20 adoption/OE21 implementation

In September 2020, during OE20, a student working on her Masters In Public Health began her internship with THRIVE and took ownership of gathering data for a policy/practice change. OEI knew that those in Stark County with a sexually transmitted infection (STI) present or treated during the pregnancy were 1.7 times more likely to have a baby born under 1,500 grams. OEI also knew that the community health workers (CHWs) funded through THRIVE had the opportunity to discuss reproductive health with their clients. Prior to the end of OE20, an agreement was signed with the THRIVE Pathways HUB manager for adoption and OE21 implementation of a program to assess the knowledge of the CHWs on family planning, birth control and STI topics and use the assessment to create a training to improve the knowledge of the CHWs on these topics. In October of 2020, she completed the initial assessment of CHWs knowledge and conducted the training in November, completing Phase 1 of the agreement. In addition to the live training, the intern also recorded the training for future use, created a bookmarked PDF for quick reference on various STI's to assist the CHWs and a one page reference sheet on the birth control options provided by the managed care plans most utilized in Stark County. Phase 2 included monitoring of pathways completed and education provided. The reproductive life pathway informs us if a client has a reliable birth control method in place while the family planning pathways is utilized when the client does not have a plan as to if/when they would like to become pregnant again and the CHW does a training that explains the different methods of birth control available and refers the client through a Medical Referral to start the process of obtaining preferred method.

	Reproductive Life Pathways completed	Family Planning Pathways completed	STI educations documented
October 1, 2020-December 31, 2020	96	27	3
January 1, 2021-December 9, 2021	462	25 complete 26 incomplete	38

Future Planning: While no additional CHWs completed the training at the time of this report, it would be of benefit for the training to be reviewed not only by new CHWs but current CHWs to improve their knowledge and confidence in discussing these topics. Based on the data above, it would also be of benefit to understand why some family planning pathways are not being fully completed.

SDOH Policy & Practice Change

Adolescent Health/Family Planning Workgroup

OE21 Progress

In October 2020, a member of the adolescent health/family planning group reached out as Stark County Health Department received a new grant focused on preconception and inter-conception care of women's health. Part of the grant required a committee that mirrored what was already represented on the adolescent health/family planning workgroup. Rather than creation of a new committee, it was determined that the group would be able to work to meet the needs of both the OEI grant and the preconception health grant. This decision helped to further reinforce the work that was already being conducted. Throughout OE21, the group supported a community survey focused on 18-44 year olds in Stark County to better understand barriers to care. The survey was open from July 1, 2021 until August 31, 2021 and in addition, a focus group was held on August 25, 2021.

In both the survey and focus group results, a need for extended/non-traditional office hours for medical visits was identified due to women's work schedule and/or the appointment times available. "I think that doctors forget that people have to work during the day" was one comment entered in the survey by a respondent. In the focus group, the following were a few of the suggestions on what could improve access to healthcare for women ages 18 to 44:

- More affordable options
- Evening and weekend office hours
- Mobile clinics - go to where people are

As a result of this work, Stark County Health Department recognized the need to extend hours for their STI clinics and is beginning to explore also extending hours of their Reproductive Health & Wellness clinics. This was identified as a practice change aimed at improving equitable access to care. As this change is implemented during OE22, Stark County Health Department will be providing the following data for monitoring purposes on a quarterly basis:

1. Number of clients served
2. Demographic information of clients served, including but not limited to: gender identity, race/ethnicity, age, and zip code.

By monitoring this data, the group hopes to be able to identify from what geographic areas clients are from and to better understand the demographic of who is utilizing these extended hours. This may allow for further expansion of extended hours at other clinic locations in Stark County.

Future Planning: During OE22, Stark County Health Department will be conducting a media/marketing campaign as another concern brought up in the survey and focus groups was residents do not know where to go for help.

SDOH Policy & Practice Change

Adolescent Health/Family Planning Workgroup

OE21 Progress

In addition, it was also identified that Canton City Public Health was in discussions with a teacher at a local middle school on conducting a presentation about STI's with their students. This presented an opportunity for an additional policy/practice change. The project was brought up to the SDOH Team who discussed concerns with a presentation such as ensuring additional information was included such as details on sex/human trafficking, domestic violence, resources on where to go for care and where to find additional medically accurate information. When these points were brought up to the group that would be conducting the presentation, they agreed with additional information. It was also decided that in order to determine if knowledge improved as a result of the presentation for monitoring efforts, an anonymous short pre/post assessment would be drafted by the SDOH team and executed prior to and after the presentation.

The theory is that if we are able to get into schools to discuss STI's, how they can impact persons long term, and how to protect themselves, it can help youth to be more educated about these topics and make better choices/know where to go to stay healthy. By taking steps to prevent STI's there is a good chance that those steps will also help to reduce the chance of them becoming pregnant.

The goal is for at least one presentation to be conducted over the OE22 grant cycle. CCPH presenter or designee will provide Ohio Equity Institute (OEI) via Family Planning/Adolescent Health SDOH Team with the following information within 60 days of the presentation:

1. Pre/Post assessment raw scores
2. School Grade(s) of those who were presented to
3. Number of students attending the presentation
4. If available, number of students who were opted out of the presentation

SDOH Policy & Practice Change

Adolescent Health/Family Planning Workgroup

Adolescent Health/Family Planning Workgroup	Totals
# of meetings held	7
# of Agencies Represented	9
Average percentage of members attending	80%
# of policy/practice changes recommended	2
# of policy/practice changes implemented	1

OE20 Practice Implementation	What did we do? Count	How well did we do it? Percentage
CHWs assessed on reproductive health knowledge	14	100%
Trainings offered	1	
CHWs participating in trainings	14	100%
CHWs completed post training assessment	12	86%
What difference did it make?		
% of CHW with increased reproductive health knowledge	Overall, the performance on the true and false section declined after the lecture. The accumulative score decreased by 1.4% in the post-test. Overall, after the lecture, there was a decline in scores in the multiple-choice section. The difference in the overall percentage was –2%.	
% of CHW who feel comfortable in discussing reproductive health topics with mothers	There was a 2% increase in the percentage of respondents that reported feeling comfortable with talking about family planning with their clients and a 10.7% decrease in the percentage of those that reported neutral. There was an 11% increase in the percent of CHWs that reported being comfortable talking about STIs. There was a 4% decrease in the amount that reported neutral.	

Future Planning

When looking to OE22 and beyond, THRIVE continues to see areas for improvement.

In considering how the local neighborhood navigation strategy be improved to better reach Black women and/or better connect women to clinical/social services, we plan to explore:

- Integration of Neighborhood Navigator and Health Equity Coordinator with City of Canton Fire Department to provide support to the fire department and EMTs to 1) identify unsafe sleep environments and 2) provide referrals to Navigator for housing related issues.
- Connection of Neighborhood Navigator with Crisis Center, Stark County Urban League and local community food banks and distribution centers including Stark Fresh.
- Connection of Neighborhood Navigator with Stark County Black Nurses Association for education, outreach and engagement with the various organizations, medical provider practices in which the nurses work.
- Connection of Neighborhood Navigator to Stark County Queens Village as presenter and referral source.

In consideration of how OEI sees the SDOH team/local policy and practice change work being enhanced to continue improving the physical and social environments in your communities to help reduce the inequities in birth outcomes Black women and families experience, we plan to explore:

1) Increase the number of client referrals that are made prior to client being evicted.

2) New Neighborhood Navigator is being hired and will be presenting to Homeless Navigation Team regarding the services that are available through this position.

3) Explore the interest and availability of funds to support the expansion of the TBRA program in other Stark County municipalities.

4) Explore the interest in establishing a Housing Navigator in Stark County.

5) Recruit representative from Stark County Urban League on SDOH Housing Team.

6) Ensure that Health Equity Coordinator is well versed on the efforts of the Navigator, SDOH Teams action plans so that the Coordinator can communicate these interventions into the work.

7) Improving relationships with Stark County Schools, particularly within Canton City to provide additional health education.

8) Continue to explore ways to improve access to improve health before pregnancy.

Data Tables

Utilizing OE21 data October 2020-December 2021

Neighborhood Navigator Outcomes				
	White	Black	Other	Total
# Women screened*	9	17	0	26
# Eligible women*	9	17	0	26
# Eligible women served	10	19	1	30
# Needs identified	18	31	2	51
# Referrals made	18	31	2	51
% Needs met	100%	100%	100%	100%
# Referrals utilized	18	31	2	51
% Referrals utilized	100%	100%	100%	100%

*Includes those who were identified/screened/determined eligible in September 2020 as they may have not been classified fully served until October 2020.

Clinical Referrals			
	Referrals Made	Referrals Utilized	% Utilized
Prenatal care	3	3	100%
Prenatal support	25	25	100%
Total	28	28	100%

Additional Referrals			
	Referrals Made	Referrals Utilized	% Utilized
Baby Items	2	2	100%
Clothing	1	1	100%
Education	1	1	100%
Housing instability	1	1	100%
Interpersonal Violence	1	1	100%
Safe sleep	11	11	100%
Transportation	5	5	100%
Utilities	1	1	100%
Total	23	23	100%

Data Tables

Utilizing 2020 birth/death data

	Birth Count	Infant Deaths*	IMR
Overall	3913	36	9.7
NH Black	500	9	**
NH White	3190	27	8.5
Hispanic/Latine Any Race	160	0	0.0

*Deaths categorized by Ethnicity/Race at Birth

**IMR not calculated as less than 10 deaths occurred

Birth Weight Groups		
	Births	Deaths
Very low birth weight (<1500g)	60	15
Low birth weight (1500-2499g)	285	11
Normal birth weight (2500-3999g)	3258	9
High birth weight (4000+g)	308	1
Unknown birth weight	2	0

Gestational Age Groups		
	Births	Deaths
Extremely preterm (<28 weeks)	27	14
Very preterm (28 to <32 weeks)	36	0
Moderate to late preterm (32 to <37 weeks)	321	10
Early term (37 to <39 weeks)	960	7
Term (39-41 weeks)	2563	5
Post Term (42+ weeks)	5	0
Unknown	1	0

Entered into prenatal care during first trimester		
	#	%
Overall	2703	69.08%
NH Black	306	61.20%
NH White	2289	71.76%
Hispanic/Latine Any Race	61	18.13%
Other	47	74.60%

Data Tables

Mothers diagnosed with…				
	preexisting hypertension	gestational hypertension	preexisting diabetes	gestational diabetes
Overall	114	462	66	282
NH Black	21	51	9	25
NH White	89	394	53	237
Hispanic/Latine Any Race	3	15	2	13
Other	1	2	2	7

Breastfeeding Status at Discharge			
	Yes	No	Unknown
Overall	2817	1094	2
NH Black	306	194	0
NH White	2361	828	1
Hispanic/Latine Any Race	96	64	0
Other	54	8	1

Mother was smoking…			
	3 months prior to pregnancy	at any point of pregnancy	during the third trimester
Overall	676	586	521
NH Black	92	80	69
NH White	571	498	444
Hispanic/Latine Any Race	10	5	5
Other	3	3	3

Inter-pregnancy Intervals (amongst singleton births)					
	Under 12 months	12-17 months	18-23 months	24+ months	Not Applicable (First Live Birth)
Overall	471	329	294	1209	1433
NH Black	94	24	20	163	180
NH White	356	277	250	983	1180
Hispanic/Latine Any Race	17	20	16	46	49
Other	27	18	19	80	24

Data Tables

Utilizing 2021 birth/death data

	Birth Count	Infant Deaths*	IMR
Overall	3913	21	5.4
NH Black	522	9	**
NH White	3176	11	3.5
Hispanic/Latine Any Race	166	2	**
*Deaths categorized by Ethnicity/Race at Birth			
**IMR not calculated as less than 10 deaths occurred			

Birth Weight Groups		
	Births	Deaths
Very low birth weight (<1500g)	44	3
Low birth weight (1500-2499g)	267	5
Normal birth weight (2500-3999g)	3300	10
High birth weight (4000+g)	299	0
Unknown birth weight	3	3

Gestational Age Groups		
	Births	Deaths
Extremely preterm (<28 weeks)	20	4
Very preterm (28 to <32 weeks)	36	0
Moderate to late preterm (32 to <37 weeks)	312	3
Early term (37 to <39 weeks)	1033	7
Term (39-41 weeks)	2504	5
Post Term (42+ weeks)	6	1
Unknown	2	1

Entered into prenatal care during first trimester		
	#	%
Overall	2708	69%
NH Black	326	63%
NH White	2279	72%
Hispanic/Latine Any Race	71	43%
Other	32	

Data Tables

Mothers diagnosed with…				
	preexisting hypertension	gestational hypertension	preexisting diabetes	gestational diabetes
Overall	130	483	85	287
NH Black	24	60	10	31
NH White	100	410	69	245
Hispanic/Latine Any Race	5	11	3	7
Other	1	2	3	

Breastfeeding Status at Discharge			
	Yes	No	Unknown
Overall	2751	1160	2
NH Black	302	220	0
NH White	2303	871	2
Hispanic/Latine Any Race	108	58	0
Other	38	11	0

Mother was smoking…			
	3 months prior to pregnancy	at any point of pregnancy	during the third trimester
Overall	556	492	417
NH Black	87	77	65
NH White	460	409	346
Hispanic/Latine Any Race	5	3	3
Other	4	3	3

Inter-pregnancy Intervals (amongst singleton births)					
	Under 12 months	12-17 months	18-23 months	24+ months	Not Applicable (First Live Birth)
Overall	430	381	281	1219	1440
NH Black	80	29	32	172	177
NH White	323	332	232	973	1194
Hispanic/Latine Any Race	24	14	15	56	51
Other	3	6	2	18	18

Additional Resources

Healthy People 2020
http://www.healthypeople.gov

Ohio Department of Health
Application Gateway
http://www.odhgateway.odh.ohio.gov
Youth Risk Behavior Survey
https://odh.ohio.gov/wps/portal/gov/odh/know-our-programs/youth-risk-behavior-survey/youth-risk-behavior-survey
Ohio 2020-2022 State Health Improvement Plan
https://odh.ohio.gov/wps/portal/gov/odh/about-us/sha-ship/State-Health-Improvement-Plan

Canton City Public Health
Stark County Community Health Improvement Plan 2020-2022
https://cms7files1.revize.com/starkcountyoh/Stark-County-2020-2022-CHIP-Revised-12-20%20-%20Copy.pdf

CityMatCH
http://www.citymatch.org

Maps on Page 7 made utilizing Spark Map. https://sparkmap.org/map-room/

Analysis contained within this report conducted were conducted by Jessica Boley, RD, LD THRIVE Epidemiologist I. At the time of this release (January 2022), 2020 death data and 2021 birth/death data was preliminary and subject to change.

Birth and death data was accessed from ODH Data Warehouse. Final access for analysis 1/10/2022.

"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 1/7/2022.

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OEI 2.0
Grant #7620011OE0221
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

NN
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 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 Monthly/Quarterly /Annual Reports

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

Stark County THRIVE

Rev. 8/2020

Five-year Birth Outcomes Report for Stark County
2015-2019

Report completed by Jessica Boley, RD, LD. For questions regarding information contained, please email jboley@cantonhealth.org
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Stark County is located in northeast Ohio. It has a 2019 population estimate of 360,606 persons and is one of the top 10 most populated counties in Ohio.

Counts and rates of births												
	2015		2016		2017		2018		2019		5 Year average	
	#	Rate	#	Rate	#	Rate	#	Rate	#	Rate	#	Rate
Stark County Births/Birth Rate	4180	45.84	4205	46.52	3990	44.50	4060	45.41	4094	46.07	4106	45.67

Birth rate is per 1,000 in birthing population ages 10-49. From 2015-2019, Stark County residents experienced a 5-year average of 4,106 births. On average, Alliance City accounted for 6.5% of those births, Canton City 32.5%, while Massillon City accounted for 11.6%. The remainder of the births occurred to those outside the 3 city limits.

Birthing Parent's Race												
	2015		2016		2017		2018		2019		5 Year average	
	#	%	#	%	#	%	#	%	#	%	#	%
White	3561	85.2%	3590	85.4%	3424	85.8%	3438	84.7%	3436	83.9%	3490	85.0%
African American (Black/Brown)	454	10.9%	476	11.3%	456	11.4%	511	12.6%	544	13.3%	488	11.9%
Japanese/Asian	6	0.1%	9	0.2%	3	0.1%	6	0.1%	11	0.3%	7	0.2%
Native American/Indigenous	6	0.1%	5	0.1%	1	0.0%	2	0.0%	6	0.1%	4	0.1%
Hawaiian and Pacific Islander/Filipino	12	0.3%	5	0.1%	11	0.3%	7	0.2%	8	0.2%	9	0.2%
Other Asian	27	0.6%	28	0.7%	41	1.0%	34	0.8%	26	0.6%	31	0.8%
Other/Unknown	114	2.7%	92	2.2%	54	1.4%	62	1.5%	63	1.5%	77	1.9%
Total	4180	100.0%	4205	100.0%	3990	100.0%	4060	100.0%	4094	100.0%	4106	100.0%

Birthing Parent's Ethnicity												
	2015		2016		2017		2018		2019		5 Year average	
	#	%	#	%	#	%	#	%	#	%	#	%
Hispanic/Latine	129	3.1%	133	3.2%	132	3.3%	162	4.0%	167	4.1%	145	3.5%
Non-Hispanic/Latine	4049	96.9%	4072	96.8%	3857	96.7%	3898	96.0%	3925	95.9%	3960	96.5%
Unknown	2	0.0%	0	0.0%	1	0.0%	0	0.0%	2	0.0%	1	0.0%
Total	4180	100%	4205	100%	3990	100%	4060	100%	4094	100%	4106	100%

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Birthing Parent's Race & Ethnicity												
	2015		2016		2017		2018		2019		5 Year average	
	#	%	#	%	#	%	#	%	#	%	#	%
Non-Hispanic/Latine White	3514	84.1%	3514	83.6%	3310	83.0%	3325	81.9%	3319	81.1%	3396	82.7%
Non-Hispanic/Latine Black	447	10.7%	468	11.1%	452	11.3%	505	12.4%	540	13.2%	482	11.7%
Non-Hispanic/Latine Other	88	2.1%	90	2.1%	95	2.4%	68	1.7%	66	1.6%	81	2.0%
Hispanic/Latine White	47	1.1%	76	1.8%	113	2.8%	113	2.8%	116	2.8%	93	2.3%
Hispanic/Latine Black	7	0.2%	8	0.2%	4	0.1%	6	0.1%	4	0.1%	6	0.1%
Hispanic/Latine Other	75	1.8%	49	1.2%	15	0.4%	43	1.1%	47	1.1%	46	1.1%
Unknown	2	0.0%	0	0.0%	1	0.0%	0	0.0%	2	0.0%	1	0.0%
TOTAL	4180	100%	4205	100%	3990	100%	4060	100%	4094	100%	4106	100%

The majority of births in Stark County were to Non-Hispanic/Latine (NH) White birthing parents. This is comparable to the overall population in Stark County in which approximately 86% of persons identify as Non-Hispanic/Latine (NH) White.

Age of Birthing parent at delivery												
	2015		2016		2017		2018		2019		5 Year average	
	#	%	#	%	#	%	#	%	#	%	#	%
Less than 15	3	0.1%	0	0.0%	0	0.0%	2	0.0%	5	0.1%	2	0.0%
15 to 17	68	1.6%	53	1.3%	64	1.6%	54	1.3%	72	1.8%	62	1.5%
18 to 19	207	5.0%	210	5.0%	205	5.1%	174	4.3%	189	4.6%	197	4.8%
20 to 24	1071	25.6%	993	23.6%	969	24.3%	946	23.3%	922	22.5%	980	23.9%
25 to 29	1375	32.9%	1392	33.1%	1319	33.1%	1329	32.7%	1352	33.0%	1353	33.0%
30 to 34	988	23.6%	1043	24.8%	965	24.2%	1069	26.3%	1030	25.2%	1019	24.8%
35 to 39	393	9.4%	452	10.7%	406	10.2%	413	10.2%	448	10.9%	422	10.3%
40 to 44	69	1.7%	56	1.3%	61	1.5%	65	1.6%	75	1.8%	65	1.6%
Over 44	6	0.1%	6	0.1%	1	0.0%	8	0.2%	1	0.0%	4	0.1%
Total	4180	100%	4205	100%	3990	100%	4060	100%	4094	100%	4106	100%

On average over the 5 years, births to those under the age of 20 accounted for 6.4% of the births in the county. Of those who identified as Hispanic/Latine any race, 17% of their births were to those under 20 years old. For those who identified as NH African American/Black/Brown, 12% of births were to those under 20. Five percent of births to those who identified as NH White were to those under 20 years old.

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Birthing Parent's Education Level												
	2015		2016		2017		2018		2019		5 Year average	
	#	%	#	%	#	%	#	%	#	%	#	%
8th grade or less	75	1.8%	100	2.4%	91	2.3%	104	2.6%	94	2.3%	93	2.3%
9th through 12th grade - no diploma	359	8.6%	352	8.4%	299	7.5%	347	8.5%	336	8.2%	339	8.2%
High School graduate or GED completed	1233	29.5%	1282	30.5%	1305	32.7%	1329	32.7%	1401	34.2%	1310	31.9%
Some college credit, but no degree	967	23.1%	922	21.9%	846	21.2%	837	20.6%	769	18.8%	868	21.1%
Associate degree	428	10.2%	407	9.7%	376	9.4%	340	8.4%	377	9.2%	386	9.4%
Bachelor's degree	760	18.2%	755	18.0%	728	18.2%	745	18.3%	739	18.1%	745	18.2%
Master's degree	297	7.1%	315	7.5%	268	6.7%	289	7.1%	304	7.4%	295	7.2%
Doctorate degree or Professional degree	55	1.3%	72	1.7%	76	1.9%	68	1.7%	71	1.7%	68	1.7%
Unknown	6	0.1%	0	0.0%	1	0.0%	1	0.0%	3	0.1%	2	0.1%
Total	4180	100%	4205	100%	3990	100%	4060	100%	4094	100%	4106	100%

According to American Community Survey (ACS) data from 2015-2019, 38.22% of Stark County residents aged 25 and over didn't complete any additional schooling beyond high school.

Births to those that received prenatal care by race/ethnicity-may not equal 100%												
	2015		2016		2017		2018		2019		5 Year average	
	#	%	#	%	#	%	#	%	#	%	#	%
Non-Hispanic/Latine White	3414	97.2%	3478	99.0%	3265	98.6%	3288	98.9%	3289	99.1%	3347	98.5%
Non-Hispanic/Latine Black	425	95.1%	461	98.5%	445	98.5%	496	98.2%	526	97.4%	471	97.6%
Non-Hispanic/Latine Other	84	95.5%	87	96.7%	95	100.0%	68	100.0%	66	100.0%	80	98.3%
Hispanic/Latine White	45	95.7%	75	98.7%	110	97.3%	105	92.9%	113	97.4%	90	96.3%
Hispanic/Latine Black	7	100.0%	7	87.5%	4	100.0%	6	100.0%	4	100.0%	6	96.6%
Hispanic/Latine Other	69	92.0%	47	95.9%	14	93.3%	40	93.0%	45	95.7%	43	93.9%
Total	4044	96.7%	4155	98.8%	3933	98.6%	4003	98.6%	4043	98.8%	4036	98.3%

There were two births to those whose race/ethnicity were unknown and not included in table above.

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If had prenatal care, Trimester of first prenatal appointment												
	2015		2016		2017		2018		2019		5 Year average	
	#	%	#	%	#	%	#	%	#	%	#	%
First Trimester	2454	60.7%	2436	58.6%	2215	56.3%	2566	64.1%	2735	67.6%	2481	61.5%
Second Trimester	863	21.3%	964	23.2%	879	22.3%	1078	26.9%	1059	26.2%	969	24.0%
Third Trimester	205	5.1%	168	4.0%	167	4.2%	223	5.6%	195	4.8%	192	4.7%
Unknown	523	12.9%	587	14.1%	673	17.1%	136	3.4%	54	1.3%	395	9.8%
Total	4045	100%	4155	100%	3934	100%	4003	100%	4043	100%	4036	100%

Healthy People 2020 Objective MICH-10.1 was to increase the proportion of pregnant women who receive prenatal care beginning in the first trimester to 84.8%. While there are some unknowns, on average just over 60% of pregnant parents entered prenatal care in the first trimester of pregnancy.

Over the 5 years, on average, 98.3% of pregnant parents received some sort of prenatal care. The lowest percentage was in 2015 where only 96.7% of pregnant persons received prenatal care. According to The American College of Obstetricians and Gynecologists, “Women who receive early and regular prenatal care are more likely to have healthy infants. Prenatal care includes a process of ongoing risk identification and assessment in order to develop appropriate care plans. This plan of care should take into consideration the medical, nutritional, psychosocial, cultural, and educational needs of the patient, and it should be periodically reevaluated and revised in accordance with the progress of the pregnancy…The first visit for prenatal care typically occurs in the first trimester. The frequency of follow-up visits is determined by the individual needs of the women and an assessment of her risks.”

If had prenatal care, Adequacy of Prenatal Care based on Kotelchuck Index												
	2015		2016		2017		2018		2019		5 Year average	
	#	%	#	%	#	%	#	%	#	%	#	%
Inadequate (received less than 50% of expected visits)	599	14.8%	541	13.0%	520	13.2%	681	17.0%	666	16.5%	601	14.9%
Intermediate (50%-79%)	343	8.5%	407	9.8%	266	6.8%	404	10.1%	453	11.2%	375	9.3%
Adequate (80%-109%)	1375	34.0%	1344	32.3%	1116	28.4%	1299	32.5%	1370	33.9%	1301	32.2%
Adequate Plus (110% or more)	1196	29.6%	1275	30.7%	1354	34.4%	1481	37.0%	1500	37.1%	1361	33.7%
Unknown	532	13.2%	588	14.2%	678	17.2%	138	3.4%	54	1.3%	398	9.9%
Total	4045	100%	4155	100%	3934	100%	4003	100%	4043	100%	4036	100%

The Kotelchuck Index, also referred to as the Adequacy of Prenatal Care Utilizations (APNCU) Index, utilizes two elements form birth certificate data: when prenatal care began and the number of prenatal visits from when care began until delivery. The Index classifies the adequacy of initiation (what month of pregnancy did prenatal care begin) and the adequacy of received services (a ratio of observed to expected number of visits). Limitations of this Index include: it does not measure the quality of care, it may not measure the adequacy of care for high-risk people and the calculation depends on the accuracy of patient or health care providers recall of first prenatal appointment and number of subsequent appointments.

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Birthing Parent's BMI Prior to Pregnancy												
	2015		2016		2017		2018		2019		5 Year average	
	#	%	#	%	#	%	#	%	#	%	#	%
Underweight (under 18.5)	170	4.1%	156	3.7%	144	3.6%	116	2.9%	139	3.4%	145	3.5%
Normal (18.5-24.9)	1777	42.5%	1761	41.9%	1637	41.0%	1637	40.3%	1615	39.4%	1685	41.0%
Overweight (25-29.9)	1021	24.4%	1081	25.7%	985	24.7%	1033	25.4%	1039	25.4%	1032	25.1%
Obese (over 30)	1135	27.2%	1174	27.9%	1208	30.3%	1269	31.3%	1289	31.5%	1215	29.6%
Unknown	77	1.8%	33	0.8%	16	0.4%	5	0.1%	12	0.3%	29	0.7%
Total	4180	100%	4205	100%	3990	100%	4060	100%	4094	100%	4106	100%

Healthy People 2020 set a goal of increasing the proportion of women delivering a live birth who had a healthy weight (normal BMI) prior to pregnancy to 57.8% (MICH-16.5). Healthy People 2030 has updated the goal (MICH-13) to 47.1% of mothers. Over the 5 years on average, 41% of birthing parents had a healthy weight prior to pregnancy.

Enrolled in WIC during pregnancy												
	2015		2016		2017		2018		2019		5 Year average	
	#	%	#	%	#	%	#	%	#	%	#	%
Yes	1760	42.1%	1768	42.0%	1564	39.2%	1513	37.3%	1451	35.4%	1611	39.2%
No	2412	57.7%	2435	57.9%	2420	60.7%	2544	62.7%	2638	64.4%	2490	60.6%
Unknown	8	0.2%	2	0.0%	6	0.2%	3	0.1%	5	0.1%	5	0.1%
Total	4180	100%	4205	100%	3990	100%	4060	100%	4094	100%	4106	100%

Countywide, WIC participation has decreased over 6% from 2015-2019. Those who receive Medicaid, despite income level, are adjunctively eligible to receive WIC.

Insurance Coverage during delivery												
	2015		2016		2017		2018		2019		5 Year average	
	#	%	#	%	#	%	#	%	#	%	#	%
Medicaid	1700	40.7%	1877	44.6%	1798	45.1%	1822	44.9%	1785	43.6%	1796	43.8%
Private Insurance	2109	50.5%	2053	48.8%	1958	49.1%	1967	48.4%	2077	51.2%	2033	49.5%
Self-Pay/uninsured	157	3.8%	181	4.3%	174	4.4%	216	5.3%	181	4.5%	182	4.4%
CHAMPUS/TRICARE	4	0.1%	9	0.2%	15	0.4%	8	0.2%	14	0.3%	10	0.2%
Other government (Fed, State, Local)	191	4.6%	58	1.4%	13	0.3%	14	0.3%	8	0.2%	57	1.4%
Other	4	0.1%	4	0.1%	8	0.2%	10	0.2%	10	0.2%	7	0.2%
Unknown	15	0.4%	23	0.5%	24	0.6%	23	0.6%	19	0.5%	21	0.5%
Total	4180	100%	4205	100%	3990	100%	4060	100%	4094	100%	4106	100%

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Delivery Method												
	2015		2016		2017		2018		2019		5 Year average	
	#	%	#	%	#	%	#	%	#	%	#	%
Vaginal birth after C-section (VBAC)	46	1.1%	49	1.2%	53	1.3%	56	1.4%	46	1.1%	50	1.2%
Vaginal birth (not VBAC)	2823	67.5%	2844	67.6%	2697	67.6%	2719	67.0%	2745	67.0%	2766	67.4%
Primary C-section	770	18.4%	734	17.5%	757	19.0%	686	16.9%	704	17.2%	730	17.8%
Repeat C-section	538	12.9%	578	13.7%	481	12.1%	598	14.7%	598	14.6%	559	13.6%
Unknown	3	0.1%	0	0.0%	2	0.1%	1	0.0%	1	0.0%	1	0.0%
Total	4180	100%	4205	100%	3990	100%	4060	100%	4094	100%	4104	100%

Deliveries by gestational age												
	2015		2016		2017		2018		2019		5 Year average	
	#	%	#	%	#	%	#	%	#	%	#	%
Extremely preterm (<28 weeks)	24	0.6%	43	1.0%	28	0.7%	26	0.6%	23	0.6%	29	0.7%
Very preterm (28 to <32 weeks)	34	0.8%	32	0.8%	41	1.0%	43	1.1%	31	0.8%	36	0.9%
Moderate to late preterm (32 to <37 weeks)	353	8.4%	332	7.9%	312	7.8%	338	8.3%	328	8.0%	333	8.1%
Early term (37 to <39)	945	22.6%	1009	24.0%	971	24.3%	948	23.3%	997	24.4%	974	23.7%
Term (39-41)	2812	67.3%	2781	66.1%	2626	65.8%	2697	66.4%	2707	66.1%	2725	66.4%
Post Term (42+)	6	0.1%	6	0.1%	9	0.2%	5	0.1%	5	0.1%	6	0.2%
Unknown	6	0.1%	2	0.0%	3	0.1%	3	0.1%	3	0.1%	3	0.1%
Total	4180	100%	4205	100%	3990	100%	4060	100%	4094	100%	4106	100%

Premature deliveries by gestational age												
	2015		2016		2017		2018		2019		5 Year average	
	#	%	#	%	#	%	#	%	#	%	#	%
Total <32 weeks gestation	58	1.4%	75	1.8%	69	1.7%	69	1.7%	54	1.3%	65	1.6%
Total <37 weeks gestation	411	9.8%	407	9.7%	381	9.5%	407	10.0%	382	9.3%	398	9.7%

Healthy People 2020 determined the goal of reducing very preterm (<32 weeks' gestation) to 1.5% (MICH-9.4) of births and reduce total preterm (<37 weeks' gestation) to 9.4% (MICH-9.1). For Healthy People 2030, a singular goal of reducing preterm births is Objective MICH-07 with the same target as 2020 of 9.4%. Gestational age based on clinical estimate of gestation.

Newborns with Low Birth Weight												
	2015		2016		2017		2018		2019		5 Year average	
	#	%	#	%	#	%	#	%	#	%	#	%
Very Low Birth Weight (<1500g)	54	1.3%	63	1.5%	58	1.5%	70	1.7%	52	1.3%	59	1.4%
Low Birth Weight (1500-2499g)	270	6.4%	288	6.8%	266	6.7%	309	7.6%	287	7.0%	284	6.9%

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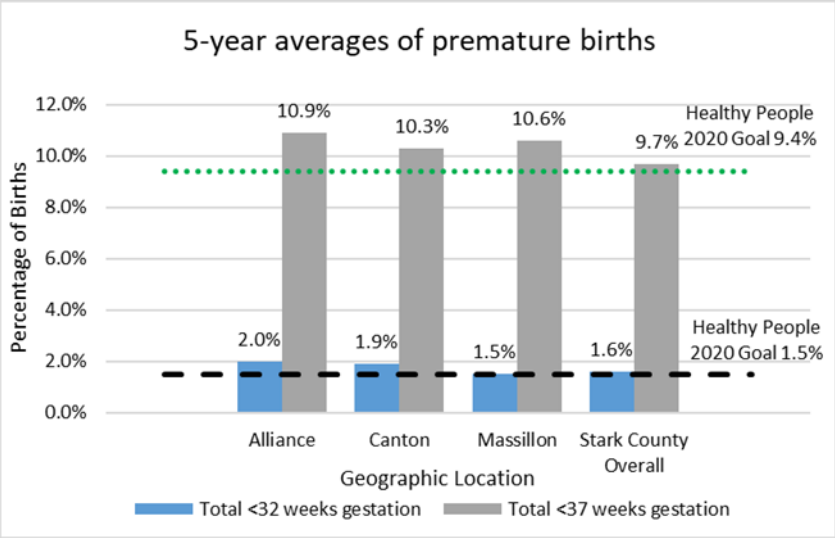
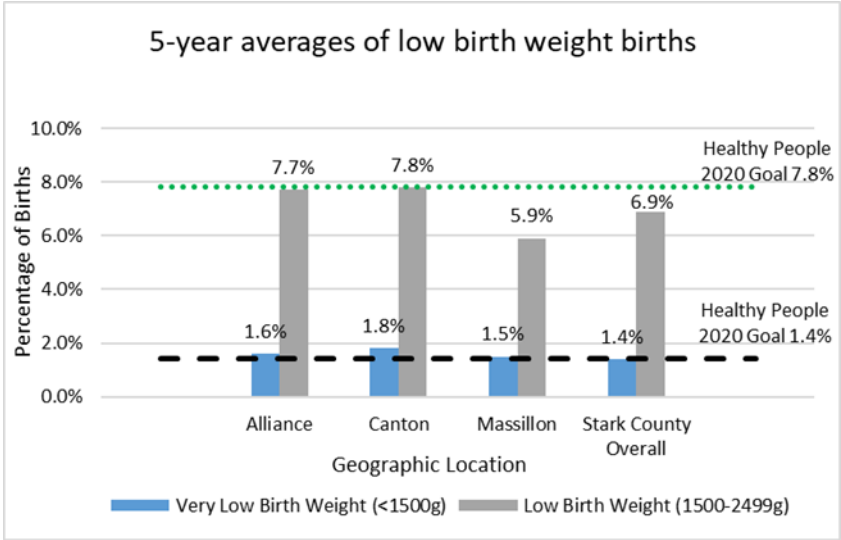
Healthy People 2020 set a goal of reducing very low birth weight (<1,500g) births to 1.4% (MICH-8.2) and reducing low birth weight births (1,500-2,499g) to 7.8% of births. For Healthy People 2030, reducing low birth weight births is not an objective.





Smoking Status												
	2015		2016		2017		2018		2019		5 Year average	
	#	%	#	%	#	%	#	%	#	%	#	%
Smoked 3 months prior to pregnancy	912	21.8%	862	20.5%	842	21.1%	755	18.6%	697	17.0%	814	19.8%
Smoking during First Trimester	789	18.9%	730	17.4%	718	18.0%	642	15.8%	614	15.0%	699	17.0%
Smoking during Second Trimester	703	16.8%	651	15.5%	653	16.4%	575	14.2%	564	13.8%	629	15.3%
Smoking during Third Trimester	689	16.5%	631	15.0%	632	15.8%	554	13.6%	548	13.4%	611	14.9%
Smoked at Any time during Pregnancy	796	19.0%	734	17.5%	724	18.1%	647	15.9%	618	15.1%	704	17.1%

Healthy People 2020 set a goal (MICH-16.3) that 87.8% of women delivering a live birth did not smoke 3 months prior to pregnancy. Over the 5-year average, 80.2% of Stark County residents who gave birth did not smoke 3 months prior with 2019 having the highest percentage who did not smoke at 83%.

Report completed by Jessica Boley, RD, LD. For questions regarding information contained, please email jboley@cantonhealth.org
"These data were provided by the Ohio Department of Health. The Department specifically disclaims responsibility for any analyses, interpretations or conclusions".
Throughout this report, birthing person/parent is utilized to identify the person who gave birth.

References

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Data contained within this report is gathered from Ohio Department of Health Vital Statistics. Tables and graphs include births to those who resided in the Stark County limits during their delivery unless otherwise stated.

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January 2021-December 2021	Counts/Percentage of births			
2021 data is considered preliminary & subject to change.	**Overall**	**Non-Hispanic/ Latine Black**	**Non-Hispanic/Latine White**	**Hispanic/Latine Any Race**
Total Births	3913	522	3176	166
Births <32 weeks gestation % of births	56 1.4%	12 2.3%	38 1.2%	*Less than 10 births recorded
Total pre-term births <37 weeks gestation	368 9.4%	68 13.0%	276 8.7%	17 10.2%
Very low birth weight (<1,500 g)	46 1.2%	10 2.0%	31 1.0%	*Less than 10 births recorded
Low birth weight (<2,500 g)	313 8.0%	70 13.4%	227 7.1%	10 6.0%
Count of infant deaths	21	9	10	2

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Canton City Public Health

Stark County THRIVE (Toward Health Resiliency for Infant Vitality & Equity) works alongside other community organizations and stakeholders to provide support, information, and data to help move the community toward reaching long-term measures in infant vitality by identifying local causes of infant mortality and executing interventions to lower the number of infant deaths in our community.

Interested in learning more?
http://cantonhealth.org/thrive/
www.facebook.com/StarkCoTHRIVE
234-410-3087

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Births <32 weeks gestation % of births	63 1.6%	13 2.6%	47 1.5%	*Less than 10 births recorded
Total pre-term births <37 weeks gestation	384 9.8%	59 11.8%	294 9.2%	24 15.0%
Very low birth weight (<1,500 g)	61 1.6%	15 3.0%	42 1.3%	*Less than 10 births recorded
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