Ohio Equity Institute Annual Report

Fiscal Year 2022

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And

the women and families of Stark County

OEI 2.0 Grant #07620011OE0422

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Executive Summary

In 2022, Stark County residents experienced 3,814 births. Non-Hispanic/Latine (NH) White birthing parents accounted for 3,060 (80.2%) of the births, while Non-Hispanic/Latine (NH) Black/African American birthing parents accounted for 397 (10.4%) births. Hispanic/Latine parents of any race accounted for 182 (4.8%) births.

Stark County families experienced the loss of 22 infants in 2022 an infant mortality rate (IMR) of 5.8 per 1,000 live births. NH White families lost 12 infants (IMR: 3.9) while NH African American families lost 8 infants (IMR not calculated due to rates based on counts less than 10 are considered unstable). This is consistent with 2021 in which Stark County families experienced the loss of 21 infants resulting in an IMR of 5.6 per 1,000 live births. 2022 birth and death data is considered preliminary and subject to change.

PUBLIC HEATH PROBLEMS TO BE ADDRESSED

- **Long Term Measure:** By December 31, 2024, achieve an African American infant mortality rate of less than 8.4 in Stark County. (State of Ohio Goal)
  - Over the period from 2020-2022, the IMR for Non-Hispanic/Latine Black/African American community was 14.9 per 1,000 live births
    - (Deaths: 21 Births: 1414)
- **Long Term Measure:** By December 31, 2024, achieve an overall infant mortality rate of less than 5.0 in Stark County (Healthy People 2030 Goal)
  - In 2022, preliminary data shows the Stark County IMR is 5.8 per 1,000 live births.
- **Long Term Measure:** By December 31, 2024, achieve an African American prematurity percentage of less than 11.1 in Stark County. HP2030 target 9.4%
  - In 2022, preliminary data shows that the percentage of premature births in the Stark County Non-Hispanic/Latine Black/African American community was 16.4%.

The goal and purpose of Stark County's Ohio Equity Institute's funded work is to improve the equity for birthing parents in Stark County to reduce inequities 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.

This report highlights work in progress and completed during the Ohio Equity Institute 2022 grant cycle (OE22). It reflects upon our progress, successes, challenges and future progression to continue improving the health and well being of Stark County families.

Our Story So Far

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.

Stark County THRIVE is a grantee of the Ohio Department of Health, Ohio Department of Medicaid, Ohio's Medicaid Managed Care Plans and local foundations.

OUR PURPOSE

The purpose of Stark County's OEI 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.

All babies in Stark County will celebrate their first birthday

Our Focus

OEI work focuses on three different areas:

- Downstream strategies
- Upstream strategies
- Organizational change

The most significant change from previous years is the addition of the Community Health Equity Coordinator. As past work progressed, we recognized that when it came to improving disparities not only in birth outcomes and upholding the values of CCPH (Quality, Equity, Service & Trust), we needed ensure that equity is a priority that all staff and programs embrace.

Image from: healthyhighpoint.org

ROLE	STRATEGY	OUTCOME
Health Equity Coordinator	Organizational Change	• 96% of staff completed organizational self-assessment • 14 EVRE team meetings held • 11 health & racial equity trainings given • 35 staff attended November BLT sessions
Neighborhood Navigation	Downstream Strategies	• Met 10% of goal for pregnant clients served • 100% referred from non-traditional sources
Social Determinants of Health (SDOH) Committee	Upstream Strategies	• Improved knowledge of resources through the Dear Stark Women campaign • Continued movement on strategies focus on adolescent health
Epidemiologist	Organizational Capacity	• Local expert in data related to birth outcomes • Improved data dissemination • Data Analytics Certificate
Project Coordinator	Organizational Capacity	• OEI project administration and oversight • CCPH Performance Management reporting • Grant management & partner collaboration

Community Context

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.

As redlining and "economic investments" impacted communities, especially 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. Residents in this area primary consisted of Black/African American families. As a result, people residing in these areas are disproportionately impacted by: high poverty, low educational attainment, chronic health conditions, and unemployment.

With the addition of the Community Health Equity Coordinator, Community Roundtables were held in order to get feedback on steps CCPH is taking to ensure we are gathering and utilizing community input on internal changes to improve health & race equity.

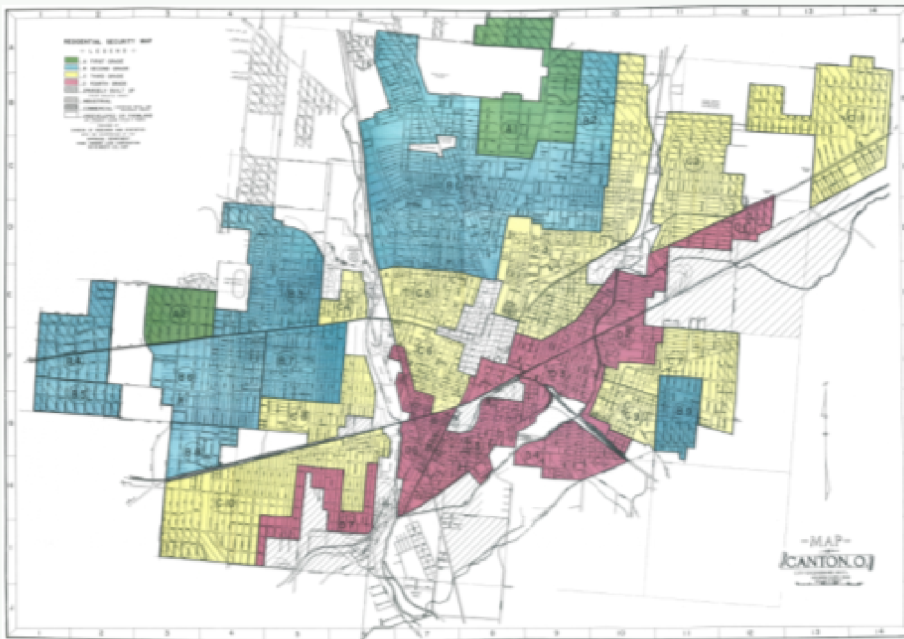


Image from: https://guides.osu.edu/maps/redlining

64%

of Stark County census tracts have low access to food sources

26%

of Stark County children under 5 live in poverty

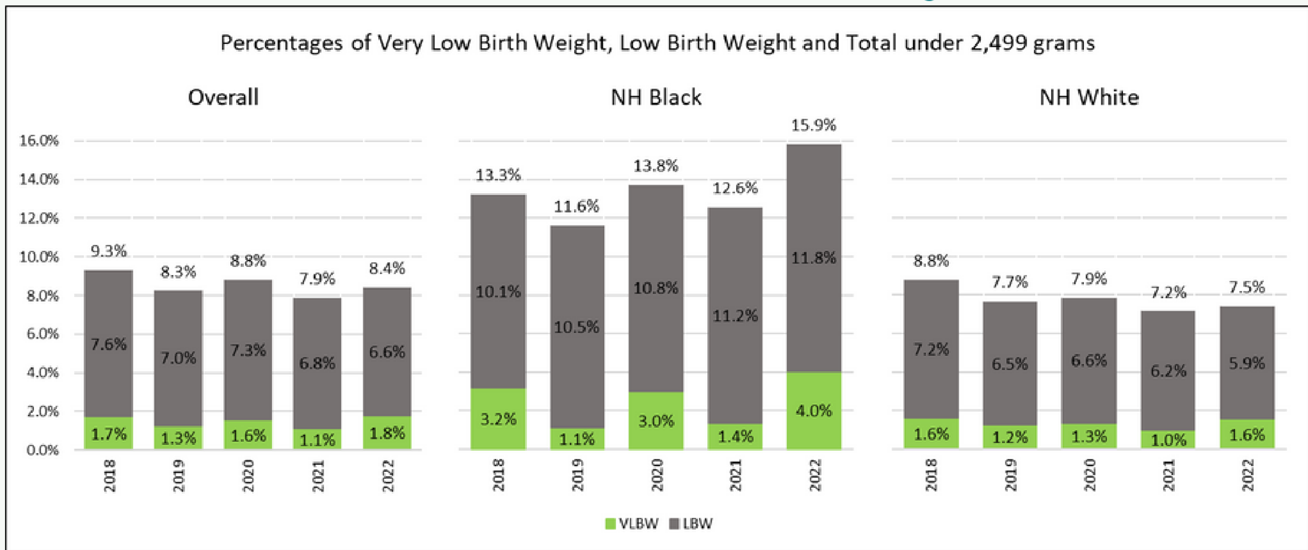
76%

of Stark County residents attended a routine checkup in 2019

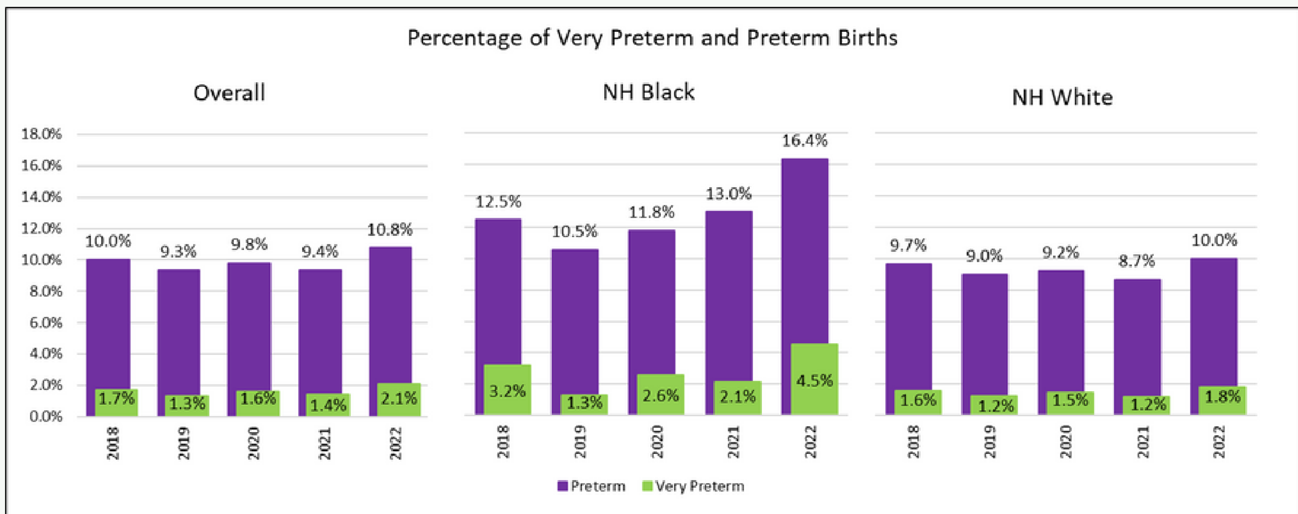
Birth Outcomes in Stark County

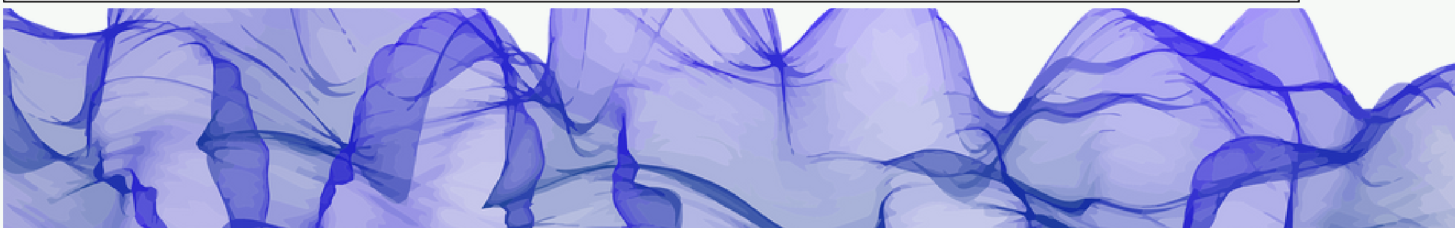
Premature and low birth weight births are common indicators monitored overall. In 2022, the percentage of very low birth weight (VLBW=less than 1,500g) accounted for 1.8% of births overall. Since 2018, there has been a gradual decline in low birth weight (LBW=1,500-2,499g) births accounting for 6.6% of births. This is largely influenced by the decrease we have seen in LBW births to birthing parents who identify as Non-Hispanic (NH) White who make up on average 80% of Stark County birthing parents overall. We are continuing to see an increase in both LBW and VLBW births to birthing parents who identify as NH Black/African American.

The graph below shows the total percentage of births under 2,499 grams at the top of the columns and breaks it down between VLBW and LBW categories.



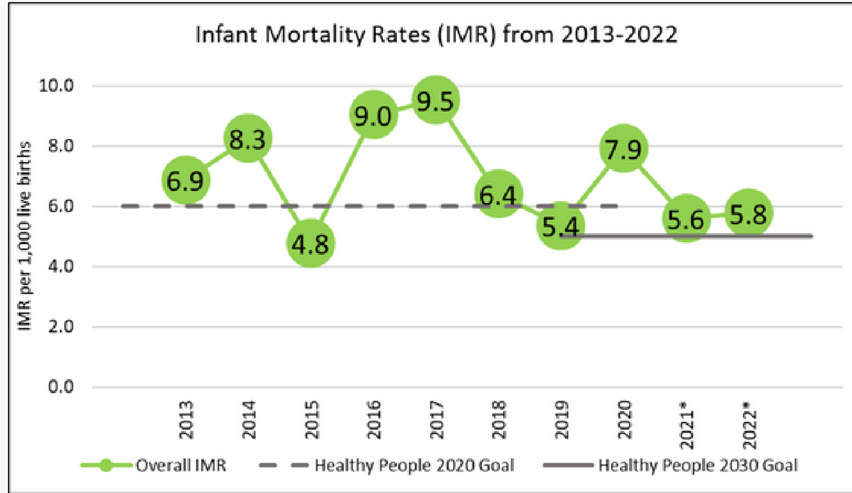
In reviewing very preterm (<32 weeks gestation) and preterm (<37 weeks gestation, includes very preterm births), Stark County overall has not seen much variance in these percentages over the past 5 years. In 2022, we saw an increase in preterm and very preterm births in the NH Black birthing residents.





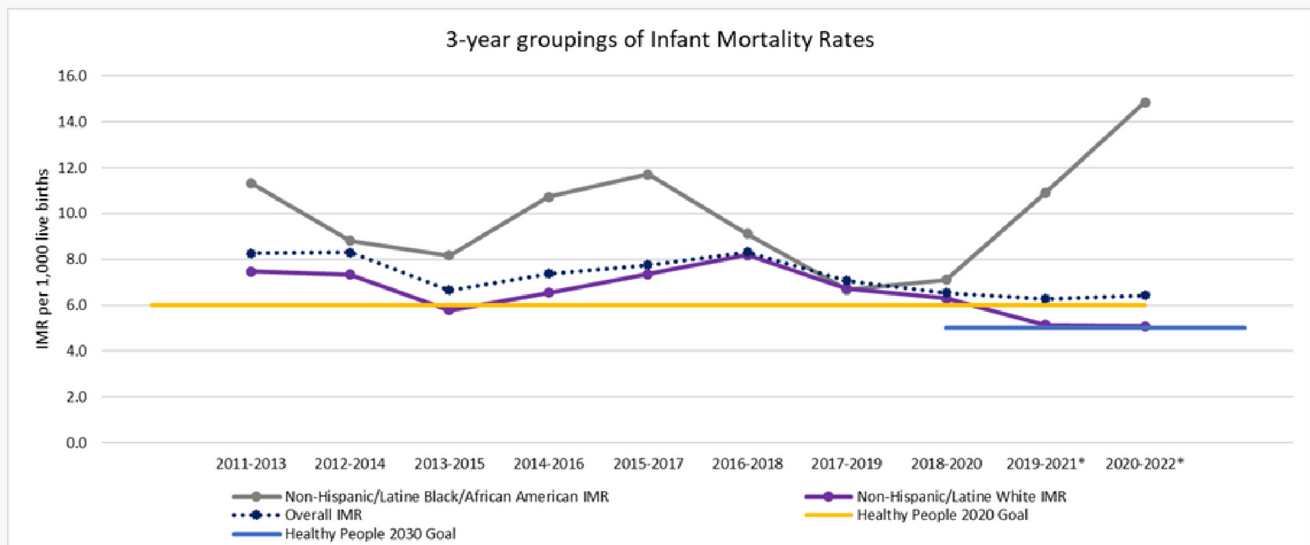
Infant Mortality in Stark County

Infant mortality rates are calculated by the number of infant deaths divided by number of infant births, multiplied by 1,000. Infant mortality rates (IMR) in Stark County since 2013 have fluctuated between 9.5 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 in 2015 and 2021. Healthy People 2030 established the goal of achieving an IMR of 5.0.



During OE22, Epidemiologist completed Phase 1 of a Perinatal Periods of Risk Analysis (PPOR) utilizing data from 2016-2020. This initial phase showed that Maternal Health and Prematurity were the leading contributors to infant deaths in Stark County during this time period. While we are not able to complete this analysis by race/ethnicity, we are able to document that NH Black/African American birthing parents are most affected by LBW and preterm births.

In order to reduce variation caused by low numbers or anomaly years, we also report infant mortality rates (IMR) in 3 year groupings. These data points include all the births and infant deaths over each 3 year period.



*Births and deaths from 2021-2022 are considered preliminary and subject to change.

Neighborhood Navigation

Community outreach strategies in OE22

Initially we focused on community engagement through Navigator's presence at community events such as Juneteenth Celebration, Back to School events, this did not result in connection with Black pregnant people. We changed our approach to "go where pregnant persons were" which included women's health clinics, food bank, homeless navigation intake, and social media.

We determined that establishing relationships for bi-directional referrals increased our served percentage. Other community outreach strategies typically include providing a list of community resources and phone number without conducting subsequent follow up with the client to determine successful attainment of the needed services. OEI Navigation services filled gaps in existing outreach networks by providing follow up contacts to clients and focusing on services that related to social determinants of health not just clinical services.

Outreach efforts focused on agencies, organization, businesses within the prioritized zip codes and social media most frequented by Black/African American persons.

Navigator, Community Health Equity Coordinator and Epidemiologist related their conversations with members of the Black community to identify outreach avenues. In addition, information provided as part of the listening sessions with Black/African American women facilitated by Queens Village Canton and Governor's Task Force on Eliminating Disparities' was reviewed.

- Community partners involved in Navigation included, OB/GYN offices, school districts, Stark Homeless Navigation, individuals, Akron Canton Foodbank, Stark Metropolitan Housing Authority, National Alliance on Mental Illness, churches, African American Arts Festival, Akron Children's Hospital, Crenshaw Back to School event, and My Community Health Center.

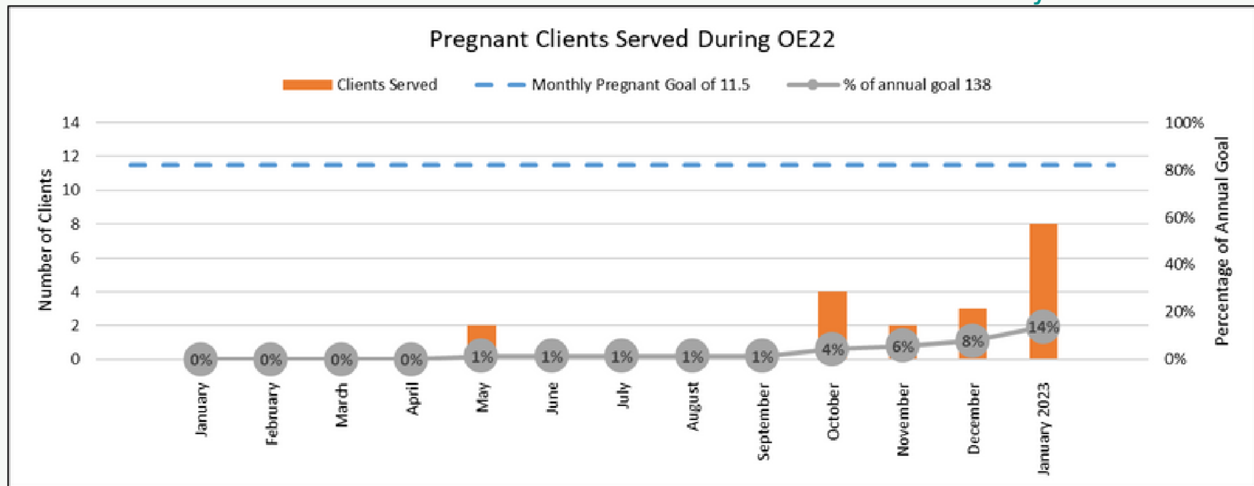
- Successes of Navigation noted by the THRIVE team include an increase in the number served, diversity in sources of referrals, and positive responses by clients served!

100%
of clients served resided in Priority Service Areas

100%
of pregnant clients served were referred from non-traditional sources

Neighborhood Navigation

During OE22, we served a total of 30 clients which included 19 pregnant clients. The majority of these clients were served in Quarter 4. Our goal for the grant cycle was to serve a total of 138 pregnant persons; we achieved 14% of that goal. Quarter 4 includes those who were screened in December 2022 but not served until January 2023.



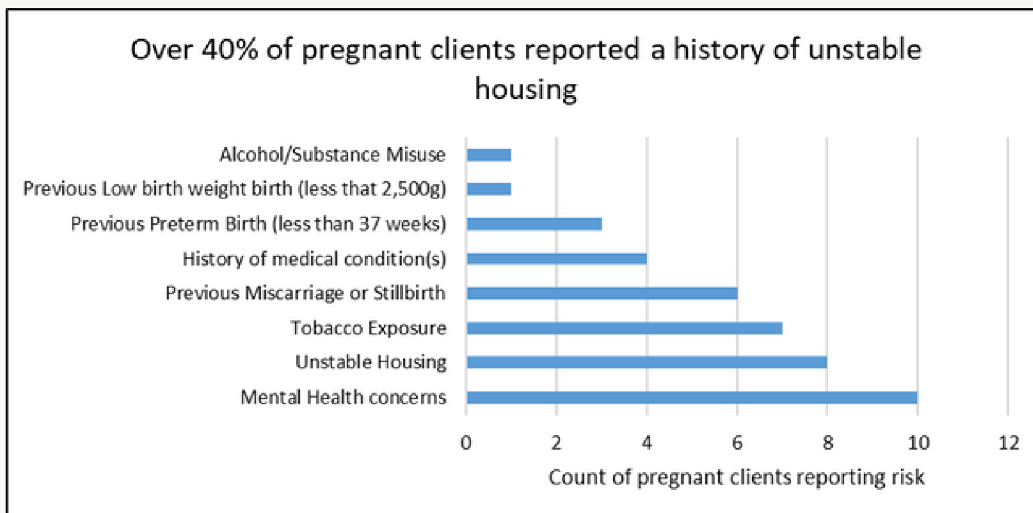
OE22	Quarter 1	Quarter 2	Quarter 3	Quarter 4	Total
Pregnant Clients Served (n)	0	2	0	17	19
Race, Ethnicity					
White, non-Hispanic/Latine	0%	100%	0%	29%	37%
Black, non-Hispanic/Latine	0%	0%	0%	53%	47%
Hispanic/Latine Any Race	0%	0%	0%	12%	11%
Other, non-Hispanic/Latine	0%	0%	0%	6%	5%
Age					
15 - 17 yrs.	0%	0%	0%	12%	11%
18 -19 yrs.	0%	0%	0%	24%	21%
20-24 yrs.	0%	50%	0%	24%	26%
25-29 yrs.	0%	50%	0%	24%	26%
30-34 yrs.	0%	0%	0%	6%	5%
35+ yrs	0%	0%	0%	12%	11%
Education					
Less than HS	0%	50%	0%	18%	21%
HS diploma/GED	0%	50%	0%	65%	63%
Some college, no degree	0%	0%	0%	12%	11%
Associate Degree	0%	0%	0%	6%	5%
Insurance Type					
Medicaid	0%	100%	0%	82%	84%
Private	0%	0%	0%	12%	11%
Uninsured	0%	0%	0%	6%	5%

Similar to years past, the majority of pregnant clients utilized Medicaid for their insurance. During the grant cycle, we did not serve any pregnant clients who were under the age of 15. Also this cycle, none of the pregnant clients served held a Bachelor's Degree or higher, while the majority had completed high school with a diploma or received their GED.

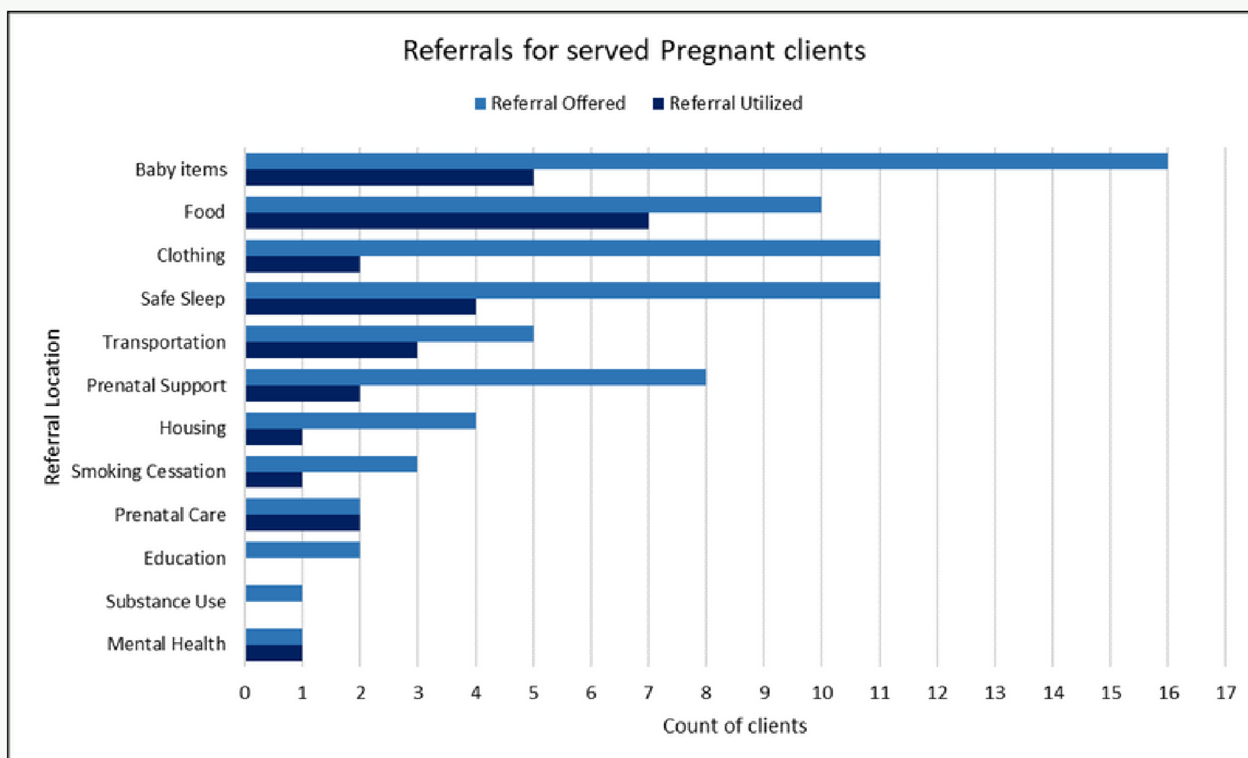
> "**Thank you so much.** You helped me more in 15 minutes than the past week of phone calls I have been making"
> -Client served

Neighborhood Navigation

During the screening process, the NN asks about topics, often categorized as risk factors, that may affect outcomes in the current pregnancy. Clients may answer yes to multiple topics. Over 50% of those served reported that they had mental health concerns including depression and anxiety. Overall, pregnant persons served reported an average of 2.1 risks per person.



Of the pregnant clients served, referrals were offered for 100% of needs identified with an average of 38% utilization overall. Clients were most in need of baby items including car seats, diapers and wipes. We leaned on our partners at the Early Child Resource Center which provides car seats after completing a safety course for 10 of the clients served and the Heart of Ohio Diaper Bank for diapers and wipes for 12 of the clients served.



Neighborhood Navigation

During follow-up contacts, clients are asked if they utilize the referral and discuss any barriers to access. OEI staff learned from client feedback that the Heart of Ohio Diaper Bank limits distribution of diapers until the client is at 32 weeks gestation; this may explain the low utilization percentage (31%) of baby items referrals. Also, some clients had difficulty with the food banks online ordering system; contact to the food bank determined that online ordering was restricted to specific days of the week. OEI staff contacted the food bank, which resulted in the food bank providing an online ordering instruction pdf that we now share with clients.

"I was referred to all of the right helpful and friendly place and surrounded by understanding people and other moms that are just like me"
-Client served

For ODH funded programs, the following referrals were made:

- WIC - 10 clients referred
- Mom's Quit for 2 - 1 client referred
- Cribs for Kids - 7 clients referred

In addition, 9 of pregnant clients served were already receiving WIC and 4 were working with a community health worker.

The biggest challenge this year, especially for non-pregnant clients served, was the lack of rental assistance programs. During the 4th quarter of 2022, many of the programs that previously provided assistance did not have any funding available.
According to the 2018 Stark County Analysis of Impediments to Fair Housing Choice report,

> "The median household income for Blacks in Stark County was $26,843 in 2016, which means that half of Black households can only afford monthly housing expenses (rent, utilities, etc.) of $671 per month. The number of rental units in Stark County that cost $699 or less per month has declined by 9.4% since 2010."

This shows that continued work needs to be done in the housing space in order support equitable outcomes for the Black/African American community in Stark County.

Family Planning & Adolescent Health Committee

Based on feedback from the Community Advisory Committee in 2019, a committee was created to work on gaps identified in Family Planning & Adolescent Health topics. The committee was smaller this year than in years past but group is actively working on recruiting new members for OE23. The group is co-lead by Jessica Boley CCPH and Kelly Potkay from Stark County Health Department (SCHD) and meets virtually bi-monthly.

STARK COUNTY THRIVE OEI 2.0 CORE TEAM

STARK COUNTY THRIVE OEI 2.0
COMMUNITY ADVISORY COMMITTEE

Social Determinants of Health Team: Family Planning & Adolescent Health
Jessica Boley, CCPH Co-Leader
Kelly Potkay, SCHD Co-Leader

COMMITTEE MEMBERS			
MentorStark Laurie Moline	**CareSource** Shauna Shell	**Stark ESC** Patti Fetzer	**Stark County Health Department (SCHD)** Ashlee Wingerter Angie Shapiro Kelly Potkay
Stark County Help Me Grow Christine Frank	**Community Partners** Dr. Amy Lakritz Tracy Herstich		

Family Planning

SCHD was able to successfully launch the "Dear Stark Women" media campaign which included a translatable landing page along with a map feature to visually show resource locations throughout Stark County. This project was supported by a community survey that was conducted in OE21 along with students from Hoover schools who provided recommendations on including SDOH indicators and researched resources to be included.

SCHD also began implementing the practice change that was adopted in OE21 of opening an "after-hours" reproductive health clinic on a monthly basis. During 2022, a total of 29 unique clients were served.

Family Planning & Adolescent Health Committee

Adolescent Health

On the adolescent health side, the group discussed and explored data relating to well visits, adolescent violence, school-based health care centers and began to explore the idea of an adolescent health symposium. In August upon completion of a report on Sexually Transmitted Infections (STI's) in Stark County, it was discovered that in 2020, adolescents ages 15-19 had 4 times higher rates of STI's than other age groups within the county. This caused the group to pivot from planning a symposium to a more concentrated effort on getting community feedback on what may be contributing to these high rates. A brief highlighting birth rates and STI rates for ages 15-19 was created and emailed to 31 individuals throughout 29 different organizations at the end of November.

Of these emails 10 respondents indicated they would participate in one or more of the following steps:

- Conducting a facilitated discussion with their internal team
  - 5 respondents
- Joining a collaborative group discussion on the topics
  - 9 respondents
- Becoming a member of the SDOH committee to move the work forward
  - 6 respondents

In addition, an opportunity arose to collaborate with a group working with adolescents to gain their unique perspective. As a result of these efforts and in order to ensure we are getting meaningful feedback from the Black/African American and adolescent communities, the group decided to pause on a finalization of their policy/practice change identification until additional meetings can be held in the first quarter of 2023.

Housing Team

OEI staff works alongside local organizations and community members 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.

Through a facilitated process the THRIVE 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.

The SDOH Housing Team selected policies/programs to increase community awareness of various housing options; access to stable housing for pregnant persons; early identification of pregnant persons and families with child(ren) calling into the Homeless Hotline and referral to Navigation; Tenant Based Rental Assistance Program for pregnant persons which includes case management and legal support.

As of August 23rd,the Stark OEI SDOH Housing Team disbanded for the following reasons,

a) THRIVE OEI is currently implementing a strategic planning process to guide the future direction and focus of the THRIVE OEI collaborative in addressing Infant Vitality, Maternal Health and Elimination of Disparities; if housing is identified as a priority from this process housing will be revisited as a SDOH priority; and

b) funding for the Tenant Based Rental Assistance program is no longer available. Project Coordinator will reach out to the former committee members if new funding becomes available from local sources or through the state such as the expansion of the Healthy Beginnings At Home, currently implemented in other OEI communities.

During a 6 month period, of the pregnant persons calling Homeless Navigation less than 15% gave consent for referral to THRIVE.

4 families were supported through the Tenant Based Rental Assistance Program for approximately $8,000

Community Health Equity Coordinator

By June of 2020, the United States entered a new era of civil unrest, motivating Canton City Board of Health to declare Racism a Public Health Crisis. As an internal team began to move forward on action steps laid out, the COVID-19 pandemic hindered staff's ability to make meaningful progress.

With OE22 supporting an increase in internal capacity, CCPH was able to post and hire a Community Health Equity Coordinator to lead this value-based work and in March 2022, Serena Draper Hendershot, was brought onto the Stark OEI team.

OE22 focused on:

- Establishing a Race Equity Core Team
- Completion of an Organizational Health Equity Assessment
- Bi-directional communication with community stakeholders
- Creation of 2023 Action Plan

Establishing a Race Equity Core Team

The first task to tackle was the creation of a racial equity core team as modeled by the Government Alliance on Race Equity (GARE). The core team now known as the Evolving Vision of Race and Equity (EVRE) Team is led by Serena and is made up of an additional six internal and two external members. Additional details can be found in Appendix.

Internal members include:

- Brock Bucklew - Environmental Health
- Michelle Streetman - Office of Public Health Information & Innovation (OPHII)
- Sarah Thomas - Nursing
- Ronald Jones - Air Pollution Control
- Josh Fontes - Environmental Health
- Linda Parr -Women, Infants & Children (WIC)

External members include:

- Richard Harper, Esq. - Stark County Prosecutor's Office
- Gino Haynes - Canton For All People

"A question that I recommend organizations ask themselves is how are you ensuring that your organization understands the population being served — and are you reflecting the population being served? It's also about intention — what are you trying to achieve and how are you trying to achieve it?"
Tosan Boyo, M.P.H

"Equity work is fundamentally quality work."

Community Health Equity Coordinator

Organizational Health Equity Assessment

Once the EVRE Team was established, they began the work on their first big project, completion of an organizational Health Equity Assessment. They began by reviewing the Bay Area Regional Health Inequities Initiative (BARHII) toolkit to identify portions to be used along with identification of additional questions to understand staff knowledge and capacity to address health and racial equity inequities/disparities. Once the questions were finalized, it was sent to the THRIVE Epidemiologist to create and launch the final product through Alchemer. With support from the Health Commissioner and the Division Leadership Team, the initial request for responses was sent out on July 18 and upon the survey closing on August 26, 2022, the response rate reached 96%.

93%

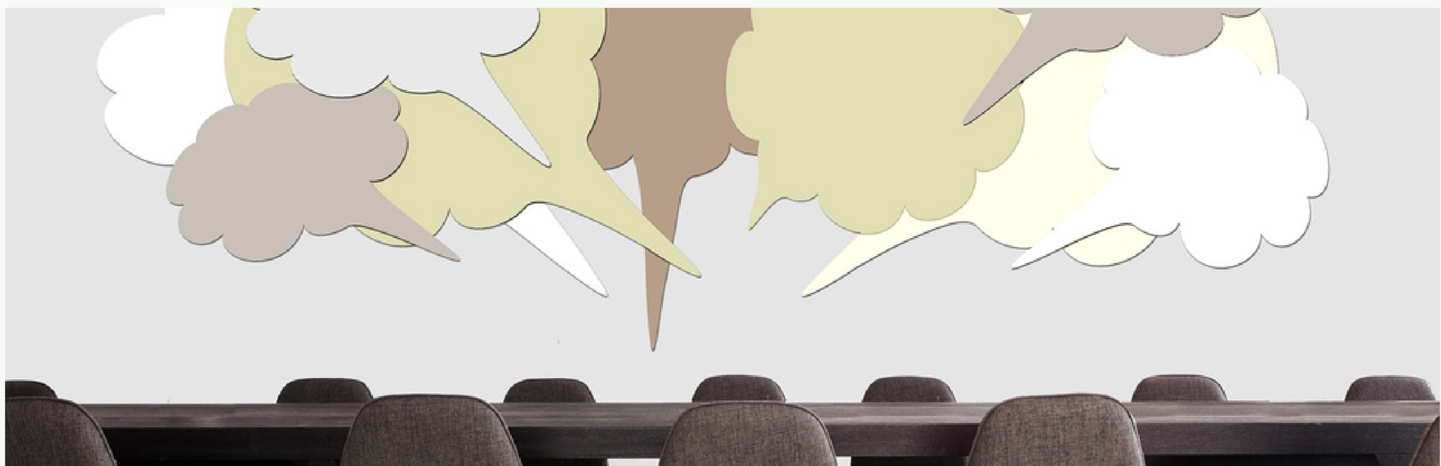
of staff participated in an "Introduction to Health & Racial Equity" Training

Bi-directional communication with community stakeholders

The OEI Team then shifted its focus and also executed an external collaborating partner survey which was released to over 60 community members, with about 22 respondents. This survey in addition to Community Roundtable Discussions held in April & October 2022, and the internal self-assessment brought to light CCPH training needs and the need for capacity building for the Health Equity position along with showing the need to strengthen and create new community partnerships.

40

individuals participated in either Community Roundtable discussion or Collaborating Partners survey



Community Health Equity Coordinator

Creation of racial equity action plan

Based on information gleaned from the surveys and roundtable discussions, Serena led the EVRE team to divide the racial equity action plan into workgroups that would ensure each layer of CCPH would be able to contribute and actively work towards the goals within the action plan.

Looking towards the overarching vision to implement strategies that center the lived experiences of communities of color impacted by health and racial disparities in Canton City, the four workgroups were identified as;

- Data & Communications
- Policy & Personnel
- Power & Partnerships
- Internal & External Education.

Guiding Statement
Implement equitable strategies that center the lived experiences of communities of color impacted by health and racial disparities in Canton City.

By taking these four approaches, we wanted to assure that BIPOC (Black, Indigenous, and other People of Color) were being represented and considered in the work of the department at all levels. It was also important we are intentional about equity focused policies ensuring they are not contributing to the disparities we see in the community, while also changing the current power dynamics of our programs to assure that BIPOC participate in the decision-making process. And lastly, providing ongoing education to our current staff and other organizations which represent social determinants of health sectors.

Operationalizing Organizational Change

Since the EVRE team has representation from each division, normalizing the organizational change has been necessary to advance racial equity. In October of 2022, staff attending the annual all-staff meeting received an introduction to health and racial equity training. As an action step beyond the training, CCPH staff were given a next step options which included:

- Joining the quarterly book club
  - 2023 Q1 Book choice-White Fragility by Robin DiAngelo
- Attending a Building Longer Tables session focused on equity
  - Monthly learning series in collaboration with CCPH Workforce Development Specialist
- Completion of a self-paced training through GARE

EVRE representatives, oversaw their division commitments and achieved at least 80% of each division committing or completing a learning commitment.

Epidemiologist

During OE22, Epidemiologist was focused on the following tasks:

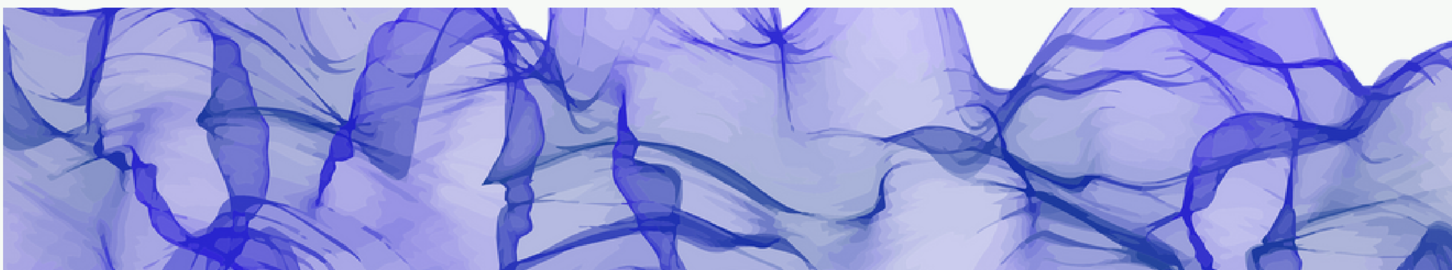
- Monitoring and Evaluating
  - Health Equity Activities
  - Upstream & Downstream Activities
  - Birth Outcomes
- Data Analysis and Dissemination

Monitoring & Evaluation

Work done by Jessica Boley, THRIVE epidemiologist this cycle focused largely on monitoring and evaluation. Utilizing skills taught by the Miami University Discovery Center for Evaluation, Research & Professional Learning, Jessica supported Serena Draper Hendershot, Community Health Equity Coordination with collection of meaningful and measurable data to document progress being made. Jessica and Serena designed and implemented surveys to collect information, analyzed the data to identify items to include in the EVRE action plan, and selected performance measures to evaluate the work being done.

Since Jessica co-leads the SDOH Family Planning & Adolescent Health Committee, she was able to provide the group with data to inform their strategies. Work done in this space is more difficult to evaluate population impact but group has been communicating well to review program impact and are planning to utilize this program data to make future changes. Regarding downstream activities, Jessica was able to get a unique perspective on Neighborhood Navigation work when she began screening and serving clients. From September-December 2022, she successfully screened over 20 clients. By working in this role, she was able to gain knowledge which not only will assist when onboarding the next person to fill that role but also allowed for purposeful input on potential changes to the screening tool for the next grant cycle which can improve future analysis.

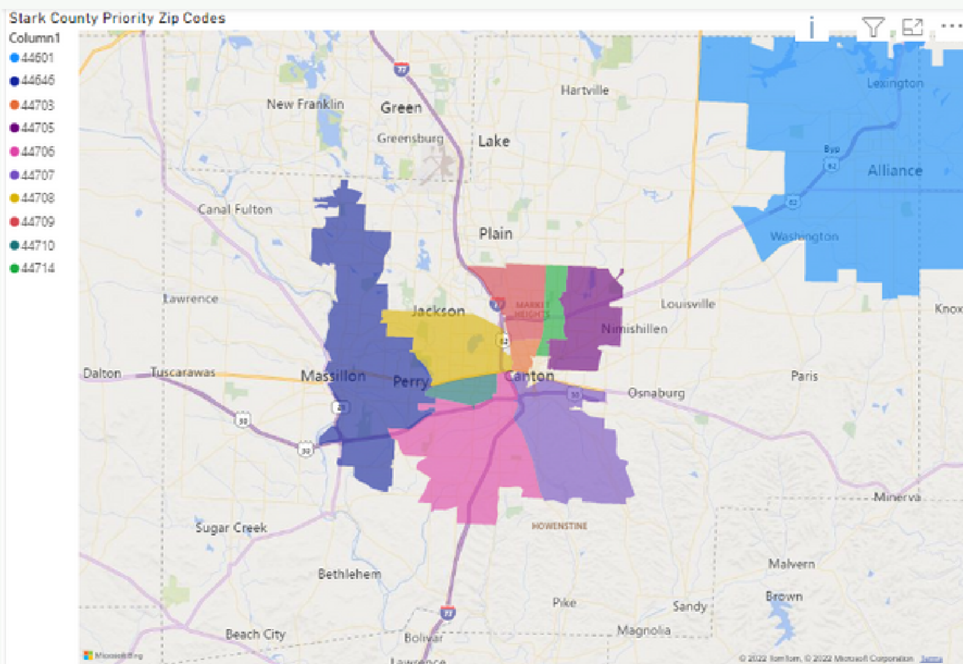
Throughout the year, epidemiologist has the opportunity to monitor and evaluate birth outcomes for Stark County residents overall, in collaboration with Kent State University Pathways HUB Evaluation team for those who work with THRIVE Community Health Workers (CHW), and for quarterly reporting to ODH including a focus on Priority Service Areas (PSA).



Epidemiologist

Data Analysis & Dissemination

The grant cycle started with determination of Priority Service Areas (PSA). With initial analysis completed by ODH, Stark County OEI chose to set the priority service areas as the following zip codes. For additional details including methodology, see **OE22 Priority Service Areas** in the Appendix.



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Zip Codes were the priority focus during OE22

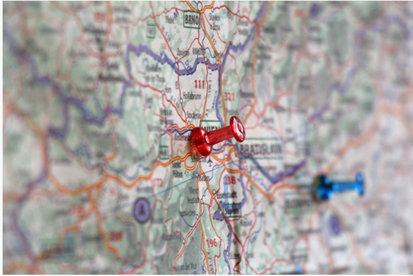
92%

of Data Analysis Plan activities completed

Throughout the year, epidemiologist completed Phase I of the Perinatal Periods of Risk (PPOR) Analysis with plans to complete Phase 2 during the OE23 grant cycle after gathering community feedback on desired reference group for analysis.

In order to keep track of activities completed throughout the year, Jessica reviewed the Data Analysis Plan quarterly. She worked with learning Alchemer and Canva to enhance data collection and dissemination along with completing her Data Analytics Certificate program through Columbus State Community College. These programs allowed for her to release more meaningful data briefs to guide change and improve transparency with different levels of stakeholders.

Opportunities for Improvement



Neighborhood Navigation

- Expand outreach to OB/GYNs to inform about Navigation services for pregnant clients.
- Revisit the messaging used by Homeless Navigation Intake Specialists to increase consent for referrals
- Increase referrals from CCPH divisions
- Engage with courts, first-responders and jail to inform of Navigation services.

Stronger Together

Organizational Health Equity Capacity

In OE23, CCPH Health & Racial Equity Initiatives will:

- Create and strengthen new community partnerships
- Increase staff knowledge on social conditions impacting health outcomes
- Improve staff's comfortability engaging in conversation regarding race relations

SDOH & Policy/Practice Change

We recognize the gaps in community feedback during the OE22 cycle. The team will be working closely with the community to utilize strategies that they feel would be best in addressing these issues during OE23.

Epidemiology & Data Analysis

Looking forward to OE23, Epidemiologist is wanting to improve data dissemination and reporting to get more data out to the community so communities are able to utilize it to continue making meaningful changes.

Project Coordination

- Incorporate strategic planning results in THRIVE OEI workplan where appropriate
- Continue engagement efforts to increase representation from Black/African American community with focus on pregnant persons

Moving Forward

OE22 held its share of successes, challenges and adjustments. We celebrated the addition of the Community Health Equity Coordinator. We improved upon our data dissemination and are including steps in the Race Equity Action Plan to continue to release meaningful data to the community in a digestible way. We continued to be challenged by the Neighborhood Navigation work but were able to adjust by other OEI team members stepping up to screen and served clients. We were successful in that 100% of our clients served resided within our Priority Service Areas.

As we look forward to OE23, we are encouraged by identified ways to improve, the continued support at the State and Local level, and feel the sense of urgency to accelerate progress in our work.

Health & Racial Equity

With the support from the Health Commissioner and the Division Leadership Team, the Health & Racial Equity work made tremendous strides. As an organization we are looking forward to implementing CCPH Health & Racial Equity principles in all that we do.

SDOH work

In OE23, the Family Planning and Adolescent Health Team continue working with communities to:

- Reduce teen birth and sexually transmitted infection (STI) rates
- Improve disparities in teen birth and STI rates

Neighborhood Navigation

In OE23, we will be working towards expansion of Neighborhood Navigation services within My Community Health Center's OB/GYN medical group; improving engagement with pregnant persons.

To improve outcomes and impact systems that cause health inequities we recognize this work cannot be done alone, we encourage you to reach out to us to see how you can be a part of the THRIVE collaborative.

Disclaimer & Contact

Analysis contained within this report were conducted by Jessica Boley, RD, LD THRIVE Epidemiologist I. All calculations in the graphs and charts 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), Hispanic/Latine Any Race unless otherwise noted.

At the time of this release (January 2023) 2021 & 2022 birth and death data was preliminary and subject to change. The Ohio Department of Health provides access to birth and death data via the Secure Data Warehouse. Data contained in this report was accessed for analysis no later than 1/4/2023.The Department specifically disclaims responsibility for any analyses, interpretations or conclusions"

OEI data accessed from ODH RedCap System; final access for analysis on 1/5/2023.
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