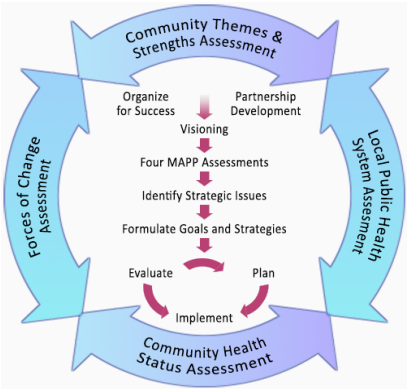
Stark County Community Health Improvement Plan
2017-2019 Evaluation Report

The Stark County Health Department (SCHD) began facilitating the community health needs assessment process, in 2010, to meet the requirements of the Affordable Care Act for nonprofit hospitals and Public Health Accreditation Board standards for health departments. The assessment is a systematic examination of the health status indicators of the population that is used to identify key problems and assets within the community. The ultimate goal of the community health assessment is to develop strategies to address the community's health needs and identified issues. The assessment process is supported and guided by local public health departments, healthcare systems, mental health, social service agencies, and non-profit organizations.

The Stark County Community Health Needs Assessment (CHNA) Advisory Committee follows the Mobilizing for Action through Planning and Partnerships (MAPP) Model. MAPP is a community-wide strategic planning process that assists communities with prioritizing public health issues, identifying resources for addressing those issues and developing a shared long-term Community Health Improvement Plan (CHIP). MAPP is an evidence-based approach to public health practice that includes six phases and four assessments. The three significant components underlying the foundation of this process are strategic planning, collaboration, and quality improvement.



The Stark County CHNA Advisory Committee is comprised of 29 community agencies and volunteers; including four health districts and three nonprofit hospitals that participate and are actively engaged with the assessment process. During 2019, the CHNA Advisory Committee met quarterly to discuss the work being accomplished within the community that directly aligned to the priority health areas highlighted within the 2017-2019 CHIP, to identify any emerging health issues, to organize the annual Health Improvement Summit, to finalize the 2019 Community Health Assessment (CHA) and begin developing the 2020-2022 CHIP.

The 2017-2019 Stark County CHIP was implemented over a three year time period from 2017 through 2019. The purpose of the 2019 CHIP Evaluation Report is to document and communicate the progress and challenges in achieving the goals, objectives, and implementation of strategies related to each of the priority health areas.

Since the assessment process began in 2010, the CHNA Advisory Committee has participated in, organized, created and/or completed the following:

- 2010, 2014 & 2017 Stark County Indicators Reports: This report contains secondary data sets that reflect the status of the community and can be used as a predictor of future conditions. The report illustrates trends at the county level.
- 2011 Stark County Collaborative Poll: The poll is a randomized telephone survey used to gather primary health data directly from community residents. The questions focused on the following areas: overall needs and health; general physical and mental health; access to care; immunizations; smoking and tobacco use; alcohol consumption; prescription medication abuse; obesity and access to healthy foods; exercise; and texting while driving.
- 2011, 2015 & 2019 Stark County Community Health Assessments: This assessment provides a valuable overview of the health issues and status of Stark County residents. The assessment data was collected in phases. The first phase consists of a random sample telephone survey of Stark County residents. The second phase consists of reviewing and analyzing secondary data sources to identify areas of concern. The third phase consists of a web survey of community leaders knowledgeable about public health. Additional data obtained through community focus groups was included in the 2019 assessment. The 2019 CHA was utilized to update the strategies within the 2020-2022 CHIP.
- 2012, 2017 & 2020 Community Health Improvement Plans: This plan is a guide to improve the health of the community by addressing specific strategies and activities. The plan identifies health priorities, goals and long-term key measures used by community partners to guide project development, programs, and policies targeted to improve the health outcomes of Stark County residents. The priority health areas addressed within the plan include: Assess to Health Care, Infant Mortality, Mental Health and Obesity & Healthy Lifestyles.
- 2015-2016 Community Health Improvement Plan Addendum: The addendum contains measureable objectives that better define the 2012 CHIP goals and strategies. These objectives were created from the work conducted by community coalitions and agencies that addressed one of the three priority health areas. The addendum also included a fourth priority: Infant Mortality.
- 2014, 2015, 2016, 2017 & 2018 Community Health Improvement Plan Evaluation Reports: This report evaluates the progress of the goals, objectives, and strategies being implemented within the community for each of the priority health areas and identifies any gaps, areas of improvement, and/or emerging health issues that need to be addressed.
- Health Improvement Summit: Since 2011, a Health Improvement Summit has been organized annually to provide updates, information, prioritization, and presentations for community members, agencies, and/or stakeholders on the assessment process.
- 2015 SWOT Analysis: The SWOT Analysis identified the strengths, weaknesses, opportunities for improvement, and threats that coincided with the assessment process.
- 2018 Stark County CHA Vision: *"A county where all residents have the opportunity to thrive where they live, learn, work and play".* This shared community vision provides an overarching goal for the community to work towards.

A lead organization/agency was identified to facilitate a subcommittee for each priority health area and provide quarterly reports on the CHIP outcomes. The following section of the report provides an overview of the progress made towards each of the priority health areas over the past three years (2017-2019).

Priority One: Access to Health Care

Access Health Stark County (AHSC) facilitated the initiatives addressed under the Access to Health Care priority area. AHSC is a non-profit organization that focuses on giving community residents a chance to live a better life, by providing access to a coordinated system of health care and resources to those who are underserved and/or uninsured within the community. AHSC utilizes Community Health Workers (CHWs) to help families get connected to resources.

Goal #1: ALL PEOPLE HAVE EQUITABLE ACCESS TO HEALTH CARE SERVICES

1) **Long Term Measure**: By December 2019, increase use of Community Health Workers (CHW) in Stark County by 75%.

Baseline: 2016 - 4 CHWs (3 KOBA/1 AHSC Patient Care Coordinator)
2019 - 24 CHWs (2 Moms & Babies First/16 THRIVE/6 Chronic Disease)

The long term measure to increase the use of CHWs in Stark County by 75% was met. Over the past three years (2017-2019) the number of CHWs has increased from 4 to 24 for a 500% increase overall. CHWs continue to be a major asset in connecting residents to needed resources. The 2020-2022 CHIP will utilize CHWs to accomplish several strategies that directly align to the updated long term measures.

Objective/Activity	Data (# or %)	Narrative	Agency Responsible
Develop the Stark County CHW Program Model	100%	AHSCs CHW Center provides recruitment, training, practicums, and verified certification by the Ohio Board of Nursing. AHSC also provides coaching and assistance with the integration of CHW's into organizations and/or onto multidisciplinary health teams.	AHSC
Partner with local academic institution for CHW approve certification training curriculum	100%	AHSC was officially approved as a training site (in partnership with NEOMED) in June of 2018.	AHSC; NEOMED
Establish a local CHW Network/Community to meet at least 12 times for CHW support	100%	The Peer Support Learning Community was established to provide professional education; self-care assessments; and an opportunity for CHWs to discuss and share the	AHSC

		challenges/successes of client engagement/approaches/outcomes. The committee meets on a regular basis and continues to provide support to CHWs.	
Promote the use of CHWs through at least 3 educational seminars/trainings with key stakeholders annually	100%	AHSC regularly promotes the important role CHW's play in helping communities thrive and individuals live better lives. To date, AHSC presented to: • Alliance Family Health Center • Aultman Hospital ER & Discharge Services • Aultman Hospitals OB/GYN Offices • Aultman Hospital's School of Nursing • Aultman Hospital Residents • Canton City Schools • Commquest • Early Childhood Symposium • Equitas Health • Goodwill Campus Partner Luncheon • Hall of Fame Women's Clinic • Jackson Township Fire Department • Local Foundations • Mercy Medical Center's Provider Offices • Mercy Medical Center Residents • My Community Health Center • Prevent Blindness • SCMSA Health Fair • Several Community Partners • Stark Family Health Center • Triad Deaf Services • US Department of Veterans Affairs Outpatient Clinic • Walsh University	AHSC

Participate in a Pathways HUB system to support CHW work and data collection	100%	All AHSC CHWs are licensed and have been trained on the Stark County THRIVE Pathways HUB. • 2018 - 11 THRIVE CHWs were trained on the THRIVE Pathways HUB. • 2019 - 22 THRIVE/Chronic Disease CHWs have been trained on the THRIVE Pathways HUB.	AHSC; THRIVE
Collect at least 75% of CHW salary with HUB participation reimbursement	100%	All CHWs receive reimbursement for services entered into the THRIVE Pathways HUB. AHSC is receiving funding at 75% for CHWs as a care coordinating agency.	AHSC; THRIVE; Local Agencies & Organizations

2) **Long Term Measure:** By December 2019, reduce barriers to accessing health care for vulnerable populations.

Baseline:

2015 CHA - 73% of community leaders reported residents have difficulty getting needed medical services with transportation, cost, and lack of understanding/knowledge of available services as the biggest barriers. The majority of respondents, 87.5%, indicated that they owned a vehicle. Respondents who were more likely NOT to have a vehicle include urban residents, unemployed respondents, renters, those who are not married, non-white respondents, and those with an annual income under $25,000.

2019 CHA - 90.3% of community leaders identified lack of transportation as a barrier that prevents residents from receiving necessary medical care; with lack of insurance or the ability to pay, communication issues, lack of knowledge of available services, lack of behavioral health availability, and receiving quality health care as other common barriers to receiving needed medical care. The majority of respondents, 85.8%, indicated that they owned a vehicle. Respondents who were more likely NOT to have access to reliable transportation include urban residents, unemployed respondents, those with a high school diploma or less education, renters, respondents who are not married, non-white respondents, and those with an annual income under $25,000.

The long term measure to reduce barriers to accessing health care for vulnerable populations was not met. Reducing the barriers to accessing health care for vulnerable populations remains a major concern for the CHNA Advisory Committee. Since transportation continues to be one of the major barriers identified for vulnerable populations the 2020-2022 CHIP will focus on reducing the number of low income residents who do not have access to reliable transportation.

Objective/Activity	Data (# or %)	Narrative	Agency Responsible
Complete a transportation assessment that identifies key interventions/actions to improve access to health services	100%	In 2017, the SCHD organized and facilitated a group of community agencies through a Transportation Needs Assessment. A tool was developed and administered to two groups: • Community Residents • Community Stakeholders The Stark County Transportation Work Group continues to meet as needed to discuss and work on reducing transportation barriers/gaps for Stark County residents.	SCHD
Implement at least two strategies identified in the transportation assessment	100%	The Stark County Transportation Work Group worked on and completed the following strategies during 2018: • Created a Transportation Resource Guide for community agencies to utilize when assisting clients/customers. • Created a transportation "pocket guide" for community agencies to distribute to clients/customers who may need assistance with transportation. • Worked with AHSC, SCHD, Coleman Professional Services (Peer Support Program) and Alliance Family Health Center to implemented and/or update current transportation policy/procedure to decrease the number of no-show and cancelled appointments. • Worked with Minerva United Methodist and Paris Israel Churches to implement a transportation initiative where the churches would assist community members in getting to and from their medical appointments.	SCHD

		In 2019, the Stark County Transportation Work Group developed and began implementing a work plan identifying specific objectives and strategies addressing transportation barriers.	
Research and identify a model for tele-med and/or para-med options for vulnerable populations through a FQHC, Look-Alike, or Community Health Center	100%	In 2017, a physician at My Community Health Center researched alternative healthcare models/programs for vulnerable populations. The alternative health care option identified as a possible project for Stark County was to implement a medical kiosk to assist individuals who needed health care.	My Community Health Center
Pilot at least one alternative healthcare model identified by research (kiosk/medical assistance project)	100%	My Community Health Center and North Canton Medical Foundation collaborated to pilot a Telehealth Kiosk, locate at the Refuge of Hope, a homeless shelter for men. • 2018 - The North Canton Medical Foundation funded a staff position to assist individuals utilizing the Kiosk two half days per week. Over 25 patients received medical care. • 2019 - 37 patients received medical care at the Kiosk. In September, the Refuge of Hope collaborated with another community agency to have a nurse practitioner on-site to provide care to individuals at the homeless shelter. At that point, the Telehealth Kiosk was no longer needed.	My Community Health Center & North Canton Medical Foundation
Increase the number of Community Health Centers, FQHC's, or Look-Alike facilities who offer alternative hours and scheduling for patient visits	100%	The Alliance Family Health Center officially received notification of their FQHC Look-Alike-Status in September 2018. The center also provides afterhours services (walk-ins/scheduled appointments) to accommodate patient schedules. The Mastroianni Family Center, a homeless shelter in Alliance, is open once a week for community members to receive health care. The American Heart Associations' Check Change Control Program is being offered at the center.	Alliance Community Health Center; My Community Health Center

		My Community Health Center officially received notification of their FQHC Look-Alike-Status in September 2018.	
Increase the number of residents who participate in the SARTA Medicaid Ride training	100%	In 2017 & 2018 AHSC provided education and focused on teaching clients how to utilize Medicaid benefits for rides. Several community partners provide bus passes and clients looking for work are more motivated to participate in the SARTA Medicaid Ride training. There was a 25% increase in participation between 2016 & 2018 for the SARTA Medicaid Ride training. Transportation has been identified as the number one social service by AHSC. In 2019, AHSC began to track transportation referrals, transportation pathways opened, and transportation pathways completed.	AHSC; SARTA
Train at least 100 health care providers on Cultural Influence and Health Care	100%	StarkMHAR's SC3C Committee organized an annual Populations Focus Learning series that addressed different cultural and community influences. • 2017 - 321 individuals received cultural/health care training on the following populations: African American, Youth, Hispanic and Appalachian. • 2018 - 390 individuals received cultural/health care training on the following populations: LGBTQ Youth Homelessness, Faith Based, Amish Culture & Community and Cultural Perspectives on Trauma. • 2019 - 248 individuals received cultural/health care training on the following populations: New American, Asian, Deaf & Hard of Hearing, and Mayan Cultures	StarkMHAR; United Way

3) **Long Term Measure:** By December 2019, decrease the percent of respondents from vulnerable populations reporting not having a primary care provider from 16% to 10% through FQHC's, safety net clinics or private practice.

Baseline:

2015 CHA - Most community residents 84.4% reported having one person or group that they think of as their primary care doctor; 14.8% of respondents indicated they receive health care most often from an ED/Urgent Care Center. Groups of respondents most likely to use a place other than a primary care doctor for health care include unemployed respondents, urban residents, those ages 18 to 44, minorities and those with an annual income under $50,000.

2019 CHA - Most community residents, 86.1%, reported having one person or group that they think of as their doctor or health care provider; 13.5% of respondents indicated they receive health care most often from an ED/Urgent Care. Groups of respondents more likely to use a source other than a primary care doctor include males, renters, those who are unemployed, non-white, those who are not married, respondents with an annual income $50,000 or less, those with a high school diploma or less education, urban residents, and those ages 18 to 44.

The long term measure to decrease the percent of respondents from vulnerable populations reporting not having a primary care provider to 10% was not met. Although the intended percentage wasn't reached there was a 1.7% increase in the overall percentage of respondents reporting having one person or group as their primary care provider. The 2020-2022 CHIP will continue to focus on increasing the percentage of residents who have a primary care provider.

Objective/Activity	Data (# or %)	Narrative	Agency Responsible
Promote the use of the Stark County Health Care Resource Guide to community agencies	100%	To date, AHSC distributed over 400 printed and electronic copies of the Stark County Health Care Resource Guide to community partners, agencies and members.	AHSC; Local Agencies & Organizations
100% of CHWs will coordinate referrals to primary care/specialists at FQHC's, clinics and private providers	100%	All 22 CHWs trained in the THRIVE Pathways HUB coordinate care with primary care physicians, OBs, and other specialists located at: • My Community Health Center • Alliance Family Health Center • Commquest • Mercy Ambulatory Clinic • Private Practice	AHSC; SCHD; THRIVE
Pilot at least one alternative healthcare model identified by	100%	My Community Health Center and North Canton Medical Foundation collaborated to pilot a Telehealth	Aultman's My Community Health

research (kiosk/medical assistance project)		Kiosk, locate at the Refuge of Hope, a homeless shelter for men. • 2018 - The North Canton Medical Foundation funded a staff position to assist individuals utilizing the Kiosk two half days per week. Over 25 patients received medical care. • 2019 - 37 patients received medical care at the Kiosk. In September, the Refuge of Hope collaborated with another community agency to have a nurse practitioner on-site to provide care to individuals at the homeless shelter. At that point, the Telehealth Kiosk was no longer needed.	Center & North Canton Medical Foundation

4) **Long Term Measure:** By December 2019, decrease the percent of respondents from vulnerable populations (unemployed, renters, males, ages 45-64, non-white, making less than $25,000 per year) who report not having health insurance from 10% to 5%.

Baseline: 2015 CHA - 4.8% of respondents reported not having health insurance.
2019 CHA - 8% of respondents reported not having health insurance.

The long term measure to decrease the percent of respondents from vulnerable populations who report not having health insurance was not met. Changes to the Affordable Care Act over the last several years have played a role in the outcome of this measure. It is still important to the CHNA Advisory Committee that all residents have health insurance. The 2020-2022 CHIP will continue to focus on decreasing the percentage of residents who do not have health insurance or Medicaid.

Objective/Activity	Data (# or %)	Narrative	Agency Responsible
Promote the use of the Stark County Health Care Resource Guide to community agencies	100%	To date, AHSC distributed over 400 printed and electronic copies of the Stark County Health Care Resource Guide to community partners, agencies and members.	AHSC; Local Agencies/Organizations
100% of CHWs will coordinate referrals to insurance/marketplace or available insurance options	100%	In 2017, AHSC refereed clients to LifeCare Family Health & Dental Center, connected them to a broker to help walk them through the process, and/or	AHSC; SCHD; THRIVE

		provides instructions on how to access/navigate healthcare.gov. In 2018, the following efforts were made by local foundations/agencies to assist residents with obtaining health insurance during open enrollment: • Local agencies/libraries distributed information • Two Repository articles were posted • Information was posted on social media In 2019, AHSC referred non-Medicaid clients to a Medicaid broker to assist with obtaining insurance and contacted the Medicaid hotline to assist Medicaid eligible clients with the application process. AHSC also collaborated with several local agencies to help connect residents to health insurance.	
Increase the utilization of Marketplace Navigators and Certified Application Counselors (CAC)	100%	In 2017, Stark County had two Certified Application Counselors. AHSC continued to refer clients to LifeCare, connect them to a broker to help walk them through the process, and/or provide instructions on how to access/navigate healthcare.gov.	FQHCs, AHSC, SCHD

Goal #2: ALL PEOPLE HAVE THE ABILITY TO LIVE THEIR HEALTHIEST LIFE

1) **Long Term Measure:** By December 2019, there will be at least a 3% decrease in the respondents from vulnerable populations (urban, non-white, unemployed) who report their health as being poor or very poor.

Baseline: 2015 CHA - 5% of respondents reported their health as being poor or very poor.
2019 CHA - 7% of respondents reported their health as being poor or very poor.

The long term measure to decrease the percentage of respondents who report their health as being poor or very poor by 3% was not met. Having a healthy community is still very important to the CHNA Advisory Committee. Improving the health of community residents will continue to be focused on and addressed in the 2020-2022 CHIP under the Obesity & Healthy Lifestyles priority health area.

Objective/Activity	Data (# or %)	Narrative	Agency Responsible
Increase AHSC Membership Program participant's personal health status by 50%	88%	In 2017 & 2018, AHSC enrolled residents into a Membership Program to build member awareness and increase overall health. A pre/post survey was implemented to clients every 3-6-9-12 months. AHSC utilized membership survey data to track health status increases; 2018 follow up data showed the following increases: • Health Status Increased by 3 Levels - 2% • Health Status Increased by 2 Levels - 13% • Health Status Increased by 1 Level - 29% • Health Status Remained the Same - 43% • Health Status Decreased - 13% In 2019, a new Executive Director took over at AHSC. The focus of the agency was redirected and the Membership Program was discontinued.	AHSC
Increase the number of healthy behaviors reported by AHSC Membership Program participants	100%	In 2017 & 2018, AHSC enrolled residents into a Membership Program to build member awareness and increase overall health. AHSC continued to utilize membership survey data to track increases in healthy behaviors; 2018 follow up data provided the following self-reported knowledge and behavior changes: • 38% reported an increase in knowledge of managing chronic disease, understanding medications, and/or increase in nutrition • 42% reported a change in behavior In 2019, a new Executive Director took over at AHSC. The focus of the agency was redirected and the Membership Program was discontinued.	AHSC
Recruit 5 health care providers to the AHSC Physician Support	100%	In 2018 & 2019, AHSC worked with the following health care providers/systems:	AHSC

Program		• Aultman Hospital • LifeCare Family Health & Dental Center • Mercy Medical Ambulatory Care Clinic • Mercy Medical Behavioral Health • Mercy Physician Offices (5) • My Community Health Center • Stark Family Health Center	
Enroll at least 300 members in the AHSC Membership Program utilizing model program options	100%	AHSC engaged and worked with chronic disease clients through the Pathways HUB to provide/refer clients to needed resources/education. • 2018 - 600 clients were served • 2019 - 317 clients were served	AHSC
Implement evidence-based or best practice diabetes prevention programs for select target communities	100%	In 2018, AHSC offered and/or provided the following to particpants in the Membership Program: • DEEP Diabetes Education • AHAs Check Change Control Program • Personal Fitness Coaching (taught by physiologist) • Nutrition & Medication Education In 2019, AHSC added the following services: • Blindness Prevention Screenings • SNAP ED 66 Medication Assessment Pathways were completed which links directly to chronic disease management.	AHSC
Increase the participation in the Walk With A Doc program in the community	100%	Participation in Walk With A Doc increase by 50% from 2016 (164) to 2017 (306); however, the program is no longer being implemented within Stark County.	United Way, Local Hospitals; LWSC

Priority Two: Mental Health

Stark County Mental Health & Addiction Recovery (StarkMHAR) facilitated the initiatives addressed under the Mental Health priority area. StarkMHAR is a multi-faceted county behavioral health board comprised of expert professionals, dedicated volunteers and concerned community leaders. StarkMHAR supports wellness and recovery through innovative funding, collaboration, education and advocacy.

Goal #1: ALL PEOPLE HAVE EQUITABLE ACCESS TO BEHAVIORAL HEALTH SERVICES AND SUPPORTS

1) **Long Term Measure:** By December 2019, decrease the average appointment wait time for clients with referrals for behavioral health services and supports by 10%.

Baseline: 2016 StarkMHAR Funded Providers - 9.38 behavioral health appointment wait time in days.
2019 StarkMHAR Funded Providers - 5.42 behavioral health appointment wait time in days.

The long term measure to decrease the average appointment wait time for behavioral health services/supports by 10% was met. The overall appointment wait time was decreased by 42% over the past three years. Accessing behavioral health services/supports quickly still remains an issue for many Stark County residents. The 2020-2022 CHIP will continue to focus on reducing the wait list time for initial behavioral health assessment & services.

Objective/Activity	Data (# or %)	Narrative	Agency Responsible
Train 100 behavioral health providers on the Cultural Competency Linguistic Model	100%	StarkMHAR's SC3C Committee organizes Cultural & Linguistic Competency related trainings. • 2017 - 8 Cultural Linguistic Competency trainings were held, training 566 individuals. • 2018 - 10 Cultural Linguistic Competency trainings were held, training 496 individuals. • 2019 - 4 Populations Focus Learning trainings were held, training 248 individuals.	StarkMHAR
100% of behavioral health providers will coordinate referrals with CHW's for behavioral health services and supports		Over the last three years (2017-2019) all CHWs have received training on the THRIVE Pathways HUB to coordinate care with primary care physicians, OBs, and other primary care specialists. The focus was not expanded to include behavioral health providers during this timeframe, so this objective was not addressed.	StarkMHAR; AHSC
Reduce waiting lists county-wide for same day access to care and	42%	This objective was added under this goal in 2018, since StarkMHAR is actively working to shorten the wait time	StarkMHAR

ongoing services.		to receive behavioral health care and services for Stark County residents. • 2017 - 7.45 appointment wait time in days. • 2018 - 6.41 appointment wait time in days. • 2019 - 5.42 appointment wait time in days.	

2) Long Term Measure: By December 2019, increase the number of behavioral health and substance abuse treatment and prevention programs and supports by 25%.

Baseline: 2017 StarkMHAR Funded Programs - 90 programs addressing behavioral health system gaps received funding.
2019 StarkMHAR Funded Programs - 204 programs addressing behavioral health system gaps received funding.
The long term measure to increase the number of behavioral health and substance abuse treatment and prevention programs/supports by 25% was met. Behavioral health and substance abuse treatment and prevention programs/supports increased 126%, overall.

Objective/Activity	Data (# or %)	Narrative	Agency Responsible
Assess the behavioral health system to identify existing gaps	100%	StarkMHAR assessed the behavioral health system as part of the agency's strategic planning process in order to identify all pre-existing gaps. StarkMHAR is currently in the process of completing a Recovery Oriented System of Care (ROSC) Assessment to further identify existing gaps.	StarkMHAR
Research and identify funding to address gaps identified in behavioral health system	100%	StarkMHAR provided funding to programs within the community addressing gaps identified within the behavioral health system. Funding for programming is determined based on priority area and community need. • 2017 - 90 programs received funding • 2018 - 107 programs received funding • 2019 - 97 programs received funding	StarkMHAR
Complete a transportation assessment that identifies key interventions/actions to improve	100%	The SCHD organized and facilitated a group of community agencies through a Transportation Needs Assessment. A tool was developed and administered to	SCHD

access to behavioral health services		two groups: • Community Residents • Community Stakeholders The Stark County Transportation Work Group continues to meet quarterly to discuss and work on reducing transportation barriers/gaps for Stark County residents.	
Implement at least two strategies identified in the transportation assessment	100%	The Stark County Transportation Work Group worked on and completed the following strategies during 2018: • Created a Transportation Resource Guide for community agencies to utilize when assisting clients/customers. • Created a transportation "pocket guide" for community agencies to distribute to clients/customers who may need assistance with transportation. • Worked with AHSC, SCHD, Coleman Professional Services (Peer Support Program) and Alliance Family Health Center to implemented and/or update current transportation policy/procedure to decrease the number of no-show and cancelled appointments. • Worked with Minerva United Methodist and Paris Israel Churches to implement a transportation initiative where the churches would assist community members in getting to and from their medical appointments. In 2019, the Stark County Transportation Work Group developed and began implementing a work plan identifying specific objectives and strategies addressing transportation barriers.	SCHD

Goal #2: ALL PEOPLE ARE AWARE OF MENTAL HEALTH SERVICES AND SUBSTANCE ABUSE PREVENTION

1) **Long Term Measure**: By December 2019, increase Mental Health First Aid Training by 50%.

Baseline: 2016 StarkMHAR - 584 individuals trained on Mental Health First Aid
2019 StarkMHAR - 1,344 individuals trained on Mental Health First Aid

The long term measure to increase Mental Health First Aid Training by 50% was met. The overall number of individuals trained increased by 130% over the past three years (2017-2019). The high suicide rate is still a major concern for the CHNA Advisory Committee. The 2020-2022 CHIP will focus on decreasing the suicide rate for youth and adults, as well as strengthen access to and delivery of suicide care throughout the county.

Objective/Activity	Data (# or %)	Narrative	Agency Responsible
Increase awareness and importance of the Mental Health First Aid Training to the community	100%	StarkMHAR provided the Mental Health Fist Aid Training to community residents and adolescents. The Mental Health First Aid training teaches participants how to help someone who is developing a mental health problem or experiencing a mental health crisis. • 2017 - 660 individuals trained • 2018 - 426 individuals trained • 2019 - 258 individuals trained Overall 1,344 individuals received the Mental Health First Aid Training from 2017-2019.	StarkMHAR & Community Partners
Research and identify funding to address gaps identified in behavioral health system	100%	StarkMHAR provided funding to programs within the community addressing gaps identified within the behavioral health system. Funding for programming is determined based on priority area and community need. • 2017 - 90 programs received funding • 2018 - 107 programs received funding • 2019 - 97 programs received funding	StarkMHAR

2) **Long Term Measure:** By December 2019, increase the awareness of suicide prevention by increasing the utilization of the crisis text line by 10% and utilization of mobile response.

Baseline:
2017 StarkMHAR – crisis text line: 1,886 conversations, 1,033 texters, 6 active rescues
mobile response unit: 358 responses (144 youth, 214 adult)
2019 StarkMHAR - crisis text line: 1,463 conversations, 1,060 texters, 13 active rescues
mobile response unit: 1,008 responses (333 youth, 675 adult)
The long term measure to increase the awareness of suicide prevention by increasing the utilization of the crisis text line and mobile response unit by 10% was met. Overall, the number of individual texters and active rescues implemented through the crisis text line increased by 2% and 116%, respectively. The total number of mobile responses increased by 181% overall. The high suicide rate is still a major concern for the CHNA Advisory Committee. The 2020-2022 CHIP will focus on strengthening the access to and delivery of suicide care throughout the county.

Objective/Activity	Data (# or %)	Narrative	Agency Responsible
Increase community knowledge on how to recognize the signs and symptoms of depression and suicidal behavior	100%	StarkMHAR increased community knowledge on how to recognize the signs and symptoms of depression and suicidal behaviors through the following training and educational outreach: In 2018: • 505 community members received Question, Persuade, Refer(QPR) Sucide Prevention Training • 400 Timken Company employees received education on the warning signs of, risk factors for, and where to seek help on suicide • Numerous communications/events were focused on raising awareness around mental health and suicide through local media efforts such as Healthy Minds Magazine. In 2019: • 120 community members received QPR Suicide Prevention Training.	StarkMHAR

		• 73 trainings were provided by StarkMHAR and other behavioral health organizations on mental health, suicide, substance abuse, and stress/mental health wellness. The following agencies/businesses received education law enforcement, school resource officers, local universities, Leadership Stark County, Timken Company, and Pro Football Hall of Fame.	
Increase the number of people trained in QRP at community and college campuses	100%	StarkMHAR provided QPR Suicide Prevention Training to community residents & college campuses. QPR teaches 3 simple steps that anyone can learn to help save a life from suicide. People trained in QPR learn how to recognize the warning signs of a suicide crisis and how to question, persuade, and refer someone to help. Overall 1,008 individuals (460 university affiliations) received QPR training from 2017-2019.	StarkMHAR
Increase the number of clinicians/providers trained in Zero Suicide	100%	Zero Suicide is a specific set of strategies and tools to be utilized by health and behavioral health care systems where risk for suicide can be detected, monitored and treated. • 2018 - StarkMHAR hosted and trained 75 clinicians/providers at the Zero Suicide Academy. • 2019 - 75 providers (15 organizations) worked to implement specific Zero Suicide strategies and tools. A follow up training will be held in 2020.	StarkMHAR

3) **Long Term Measure:** By December of 2019, decrease the suicide rate by 5%.

Baseline: 2016 StarkMHAR - 77 overall suicide rate for Stark County
2019 StarkMHAR - 73 overall suicide rate for Stark County

The long term measure to decrease the suicide rate by 5% was met. Suicide continues to be a major concern for the CHNA Advisory Committee. The 2020-2022 CHIP will focus on decreasing the suicide rate for youth and adults, as well as strengthen access to and delivery of suicide care throughout the county.

Objective/Activity	Data (# or %)	Narrative	Agency Responsible
Implement the national suicide campaign/advertisement – Man Therapy	100%	In 2017, StarkMHAR promoted and completed the national suicide campaign – Man Therapy: An Innovative Approach to Suicide Prevention in Working Aged Men. A total of 1,985 individuals visited the Man Therapy website. The website provided men with information to set them straight on the realities of suicide and mental health, and a tool to help stop the suicide deaths of so many men. Additional individuals were reached during a print campaign implemented in October 2017.	StarkMHAR
Increase utilization of suicide screening tools	100%	In 2018, several organizations trained in Zero Suicide implemented one of the following Columbia-Suicide Severity Rating Scale (C-SSRS): • Identification, Triage, and intervention Using the C-SSRS Planning Intervention: Increasing Precision, Redirecting Scarce Resources & Saving Lives • Reducing Suicide and Prevention Gun Violence in Our Communities and Military: The C-SSRS as a Method of Risk Identification in the Hands of Everyone In 2019, the C-SSR assessment was integrated into the NextGen EHR System. Currently, three treatment providers are supported by NextGen. Additionally, eight other organizations are utilizing the C-SSRS and five others integrated the assessment into their EHR. Overall 251 individuals received C-SSRS training from 2017-2019.	StarkMHAR; Stark County Providers
Increase utilization of schools implementing Signs of Suicide, or other evidence-based programs	100%	StarkMHAR continued working with the Stark County School Districts to utilize and implement best practice, evidence-based programming.	Stark County School Districts

		In 2017, school district personnel were trained on the following curriculums: 1) Youth Mental Health First Aid – this course introduces common mental health challenges for youth, reviews typical adolescent development and teaches a 5-step action plan for how to help young people in both crisis and non-crisis situations. 2) Lifelines Suicide Prevention - Lifelines is a comprehensive, schoolwide suicide prevention program for middle and high school students. The program seeks to increase the likelihood that school staff and students will know how to identify at-risk youth when they encounter them, provide an appropriate initial response, and obtain help, as well as be inclined to take such action. In 2018, 16 out of 17 school districts received training in suicide postvention best practices. School districts have increased mental health services within 93 buildings across the county and continued to partner with StarkMHAR/SCHD to implement an ongoing student survey. In 2019, all 17 school districts received training and support in suicide postvention best practices.	

4) **Long Term Measure:** By August 2019, decrease Drug Overdose deaths by 15%.

Baseline: 2016 Stark County Coroner's Report - 118 number of overdose deaths in Stark County.
2019 Stark County Coroner's Report - 103 number of overdose deaths in Stark County.

The long term measure to decrease drug overdose deaths by 15% was not met. The total number of overdose deaths decreased by nearly 13% overall from 2017-2019. Reducing the number of unintentional drug overdose deaths is still an important public health concern the CHNA Advisory Committee will continue to address. The 2020-2022 CHIP will focus on reducing overdose deaths for adults and alcohol/drug use by youth.

Objective/Activity	Data (# or %)	Narrative	Agency Responsible
Complete an evaluation of the Stark County Opiate Task Force	100%	In 2017, a survey was administered to evaluate the Stark County Opiate Task Force. The results of the survey indicated a need for Strategic Planning. In 2018, StarkMHAR contracted with an outside strategic planning consultant. A smaller planning committee was organized to work on creating a new strategic plan. The following subcommittees were established to work on and address each priority area included in the new strategic plan: Education, Task Force Processes & Procedures, Membership, Advocacy, Data and Innovation. In 2019, the Stark County Opiate Task Force added Addiction to its name, Stark County Opiate and Addiction Task Force (OATF), to better align with the changing trends in the community. This allowed the OATF to address issues related to all substances of abuse and all aspects of addiction. The annual Opiate Symposium also changed its name to Conference on Opiates and Addiction. Additionally, the OATF continued to work on its strategic plan/subcommittees in partnership with Stark County Health Department.	SCHD, StarkMHAR
Conduct evaluation and data surveillance activities to establish baseline data	100%	The Prescription Drug Overdose Committee (PDOC) collaborated with Stark County Epidemiologists to review the health monitoring system EpiCenter for unintentional overdose and non-fatal unintentional overdose visits to EDs and Urgent Cares. A monthly surveillance report is developed to track trends and compare the number of unintentional overdose visits.	SCHD; Stark County Coroner
Develop a Community Immediate Response Action Plan	100%	The Community Immediate Response Action Plan was finalized in August of 2017. The plan is updated and tested annually.	SCHD

Convene an Opiate Death Review Committee	100%	In 2017, the Stark County Opiate Fatality Review (OFR) Team was organized and met 3 times. The Team was comprised of professionals from Public Health, Mental Health, Physicians, Law Enforcement, Hospital Administrators, Emergency Medical Services, Coroner's Office, and Treatment Providers. In 2018 & 2019, the OFR Team continued to meet on a regular basis to review/track all of the unintentional overdose deaths and work on the OFR Annual Report. The Annual Report encompasses the findings of current/arising trends, new initiatives, and any information to combat the opiate epidemic. In 2019, the OFR developed and included recommendations in the Annual Report to assist with the reduction of overdose deaths. The OFR also expanded the committee to include more community agencies.	SCHD
Increase the number of physician offices that have adopted Smart Rx into their practice policies	100%	In 2017, the PDOC surveyed physicians to determine familiarity with prescribing guidelines and if a written protocol was in place for using them. In 2018, the PDOC began reaching out to local provider offices and hospitals to assess the current prescribing guideline protocols in place. In 2019, the PDOC implemented a mass mailing to local provider offices discussing the benefits and importance of integrating the Ohio Automated Rx Reporting System (OARRS) into the electronic medical records system. The PDOC created and distributed Physician Toolkits and provided trainings to interested providers. The committee also tracked the percentage of physicians	SCHD

		who utilized OARRS and integrated it into an electronic health record systems: • 2017 - 27% utilized OARRS • 2018 - 75% utilized OARRS • 2019 - 95% utilized OARRS	
Expand the Naloxone education and distribution program to school districts, law enforcement agencies, and correctional facilities	100%	In 2018, the PDOC worked with law enforcement to expand the use of naloxone. A yearly refresher course on naloxone administration was created; a new online form was created to better track data and refill requests; an inventory of naloxone was taken; and the current naloxone policy was reviewed. The PDOC also reviewed college drug abuse policies and worked with staff to incorporate peer lead activities and initiatives on campus. The committee continued working with school districts to implement prescription drug abuse prevention education and/or the Safe Home or HOPE curriculum to students, as well as provided a sample naloxone policy. In 2019, the SCHD and CCPH collaborated to develop a leave behind naloxone program for EMS. The SCHD also collaborated with the Stark County Jail System and Commquest Detox Unit to provide education and distribute naloxone kits to this vulnerable population. • Jail System - 134 kits • Detox Unit - 364 kits	SCHD; StarkMHAR
Provide training and education to 50 prescribers regarding Prescription Drug Overdose	54%	In 2018, training and/or education was provided to 19 physicians, nurse practitioners, and physician assistants regarding prescription drug overdose. In 2019, the SCHD hosted an ASAM/Ohio waiver training 8 health care providers.	SCHD
Implement a media campaign to increase awareness of the dangers of	100%	Information and education on the dangers of prescription drug abuse was provided to the general	SCHD

prescription drugs and how to discard them		public through the utilization of the Take Change Ohio ads and messaging campaign. • 2018 - SARTA busses were utilized to get the ads and messaging out to the public. • 2019 - SCHD collaborated with StarkMHAR and the Stark County Jail System to get the messaging campaign out to the public. The StarkMHAR collaboration included a 30 second clip implemented for 5 weeks through Tinseltown & Movies 10. The 30 second clip focused on prescription drug abuse awareness and made 100,000 on screen impressions and 200,000 lobby impressions. The Stark County Jail System collaboration included a combination of targeted ads (by zip code) through Carnation Cinema, Alliance Review, Q92, and WHBC94.1 with a total reach of 125,000.	
Expand the number of insurance providers by at least 15% that cover Naloxone	100%	In 2017, local insurance providers were assessed regarding naloxone coverage. It was determined that most insurance companies do cover the cost of naloxone.	SCHD
Increase availability of Naloxone in community to service entities	100%	SCHD and CCHD continue to have standing orders for Naloxone available for service entities.	StarkMHAR

5) **Long Term Measure:** By December 2019, increase the awareness and usage of parks/outdoor spaces as an additional recovery support for mental health treatment and substance use recovery.

Baseline: 2016 - No parks/outdoor spaces were designed to specifically support mental health treatment and substance use recovery.
2019 - One walking path is designed to specifically support mental health treatment and substance use recovery.
The long term measure to increase the awareness and usage of parks/outdoor spaces as an additional recovery support for mental health treatment and substance use recovery was met. The mindfulness path was very successful with several requests throughout the county for additional trails. Stark Parks also received the Parks & Rec Governor's Award for the mindfulness walking path.

Objective/Activity	Data (# or %)	Narrative	Agency Responsible
Research and identify a program/model for integrating parks/outdoor spaces as an additional recovery/treatment option for mental health.	100%	In 2017, Stark Parks researched programs for integrating parks/outdoor spaces as an additional recovery/treatment option for mental health. A strong link between outdoor/physical activity and mental health was identified.	Stark Parks
Pilot at least one program/model identified by research (mental health walks)	100%	Stark Parks and StarkMHAR collaborated to develop a "Mindfulness Walk" that focused on mindfulness and grounding techniques. Located at Petros Lake Park, this one mile walking trail includes 10 different mindful activity stations and takes the user through several types of natural environments including woodland, open fields, meadows, and near the lake. The 10 mindful activities include: • What is "Mindfulness" • Breathing • Stone Stacking • Labyrinth • Musical Notes • Stepping Stones • Meadow Meditation • Zen Sand Garden • Lake Meditation • Reflection on the User's Experience	Stark Parks; StarkMHAR

Goal #3: ALL PEOPLE HAVE THE OPPORTUNITY TO RECEIVE BEHAVIORAL AND PHYSICAL HEALTH SERVICES AT THE SAME TIME AND THE SAME PLACE

1) **Long term measure:** By December 2019, increase the number of co-locations that support and provide behavioral health and physical health services and supports by 10%.

Baseline data was not provided or collected within the timeframe of the 2017-2019 CHIP. This long term measure to increase the number of co-locations that support and provide behavioral and physical health services and supports by 10% was lofty. Although, the CHNA Advisory Committee had really good intentions, other projects and priorities took precedence.

Objective/Activity	Data (# or %)	Narrative	Agency Responsible
Promote the importance of having a behavioral health care navigator	100%	In 2018, StarkMHAR hired 2 Cultural Allies to assist individuals with navigating the health and behavioral health systems. In 2019, the cultural allies received training and began working with families mostly in Canton, Massillon, and Alliance. The families are referred to some of the following agencies: • Child & Adolescent • Coleman • CommQuest • THRIVE Over 780 African-Americans and 800 Latino/a/x-Maya individuals (youth/adults) were assisted.	StarkMHAR
Collaborate with local hospitals, FQHCs, safety net clinics or private practice to increase the utilization of behavioral health care navigators	100%	Aultman Hospital collaborated with Crisis Intervention & Recovery and CommQuest to utilize a behavioral health navigator to provide crisis intervention for patients and families in the ED. The behavioral health navigator creates a seamless linkage to all community mental health agencies. Mercy Medical Center utilized nurse navigators in the ED to assist with crisis intervention for patients and	StarkMHAR; FQHC's; Local Hospitals and Providers

		families in need, as well as provides assistance with referrals.	
Collaborate with local hospitals, FQHCs, safety net clinics or private practice to improve the integration of behavioral and physical health care	100%	Aultman Hospital, through My Community Health Center, provided assessment and referral information to patients to receive necessary mental health intervention and treatment. Aultman-Alliance Community Hospital collaborated with CommQuest Services to provide clients with a full spectrum of services including mental health, substance use and social services. CommQuest is located onsite within the main building of the hospital and develops inpatient services, expands outpatient services and provides education, prevention and treatment of alcohol, drugs and other addictive behaviors. Mercy Medical Center collaborated with CommQuest Services to offer behavioral health services at Mercy's St. Paul Square location.	StarkMHAR; FQHC's; Local Hospitals and Providers
Increase the number of primary care providers that are screening for behavioral health disorders	10%	In 2018, StarkMHAR engaged pediatricians, to begin providing behavioral health information and resources to patients.	StarkMHAR; FQHC's; Local Hospitals and Providers
Increase the number of co-locations that are completing behavioral health screenings	10%	In 2018, StarkMHAR began to research and gather baseline data for this activity/long term measure. Although, the CHNA Advisory Committee had really good intentions, this measure was lofty and other projects and priorities took precedence.	StarkMHAR; FQHC's; Local Hospitals and Providers
Train at least 100 primary care providers and/or CHWs to discuss behavioral health disorders with patients		Over the last three years (2017-2019) all CHWs have received training on the THRIVE Pathways HUB to coordinate care with primary care physicians, OBs, and other primary care specialists. The focus was not expanded to include behavioral health providers/disorders during this timeframe, so this objective was not addressed.	StarkMHAR; FQHC's; Local Hospitals and Providers; AHSC; THRIVE

Increase the number of system navigators who are able to assist with the integrated care of patients	100%	In 2018, Stark County TASC supported a Peer Support Program that responds to local EDs when an individual is seeking substance abuse treatment and/or has experienced an overdose. The goal of the program was to assist and link individual in time of need to ongoing SUD treatment. In 2019, Stark County TASC continued to support the Peer Support Program serving 446 individuals through local EDs; 375 of the individuals accepted a referral for ongoing treatment (306 attended first appointment/144 received ongoing services).	StarkMHAR

Priority Three: Infant Mortality

Managed by Canton City Public Health (CCPH), Stark County THRIVE (Toward a Healthier Resiliency for Infant Vitality and Equity) is the multi-pronged, multi-sector collaborative who facilitated the initiatives addressed under the Infant Mortality priority health area. THRIVE is comprised of Stark County residents, organizations, agencies, and businesses who focus on improving birth outcomes and reducing racial disparities in infant mortality.

Goal #1: ALL BABIES IN STARK COUNTY WILL CELEBRATE THEIR FIRST BIRTHDAY

1) **Long Term Measure:** By December 2019, decrease the overall infant mortality rate to less than 6.0.

Baseline: 2016 ODH (preliminary data) - 9.3 overall infant mortality rate
2019 ODH (preliminary data) - 4.9 overall infant mortality rate

The long term measure to decrease the overall infant mortality rate to less than 6.0 was met. Although the infant mortality rate for Stark County was significantly reduced, over the last three years (2017-2019) it still remains an important issue for the CHNA Advisory Committee. The 2020-2022 CHIP will continue to focus on reducing the overall, black and white infant mortality rate.

Objective/Activity	Data (# or %)	Narrative	Agency Responsible
Enroll at least 50 pregnant women in Pathways HUB Model program	100%	Stark County has 11 agencies that employ a total of 16 CHWs who assist pregnant women and families with children under age 1 through pathways within the HUB. • 2017 - 128 women were enrolled into the THRIVE Pathways HUB. • 2018 - 280 women were enrolled into the THRIVE Pathways HUB. • 2019 - 215 women were enrolled into the THRIVE Pathways HUB.	THRIVE; Care Coordination Agencies
Expand Centering Pregnancy program locations by 200%	100%	CenteringPregnancy programs are currently being offered at the following locations within Stark County: • Alliance Family Health Center • My Community Health Center	THRIVE; Alliance Family Health Center
Identify ongoing funding and systems support for CHWs	100%	THRIVE received the following amount of funding over the past three years (2017-2019) - $1,338,600.	THRIVE

Fully implement Pathways Community HUB Model	100%	This objective was completed in September of 2017 when the THRIVE Pathways HUB went live.	THRIVE; CCHD
Train all community health workers and nurses on the *Partners for a Healthy Baby* outreach curriculum	100%	In 2017, CHWs located at the SCHD were provided information/resources on Partners for a Healthy Baby curriculum. In 2018, THRIVE contacted Florida State University, the developer of the Partners for a Healthy Baby curriculum, to provide the full 3-day training to all CHWs and home visiting programs. In 2019, a 3-day training on the Partners for a Healthy Baby curriculum was held April 15-17; 44 CHWs and home visiting program staff attended the training.	SCHD
Expand home visiting programs and hospital facilitated community outreach and engagement	100%	Aultman WOW Van conducted education about safe sleep practices and/or referrals to Cribs For Kids at over 30 unduplicated locations reaching a total of: • 2017 - 2,539 individuals • 2018 - 1,222 individuals In 2019, CHWs referred 90 clients to Cribs For Kids. Aultman WOW Van's funding ended in 2018.	THRIVE; Community Partners
Develop and support a network of community health workers to work with pregnant women in obtaining early prenatal care and needed support services	100%	Access Health Stark County's (AHSC) CHW Center provides recruitment, training, practicums, and verified certification by the Ohio Board of Nursing. AHSC also provides coaching and assistance with the integration of CHW's into organizations and/or onto multidisciplinary health teams. A total of 16 CHW's work with pregnant women in 11 different care coordination agencies. The AHSC also has a Peer Support Learning Community that meets monthly to receive professional education; participate in self-care assessments; discuss the challenges/successes of client engagement; and share approaches/successes to obtaining client outcomes.	THRIVE; Community Partners

Increase participation in Responsible Parenting, Economic Stability, Health Marriage/Health Family Strategies, and Parenting Time Assistance Programs	100%	The Fatherhood Coalition sponsored the following events: Fishing Rodeo, Pro Football Hall of Fame With Dad, Walk Your Child to School, Reading With Your Child, and Community Hall of Fame Parade. • 2017 - 2,622 individuals participated • 2018 - 1,222 individuals participated • 2019 - 5,488 individuals participated The Early Child Resource Center conducted the following programs: Dr. Dad, Parent Café, and 24/7. • 2017 - 88 individuals participated • 2018 - 1,033 individuals participated • 2019 - 1,378 individuals participated Parenting Time Assistance Program: • 2017 - 22 orders issued • 2018 - 7 orders issued; 2 ordered enforced • 2019 - 16 orders issued	Stark County Fatherhood Coalition; Early Childhood Resource Center; Stark County Job & Family Services; Community Legal Aid

2) **Long Term Measure:** <u>By December 2019, decrease the disparity in the infant mortality rate between white and black babies by more than 50%.</u>

Baseline: 2016 ODH (preliminary data) - 2.0 disparity rate ratio
17.5 African American infant mortality rate
8.7 Caucasian infant mortality rate

2019 ODH (preliminary data) - 1.9 disparity rate ratio (2017-2019 average rate 1.4)
5.7 African American infant mortality rate
3.9 Caucasian infant mortality rate

The long term measure to decrease the disparity in the infant mortality rate between white and black babies by 50% was not met. Although the infant mortality rate for white and black babies was significantly reduced, over the past three years (2017-2019) the overall disparity rate ratio only decreased by 5%. The 2020-2022 CHIP will focus on reducing the inequity rate ratio.

Objective/Activities	Data (# or %)	Narrative	Agency Responsible
Increase awareness on how race and racism impacts poor birth outcomes and infant mortality disparity rates	100%	StarkMHAR's SC3C Committee organized an annual Populations Focus Learning series that addressed different cultural and community influences. • 2017 - 321 individuals received cultural/health care training on the following populations: African American, Youth, Hispanic and Appalachian. • 2018 - 390 individuals received cultural/health care training on the following populations: LGBTQ Youth Homelessness, Faith Based, Amish Culture & Community and Cultural Perspectives on Trauma. • 2019 - 248 individuals received cultural/health care training on the following populations: New American, Asian, Deaf & Hard of Hearing, and Mayan Cultures. Mary Church Terrell Federated Club provides Infant Mortality Awareness education and community outreach via its Speaker's Bureau with a focus on the African American community.	StarkMHAR; THRIVE
Hire and train a full-time Stark County Fatherhood Coalition Coordinator	100%	A full-time Fatherhood Coalition Coordinator was hired December of 2016 and trained in 2017.	Stark County Job & Family Services
Promote and facilitate the enrollment in CenteringPregnancy programs	100%	All THRIVE staff and CHWs educate and promote the CenteringPregnancy Model to clients.	THRIVE; Community Partners
Enroll and graduate at least 200 pregnant women from CenteringPregnancy programs	91%	Enroll and graduate at least 200 pregnant women into a CenteringPregnancy program. • 2017 - 41 women were enrolled/graduated • 2018 - 80 women were enrolled/graduated • 2019 - 60 women were enrolled/graduated Overall, 181 women were enrolled/graduated from a CenteringPregnancy program.	Alliance Family Health Center; My Community Health Center

Increase the number of fathers who are supported to become more engaged in the lives of their children	100%	The Fatherhood Coalition sponsored the following events: Fishing Rodeo, Pro Football Hall of Fame With Dad, Walk Your Child to School, Reading With Your Child, and Community Hall of Fame Parade. • 2017 - 2,622 individuals participated • 2018 - 1,222 individuals participated • 2019 - 5,488 individuals participated The Early Child Resource Center conducted the following programs: Dr. Dad, Parent Café, and 24/7. • 2017 - 88 individuals participated • 2018 - 1,033 individuals participated • 2019 - 1,378 individuals participated Parenting Time Assistance Program: • 2017 - 22 orders issued • 2018 - 7 orders issued; 2 ordered enforced • 2019 - 16 orders issued	Stark County Fatherhood Coalition; Stark County Job & Family Services,; Early Childhood Resource Center
Support the identification and training of CHW's from the areas of focus to provide support to at-risk pregnant women	100%	Access Health Stark County's (AHSC) CHW Center provides recruitment, training, practicums, and verified certification by the Ohio Board of Nursing. AHSC also provides coaching and assistance with the integration of CHW's into organizations and/or onto multidisciplinary health teams. A total of 16 CHW's work with pregnant women in 11 different care coordination agencies. The AHSC also has a Peer Support Learning Community that meets monthly to receive professional education; participate in self-care assessments; discuss the challenges/successes of client engagement; and share approaches/successes to obtaining client outcomes.	AHSC
Increase outreach and engagement with faith-based and grassroots organizations	100%	Local faith-based and/or grassroots organizations are provided funding to implement the Life Skills, Safe Sleep, and/or Parent Mentoring & Support programs: • 2017 - 4 organizations were funded	THRIVE; CCHD

		• 2018 - 7 organizations were funded • 2019 - 3 organizations were funded Mary Church Terrell Federated Club provides Infant Mortality Awareness education and community outreach via its Speaker's Bureau with a focus on the African American community.	

3) **Long Term Measure:** By December 2019, decrease the disparity in the gestational age between white and black babies by more than 50%.

Baseline:
2016 ODH (preliminary data) -

	White	Black
Very pre term < 28 weeks	30	11
Pre-Term 28-36 weeks	289	41
Early Term 37-38 weeks	822	131
Term > 39 weeks	2362	282

2019 ODH (preliminary data) -

	White	Black
Very pre term < 28 weeks	18	4
Pre-Term 28-36 weeks	280	53
Early Term 37-38 weeks	781	155
Term > 39 weeks	2238	328

The long term measure to decrease the disparity in the gestational age between white and black babies by 50% was not met. The overall disparity in the gestational age between white and black babies (very/pre-term) was decreased by nearly 17% over the past three years (2017-2019). CHWs continue to be a major asset in connecting pregnant women/women with children under age 1 to needed community resources. The 2020-2022 CHIP will utilize CHWs to accomplish activities to reduce/sustain the overall infant mortality rate.

Objective/Activity	Data (# or %)	Narrative	Agency Responsible
Increase the number of pregnant	100%	Prior to working with a CHW, 15% of the women did	THRIVE Community

women provided prenatal care by using the efficiency of the HUB Model		not have an obstetrician for prenatal care. All of the women (100%) enrolled into the THRIVE Pathways HUB are connected to an obstetrician for prenatal care.	Partners; Kent State University
Develop and support a network of CHWs to work with pregnant women in obtaining early prenatal care and needed support services	100%	Access Health Stark County's (AHSC) CHW Center provides recruitment, training, practicums, and verified certification by the Ohio Board of Nursing. AHSC also provides coaching and assistance with the integration of CHW's into organizations and/or onto multidisciplinary health teams. A total of 16 CHW's worked with pregnant women in 11 different care coordination agencies. All CHWs have received training on the THRIVE Pathways model.	THRIVE Community Partners; Kent State University
Increase the number of faith-based organizations in targeted areas providing prenatal care awareness and outreach to the community by 50%	100%	Local faith-based organizations who received funding to implement the Life Skills, Safe Sleep, and/or Parent Mentoring & Support programs: • 2017 - 3 were faith-based • 2018 - 6 were faith-based • 2019 - 2 were faith-based	THRIVE

4) Long Term Measure: By December 2019, decrease the disparity in the birth weight between white and black babies by more than 50%.

Baseline:

2016 ODH (preliminary data) -

	White	Black
Low birth weight (1500g-2499g)	227	45
Very Low birth weight (<1500g)	43	15

2019 ODH (preliminary data) -

	White	Black
Low birth weight (1500g-2499g)	214	57
Very Low birth weight (<1500g)	41	6

The long term measure to decrease the disparity in the birth weight between white and black babies by 50% was not met. Although the infant mortality rate for white and black babies was significantly reduced, over the past three years (2017-2019) the birth weight disparity increased. The 2020-2022 CHIP will focus on decreasing the infant mortality rate and inequity rate ratio between white and black babies.

Objective/Activity	Data (# or %)	Narrative	Agency Responsible
Conduct personal interviews with each CHW and their supervisors	100%	In 2018, Kent State was contracted to conduct focus groups/interviews with CHWs and supervisors. Two 1hr focus groups were held; one with CHWs and one with supervisors.	THRIVE; Kent State University
Conduct interviews with staff from each CenteringPregnancy location and facilitate focus groups with their clients		Funding was not available to support this objective; it was removed from the Infant Mortality Work Plan in 2018.	THRIVE; Kent State University
Conduct interviews with the four public health nurses and facilitate focus groups with their clients		Funding was not available to support this objective; it was removed from the Infant Mortality Work Plan in 2018.	THRIVE; Kent State University
Evaluate the CHWs' and nurses' fidelity to implementing the *Partners for a Health Baby* curriculum		Funding was not available to support this objective; it was removed from the Infant Mortality Work Plan in 2018.	THRIVE; Kent State University
Complete an assessment of programs most needed in each grassroots organization's community		Funding was not available to support this objective; it was removed from the Infant Mortality Work Plan in 2018.	THRIVE; Kent State University
Develop six case studies of fathers participating in the Fatherhood Coalition programs		Funding was not available to support this objective; it was removed from the Infant Mortality Work Plan in 2018.	THRIVE; Kent State University

Priority Four: Obesity and Healthy Lifestyles

Live Well Stark County (LWSC) and Creating Healthy Communities (CHC) facilitated the initiatives addressed within the Obesity & Healthy Lifestyles annex. LWSC is a coalition of community leaders working together to make Stark County healthier by promoting policies and programs that support wellness. LWSC's vision is to create a community in which healthy eating and exercise habits are the norm and the incidence of chronic disease resulting from poor nutrition, inactive lifestyles, and tobacco use is steadily declining. Creating Healthy Communities (CHC) is a grant funded initiative, focusing on policy, system and environmental changes, surrounding active living and healthy eating within northeast Canton, southeast Canton and the city of Massillon.

Goal #1: EVERY PERSON WILL HAVE ACCESS TO AND UTILIZE THE RESOURCES AND SERVICES NECESSARY TO ACHIEVE AND MAINTAIN A HEALTHY WEIGHT AND A HEALTHY LIFESTYLE.

1) **Long Term Measure**: By December 2019, decrease the prevalence of adult and childhood obesity by 5%.

Baseline: 2016 County Health Rankings - 31% Adult Obesity
2019 County Health Rankings - 32% Adult Obesity

The long term measure to decrease the prevalence of adult obesity by 5% was not met. Baseline data for 2016 and 2019 could not be found for the percent of childhood obesity. Obesity & Healthy Lifestyles is an annex within the 2017-2019 CHIP; developed by CCPH. Obesity & Healthy Lifestyles continues to be a major public health concern and has been added to the 2020-2022 CHIP as one of the priority health areas. The new CHIP will address obesity by increasing consumption of fruit/vegetables and physical activity.

Objective/Activity	Data (# or %)	Narrative	Agency Responsible
Increase access to outdoor recreation areas	100%	In 2017, 12 How We Roll Rides took place providing an on-road experiential learning opportunity where participants learn bike law and practice positioning themselves on the road for maximum visibility and predictability. In 2018, 4 How We Roll/Ride Buddy Rides took place. CHC also installed a bike pump at ICAN and a bike rack at Nimisilla Park. In 2019, a partnership between Habitat for Humanity, Lighthouse Ministries and CHC allowed for the following increased access to outdoor recreation areas:	CCPH; LWSC; CHC; Stark Parks

		• Making improvements to an open play space on Lighthouse Ministries property in SE Canton • Converting an abandoned lot into a pocket park in NE Canton	
Improve the walking areas of city parks by resurfacing the walking trail, adding ramps for accessibility and cleaning park areas		This objective was not addressed during the timeframe of the 2017-2019 CHIP due to oversight with the CHC grant transitioning and lack of adequate funds.	CCPH; LWSC; CHC; Stark Parks
Publish a city map identifying safe walking routes	100%	In 2017, a partnership between LWSC and Untied Way, ***Stark Walks***, mapped safe walking routes in neighborhoods within the city of Canton. The routes were mapped, walk audits were conducted and signs with the maps on them were purchased. In 2018, all of the signage was installed. In 2019, United Way and LWSC partnered with Aultman Hospital to create safe walking routes along the surrounding neighborhoods. The routes were mapped, walk audits were conducted, and signs with the maps on them were purchased and installed.	CCPH; LWSC; CHC; Stark Parks
Increase awareness and participation in the Walk With A Doc Program	100%	Participation in Walk With A Doc increase by 50% from 2016 (164) to 2017 (306); however, the program is no longer being implemented within Stark County.	CCPH; LWSC; CHC; YMCA; Local Hospitals; Local Providers
Participate in community planning efforts for community development, streets, sidewalks, parks and neighborhoods	100%	In 2017, LWSC collaborated with the Better Block Foundation, community volunteers, and local businesses to organize a Better Block Event in the Warehouse District of Canton. In 2018, LWSC collaborated with the Canton City Engineer to expand the Canton Designated and Proposed Bike Routes/Trails to include off-road multi-use sections and to connect to the larger bike & hike trail system in Canton City.	CCPH; LWSC; County Building & Engineers Office

		In 2019, the Canton City Engineers office completed the installation of a bike lane, share the road signage, and pavement markings in SE Canton. This project is ongoing with the Canton City Engineers office continuously working to connect to the larger trail system.	
Increase the amount of nutritional foods and level of physical activity in early preschool and child care centers	100%	Ohio Healthy Programs (OHP) is a voluntary designation for early care and education programs that includes training, menu improvement, policy development and family engagement activities. The training curriculum is designed to prevent childhood obesity by promoting healthy weight and growth in all children ages birth to five years old. • 2017 - Maternal & Child Health (MCH) staff provided training to 14 child care employees and assisted two child care centers with OHP (re)designation. • 2018 - CHC Coordinator received training on OHP. CHC and MCH staff provided training to 100 child care employees and assisted six child care centers with OHP (re)designation. • 2019 - CHC and MCH staff provided training to 80 child care employees and assisted nine child care centers with OHP (re)designation.	CHC; SCHD
Implement the Safe Routes To Schools program within the Canton City schools		This objective was not addressed during the timeframe of the 2017-2019 CHIP due to lack of consistent communication, funding, personnel time and resources.	CCPH
Increase access to fresh foods in neighborhoods identified as food deserts	100%	In 2017, two new stops were added to the Mobile Grocery Market's schedule located in a food desert. In 2018, the Mobile Grocery Market continued to provide access to fresh foods with an increase of 600 individuals from 2017. Several public meetings within the southeast Canton community were held to gather public input about what they want to see in a healthy	CCPH; LWSC; CHC; Stark Parks; Stark Fresh

		retail store. A healthy retail space was identified and a lease is being developed. Healthy retail store assessments were implemented in northeast Canton and Massillon. In 2019, CHC organized a partnership between Produce Perks Midwest, Aultman Health Foundation and Little Flower Family Practice to pilot a 6-month Produce Prescription program. Adult patients diagnosed with a diet-related disease were enrolled into the program to receive prescriptions for purchasing produce to support healthy behaviors, as well as nutrition education and food preparation instructions. Twenty-nine patients in NE Canton, SE Canton and Massillon completed the program with the following outcomes: 59% lost weight, 43% lowered their triglycerides and 36% lowered their A1C.	
Expand the mobile farmers' market outreach with at least three additional locations/stops	100%	In 2017, 10 new locations/stops were added to the mobile grocery market's schedule. In 2019, StarkFresh adjusted the mobile market schedule, spending more time at stops that were busy and eliminating or relocating stops that were not generating a lot of activity.	LWSC; CHC; Stark Fresh
Expand the mobile farmers' market distribution to year round delivery	50%	In 2017 the Mobile Farmer's Market purchased a refrigerated truck and expanded distribution to include both summer and fall.	LWSC; CHC; Stark Fresh
Identify and work with three convenience stores located within a food desert to implement the sale of fresh foods	75%	In 2018, existing retail stores in Massillon and NE Canton were mapped and an assessment was completed utilizing the Good Food Here Store Assessment tool. The tool identify that there was a need for healthy retail options; a lack of space for healthy retail expansion and the cost of healthy food identified as barriers. In 2019, StarkFresh identified two locations for new	LWSC; CHC; Stark Fresh

		grocery stores within the City of Canton (Downtown Canton & SE Canton). The Downtown Canton location is a community grocery store providing accessible, affordable food in the community. The location in SE Canton is a full-service nonprofit community supermarket. Both locations are slated to open in 2020.	

2) **Long Term Measure**: By December 2019, decrease the prevalence of tobacco use by 3%.

Baseline: 2016 County Health Rankings - 19% Adult Tobacco Use
2019 County Health Rankings - 20% Adult Tobacco Use

The long term measure to decrease the prevalence of tobacco use by 3% was not met. Tobacco use continues to negatively impact the health of the community. The 2020-2022 CHIP will focus on increasing the health of the community with several tobacco reducing activities that will directly align to the updated long-term measures.

Objective/Activity	Data (# or %)	Narrative	Agency Responsible
Increase the number of outdoor areas within the city of Canton designated as tobacco free areas	25%	In 2017, CCPH designated the surrounding property outside of the health department as a tobacco-free area.	CCPH; LWSC; CHC
Increase awareness and utilization of tobacco cessation services	100%	LWSC and community partners promote tobacco cessation services and programs available throughout Stark County on agency websites and social media outlets. LWSC also distributed tobacco cessation resources to all Stark Metropolitan Housing Authority (SMHA) properties. Aultman Hospital provides tobacco cessation counseling and resources to all hospitalized patients. Mercy Medical Center provides tobacco cessation education and resources to community residents.	CCPH; LWSC; CHC; Community Partners
Encourage tobacco free sporting venues at schools and parks		This objective was not addressed during the timeframe of the 2017-2019 CHIP due to limited funding and push	CCPH; LWSC; Canton City School

		back regarding policy implementation.	District; Stark Parks
Implement a model smoke-free policy with in three congregated housing areas	100%	In 2017, LWSC/CHC collaborated with SMHA to assist the agency with creating and implementing a tobacco-free policy. LWSC created Smoke-Free Housing toolkits that included: • Management Survey • Resident Survey • Quit Resources • Tobacco-Free Policy Template SMHA created a tobacco-free policy and implementation plan for all of their HUD locations. Ongoing technical assistance and support is provided to SMHA to assist with policy implementation.	CCPH; LWSC; CHC; Stark Metropolitan Housing Authority
Implement Tobacco 21 within the city of Canton	75%	In 2017, LWSC researched and identified Tobacco 21 (T21) as a possible policy to reduce tobacco use within the city of Canton. T21 is a national campaign aimed at raising the minimum legal age for purchasing tobacco and nicotine products from 18 to 21 years of age. In 2018, LWSC continued to research other communities that have passed T21; a survey was created/implemented for community members and local college students; tobacco retail audits were completed for all known stores in Canton City; a T21 subcommittee was organized and began meeting; and a draft T21 ordinance was created. In 2019, this objective was not addressed due to changes in political and organizational leadership.	CCPH; CHC

CHA – Third Cycle Update

The third assessment cycle officially began with the release of the 2019 CHA. The community participated in a prioritization process at the 2019 Annual Health Improvement Summit, to vote on the strategies for the following 2020-2022 CHIP priority health areas:

- Access to Health Care
- Mental Health
- Infant Mortality
- Obesity & Healthy Lifestyles

Subcommittees were convened for each of the priority areas to update the CHIP Implementation Plans. The subcommittees collected more reliable baseline data and tried to directly align all of the new activities to the updated long term measures. The CHIP Implementation Plans are working documents that will be implemented from 2020 through 2022. The CHIP Implementation Plans will be reviewed on a regular basis and updated as needed. An evaluation report will also be developed annually to track the progress made toward the new goals, long-term measures and activities.