

2020-2023

Fulton County

Community Health Improvement Plan

Adopted
12/9/20

TABLE OF CONTENTS

| | |
|---|----------------------|
| <u>Executive Summary</u> | <u>Pages 3-13</u> |
| <u>Introduction</u> | <u>Pages 3-5</u> |
| <u>Strategic Planning Model</u> | <u>Page 6</u> |
| <u>Partners</u> | <u>Page 7</u> |
| <u>Vision</u> | <u>Page 8</u> |
| <u>Alignment with National and State Standards</u> | <u>Pages 8-12</u> |
| <u>Action Steps</u> | <u>Page 13</u> |
| <u>Needs Assessment</u> | <u>Pages 14-18</u> |
| <u>Priorities Chosen</u> | <u>Pages 19-22</u> |
| <u>Forces of Change</u> | <u>Pages 23-26</u> |
| <u>Local Public Health System Assessment</u> | <u>Pages 27-28</u> |
| <u>Community Themes and Strengths</u> | <u>Pages 29-30</u> |
| <u>Quality of Life Survey Results</u> | <u>Pages 31-34</u> |
| <u>Resource Assessment</u> | <u>Page 34</u> |
| <u>Priority #1 Mental Health and Addiction</u> | <u>Pages 35-49</u> |
| <u>Priority #2 Chronic Disease</u> | <u>Pages 50-65</u> |
| <u>Measuring Outcomes & Contact Information</u> | <u>Page 66</u> |
| <u>Appendix A Community Resources Assessment</u> | <u>Pages 67-73</u> |
| <u>Appendix B Strategic Plan Map</u> | <u>Pages 74 - 78</u> |

EXECUTIVE SUMMARY

In 1998, The Fulton County Partners for Health began conducting community health assessments (CHA) for the purpose of measuring and addressing health status. The most recent Fulton County Community Health Assessment released in January 2020 was cross-sectional in nature and included a written survey of adults, adolescents, and children within Fulton County. The questions were modeled after the survey instruments used by the Centers for Disease Control and Prevention for their national and state Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavior Surveillance System (YRBSS) and the National Survey of Children's Health (NSCH) developed by the Child and Adolescent Health Measurement Initiative. This has allowed Fulton County to compare the data collected in their CHA to national, state and local health trends.

The Hospital Council of Northwest Ohio (HCNO) conducted focus groups for Fulton County. Focus groups are useful to find a range of opinions across groups of people and are used to gain insight for community needs. The community health assessment incorporated focus groups to uncover attitudes and factors that influence health behaviors that cannot be fully captured through survey research. The interaction between focus group participants is an important dynamic. Participants can share their thoughts and opinions, and others have a chance to reflect on the statements, offer alternative ideas, or build upon other participants' ideas. The qualitative data collected in these focus groups complement the quantitative data captured in the county health assessment survey. Qualitative data provides a deeper understanding as to why participants from the community feel and act a certain way, while quantitative data identifies the extent of a specific health issue.

The Fulton County CHA also fulfills national mandated requirements for the hospitals in our county. H.R. 3590 Patient Protection and Affordable Care Act states that in order to maintain tax-exempt status, not-for-profit hospitals are required to conduct a community health needs assessment at least once every three years, and adopt an implementation strategy to meet the needs identified through the assessment.

From the beginning phases of the CHA, community leaders were actively engaged in the planning process and helped define the content, scope, and sequence of the project. Active engagement of community members throughout the planning process is regarded as an important step in completing a valid needs assessment.

The Fulton County CHA has been utilized as a vital tool for creating the Fulton County Community Health Improvement Plan (CHIP). The Public Health Accreditation Board (PHAB) defines a CHIP as a long-term, systematic effort to address health problems on the basis of the results of assessment activities and the community health improvement process. This plan is used by health and other governmental education and human service agencies, in collaboration with community partners, to set priorities and coordinate and target resources. A CHIP is critical for developing policies and defining actions to target efforts that promote health. It should define the vision for the health of the community inclusively and should be done in a timely way.

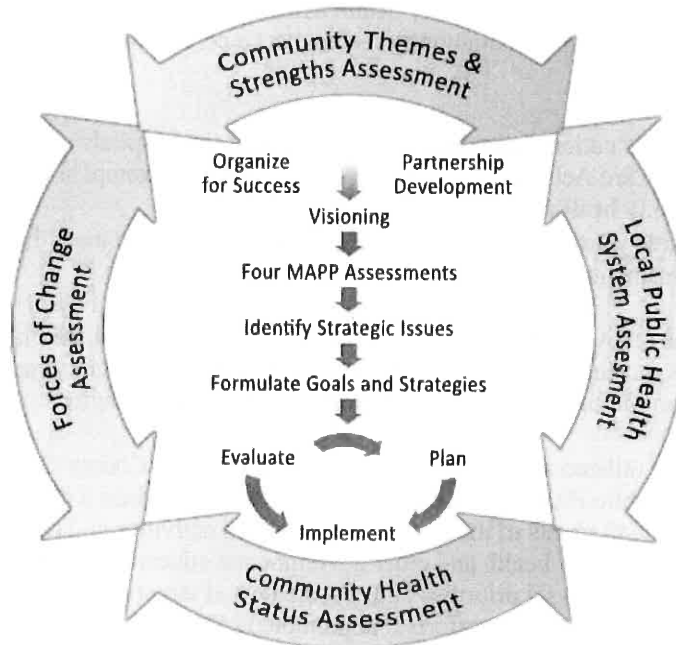
Fulton County Partners for Health utilized Fulton County Health Department and Fulton County Health Center staff to facilitate the MAPP process. Key Community leaders were invited to participate in an organized process of strategic planning to improve the health of residents of the county. The National Association of City County Health Officer's (NACCHO) strategic planning tool, Mobilizing for Action through Planning and Partnerships (MAPP), was used throughout this process.

The MAPP Framework includes six phases which are listed below:

- Organizing for success and partnership development
- Visioning
- Conducting the MAPP assessments
- Identifying strategic issues
- Formulating goals and strategies
- Taking action: planning, implementing, and evaluation

Once planning phase was completed, Fulton County Partners for Health recruited existing community workgroups to address priority issues when available and developed additional workgroups to address other identified priorities. These workgroup were tasked with detailed analysis of data and action plan development.

The MAPP process includes four assessments: Community Themes & Strengths, Forces of Change, the Local Public Health System Assessment and the Community Health Status Assessment. These four assessments were used by the Fulton County Partners for Health to prioritize specific health issues and population groups which are the foundation of this plan. The diagram below illustrates how each of the four assessments contributes to the MAPP process.



Fulton County Partners for Health members reviewed the extensive data analysis for the identified priority areas that was completed during the 2019 CHA process including; use of the Strategic Prevention Framework to identify root cause, data collection strategies when needed data was not available, and the development of a Logic Model (Strategic Plan Map) for each priority. These maps can be found in the appendix beginning on page 74. Maps were updated with additional data from 2018 Youth Health Assessment and the 2019 Adult Health Assessment. Any additional needed revisions to the established logic models and action plans will be made by the workgroups addressing those identified issues as they move forward with the work.

Figure 1.1 2020-2023 Fulton County CHIP Overview

| Overall Health Outcomes | |
|--|---|
| Increase Health Status | Decrease Premature Death |
| Priority Topics | |
| <i>Mental Health and Addiction</i> | <i>Obesity</i> |
| Priority Health Outcomes | |
| Decrease adult and youth depression Decrease adult drug dependence or abuse and youth substance (drug) use | Decrease adult, youth and child obesity |

STRATEGIC PLANNING MODEL

Beginning in January 2020, Fulton County Partners for Health met five times and completed the following planning steps:

- 1. Initial Meeting-** Review of process and timeline, finalize committee members, create or review vision
- 2. Choosing Priorities-** Use of quantitative and qualitative data to prioritize target impact areas
- 3. Ranking Priorities-** Ranking the health problems based on magnitude, seriousness of consequences, and feasibility of correcting
- 4. Resource Assessment-** Utilizing the resource assessment completed during the past CHA process, Fulton County Health Department staff reviewed and updated the resource assessment, with feedback from larger Fulton County Partners for Health members when needed, to reflect available resources to address priority issues.
- 5. Forces of Change and Community Themes and Strengths-** Open-ended questions for committee on community themes and strengths
- 6. Gap Analysis-** Determine existing discrepancies between community needs and viable community resources to address local priorities; identify strengths, weaknesses, and evaluation strategies; and strategic action identification
- 7. Local Public Health Assessment-** Fulton County Health Department staff reviewed the most recent Local Public Health System Assessment, and completed an internal assessment of the system. The assessment was sent to the larger Partners for Health group for review, feedback and recommendations for any needed changes.
- 8. Quality of Life Survey-** Review results of the Quality of Life Survey with committee
- 9. Best Practices-** Fulton County Health Center and Fulton County Health Department staff reviewed best practices and make recommendations for strategies based on their collective research.
- 10. Draft Plan-** Review of all steps taken; action step recommendations based on one or more of the following: enhancing existing efforts, implementing new programs or services, building infrastructure, implementing evidence based practices, and feasibility of implementation.
- 11. Root Cause Analysis, Logic Models, Final Plan** – Root cause analysis was conducted and development of a logic model for each priority topic that informed the action plan.

PARTNERS

The 2020-2023 Community Health Improvement Plan was drafted by agencies and service providers within Fulton County. During January 2020 -September, 2020, the committee reviewed many sources of information concerning the health and social challenges Fulton County adults, youth and children may be facing. They determined priority topics which if addressed, could improve future outcomes, determined gaps in current programming and policies and examined best practices and solutions. The committee has recommended specific action steps they hope many agencies and organizations will embrace to address the priority issues in the coming months and years. We would like to recognize these individuals and thank them for their devotion to this process and this body of work:

Fulton County Partners for Health

A Renewed Mind
Crossroads Evangelical Church
Four County ADAMhs Board
Four County Suicide Prevention Coalition
Fulton County Aging Consortium
Fulton County Board of Developmental Disabilities
Fulton County Commissioners Office
Fulton County Economic Development
Fulton County Family & Children First Council
Fulton County Health Center
Fulton County Health Department
Fulton County Job & Family Services
Fulton County Safe Communities
Fulton County Schools
Fulton County Senior Center
Fulton County Sheriff's Office
Healthy Choices Caring Communities
Maumee Valley Guidance Center
North Star BlueScope Steel
Northwestern Ohio Community Action
Ohio Farm Bureau
Ohio State University Extension
Recovery Services of Northwest Ohio
Trinity Lutheran Church of Delta
United Way of Fulton County
Village of Delta Police Department
Village of Swanton
Wauseon Police Department

The strategic planning process was facilitated by Kim Cupp, FCHD, Rachel Kinsman, FCHD and Beth Thomas, HC3

VISION

Vision statements define a mental picture of what a community wants to achieve over time while the mission statement identifies why an organization/coalition exists and outlines what it does, who it does it for, and how it does what it does.

The Vision of Fulton County Partners for Health:

Working together to improve the health of individuals, families, and our community by shifting our focus from treatment to prevention and wellness.

The Mission of Fulton County Partners for Health:

Promoting overall wellness and empowering residents.

Fulton County Partners for Health Definition of Health:

A state of complete physical, mental, and social well-being and not just the absence of sickness or frailty.

ALIGNMENT WITH NATIONAL AND STATE STANDARDS

The 2020-2023 Fulton County Health Improvement Plan priorities align perfectly with state and national priorities. Fulton County will be addressing the following priorities: chronic disease, and mental health and addiction.

U.S. Department of Health and Human Services National Prevention Strategies

The Fulton County Plan also aligns with five of the National Prevention Strategies for the U.S. population: healthy eating, active living, mental and emotional well-being and preventing drug abuse and excessive alcohol use.

Healthy People 2030

Fulton County's priorities also align with Healthy People 2030 goals. The following are examples:

- Increase the proportion of eligible people completing CDC-recognized type 2 diabetes prevention programs — D-D01
- Reduce the proportion of adults with high blood pressure — HDS-04
- Increase the proportion of adolescents with depression who get treatment — MHMD-06
- Reduce the proportion of children and adolescents with obesity — NWS-04
- Reduce the proportion of adults with obesity — NWS-03

ALIGNMENT WITH NATIONAL AND STATE STANDARDS

Ohio State Health Improvement Plan (SHIP)

The 2020-2022 SHIP serves as a strategic menu of priorities, objectives, and evidence-based strategies to be implemented by state agencies, local health departments, hospitals and other community partners and sectors beyond health including education, housing, employers, and regional planning.

The SHIP includes a strategic set of measurable outcomes that the state will monitor on an annual basis. Given that the overall goal of the SHIP is to ensure all Ohioan's achieve their full health potential, the state will track the following health indicators: self-reported health status (reduce the percent of Ohio adults who report fair or poor health) and premature death (reduce the rate of deaths before age 75).

In addition to tracking progress on overall health outcomes, the SHIP will focus on three priority topics:


Mental Health and Addiction (includes depression, suicide, youth drug use, and drug overdose deaths)
Chronic Disease (includes conditions such as heart disease, diabetes and childhood conditions [asthma and lead])
Maternal and Infant Health (includes infant and maternal mortality and preterm births)

The SHIP also takes a comprehensive approach to improving Ohio's greatest health priorities by identifying 3 priority factors that impact the 3 priority health outcomes: community conditions, health behaviors and access to care. The three priority factors include the following:

Community Conditions (includes housing affordability and quality, poverty, K-12 student success, and adverse childhood experiences)

Health Behaviors (includes tobacco/nicotine use, nutrition, and physical activity)

Access to Care (includes health insurance coverage, local access to healthcare providers, and unmet needs for mental health care)

Note: This symbol  will be used throughout the report when a priority, indicator, or strategy directly aligns with the 2020-2022 SHIP. Whenever possible, the Fulton County CHIP identifies strategies likely to reduce disparities and inequities. Throughout the report, hyperlinks will be highlighted in **bold, blue text**.

The Fulton County CHIP was required to select at least 1 priority factor, 1 priority health outcome, 1 indicator for each identified priority, and 1 strategy for each selected priority to align with the 2020-2022 SHIP.

The following Fulton County priority factors, priority indicators, and strategies very closely align with the 2020-2022 SHIP:

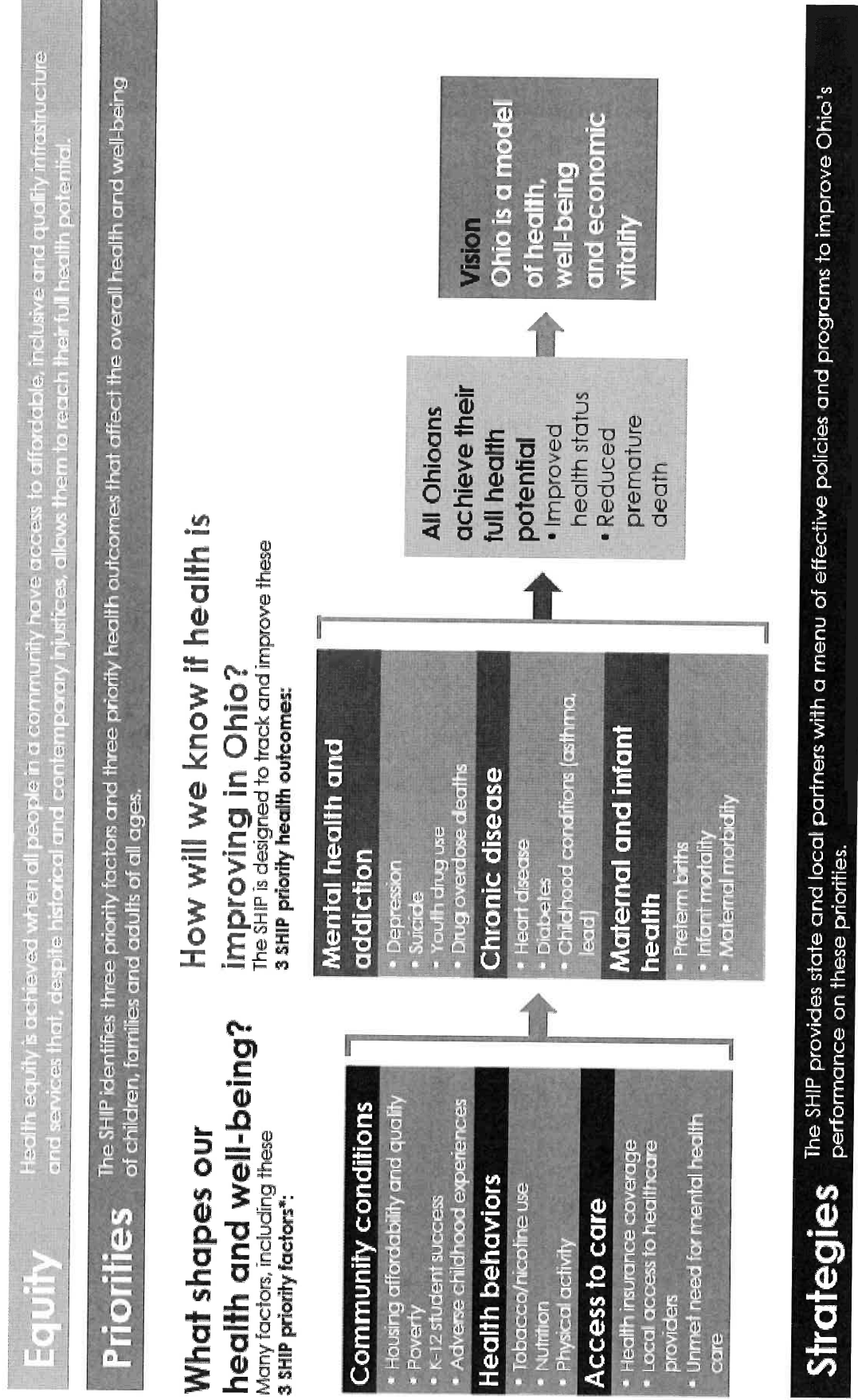
Figure 1.2: 2020-2023 Fulton County CHIP Alignment with the 2020-2022 SHIP

| Priority Outcomes | Priority Factor | Priority Indicators | Strategies to Impact Priority Indicators |
|-----------------------------|----------------------|-------------------------------|--|
| Mental Health and Addiction | Community Conditions | Adverse Childhood Experiences | School-based violence prevention and anti-bullying programs School-based social emotional instruction (PAX) Pre-School Education Programs |
| | Health Behaviors | Tobacco/Nicotine Use | Telephonic tobacco cessation program |
| Chronic Disease | Health Behaviors | Nutrition | Social Support Interventions for Healthy Eating in the Community Implement a School-Based Nutrition Education Program Point-of-purchase prompts for healthy foods Competitive pricing for healthy foods Multi-component obesity prevention interventions Farm-to-institution program Diabetes Prevention Program Community fitness programs |
| | | Physical Activity | Individually-adapted physical activity programs Hypertension screening and follow up Social Support Interventions for Physical Activity in the Community |

Maternal and Child
Health

Our Fulton County data related maternal and child health (provide data) was analyzed by members of Fulton County Partners for Health. Based on this analysis, this issue was determined not to be a priority outcome at this time, as data does not support it.

Alignment with National and State Standards, continued
 Figure 1.3: 2020-2022 State Implementation Plan (SHIP) Overview



ACTION STEPS:

To work toward improving **mental health and decreasing addiction**, the following actions steps are recommended:

1. Continue to coordinate with Four County ADAMhs Board and regional health departments to implement mental health wellness media campaign
2. Increase Youth & Adult Mental Health First Aid Training
3. Expand our school based Screening, Brief Intervention and Referral to Treatment Model
4. Expand our Universal School-Based Suicide Awareness and Education Program
6. Build community cessation partners to increase opportunities for tobacco cessation for youth and adults
7. Provide vaping presentations to middle school students in schools annually
8. Ensure our current School-Based social and emotional instruction continues to be sustainable (capacity and funding)
9. Telephonic tobacco cessation program

To work toward decreasing **chronic disease**, the following action steps are recommended:

1. Social Support Interventions for Healthy Eating in the Community
2. Hypertension screening and follow up
3. Implement a School-Based Nutrition Education Program
4. Diabetes Prevention Program Social Support Interventions for Physical Activity in the Community
5. Point-of-purchase prompts for healthy foods
6. Competitive pricing for healthy foods
7. Multi-component obesity prevention interventions
8. Farm-to-institution program
9. Community fitness programs
10. Individually-adapted physical activity programs

PRIORITY FACTORS:

The SHIP identifies the following factors that shape health and well-being:

Community Conditions

Health Behaviors

Access to Care

Multiple strategies listed above align with these SHIP priority factors. Evidence shows that CHIPs that implement strategies within these priority factors are more likely to be effective than less comprehensive approaches.

NEEDS ASSESSMENT

The Fulton County Partners for Health reviewed the 2019 Fulton County Health Assessment. The detailed primary data for each individual priority area can be found in the section it corresponds to. Partner members participated in an activity which asked them to ranking, in priority order, the most important “health problems” defined as those which have greatest impact on overall health, the most significant “risky behaviors” in our community as well as the most significant factors impacting quality of life for a healthy community

What are the most important **ADULT** “health problems” (defined as those which have greatest impact on overall health) identified in the 2019 health assessment report?

| Key Issue or Concern | Percent of Population at risk | Age Group (or Income Level) Most at Risk | Gender Most at Risk |
|---|-------------------------------|--|---------------------|
| Mental Health (1.63 ranking with lowest number indicating highest priority) | | | |
| Felt sad or hopeless two or more weeks in a row | 10% | Age: 30-64 (10%) Income < \$25K (16%) | Female (14%) |
| Considered attempting suicide | 4% | -- | -- |
| Attempted suicide | 1% | -- | -- |
| Substance Abuse (2.0 ranking with lowest number indicating highest priority) | | | |
| Binge drinker (current drinkers) | 18% | Age: <30 Income: >\$25K | -- |
| Frequent drinker (drank 3 + days/week) | 36% | Age: <30 (57%) Income: >\$25K (42%) | Male (42%) |
| Medication misuse in past 6 months | 5% | Age: 65 + (7%) Income: <\$25K (10%) | Female |
| Marijuana use in past 6 months | 2% | Age: 30-64 (4%) Income: <\$25K (3%) | Male |
| Obesity (2.1 ranking with lowest number indicating highest priority) | | | |
| Obese | 36% | Age: < 30 Income: >\$25K | Male |
| Overweight | 36% | Age: 65+ Income: < \$25K | Male |
| No physical activity in past week | 18% | -- | -- |
| Ate 5+ fruits and vegetables per da | | -- | -- |
| Suicide (2.5 ranking with lowest number indicating highest priority) | | | |
| Felt sad or hopeless two or more weeks in a row | 10% | Age: 30-64 (10%) Income < \$25K (16%) | Female (14%) |
| Considered attempting suicide | 4% | -- | -- |
| Attempted suicide | 1% | -- | -- |

NEEDS ASSESSMENT, *continued*

What are the most significant **ADULT** “risky behaviors” in our community identified in the 2016 assessment report?

| Key Issue or Concern | Percent of Population At risk | Age Group (or Income Level) Gender | Most at Risk |
|--|-------------------------------|--|--------------|
| Being Overweight (1.63 ranking with lowest number indicating highest priority) | | | |
| Fulton County adult residents either overweight or obese according to BMI | 72% | Age: 65 + Income level <\$25 K | Male |
| Poor Eating Habits (2.0 ranking with lowest number indicating highest priority) | | | |
| Adults reporting they ate no servings of fruits and vegetables per day. | 4% | | |
| Adults reporting they ate 1-to-2 servings of fruits and vegetables per day, | 31% | | |
| Adults reporting they ate 3-to-4 servings per day, | 47% | | |
| Adults reporting they ate 5 or more servings per day | 8% | | |
| Adults reporting they ate out in a restaurant or brought home take-out at least once in a typical week | 84% | | |
| Alcohol misuse/abuse (2.0 ranking with lowest number indicating highest priority) | | | |
| Binge drinker (current drinkers) | 18% | Age: <30 Income: >\$25K | -- |
| Frequent drinker (drank 3 + days/week) | 36% | Age: <30 (57%) Income: >\$25K (42%) | Male (42%) |
| Drug Misuse/Abuse (2.2 ranking with lowest number indicating highest priority) | | | |
| Medication misuse in past 6 months | 5% | Age: 65 + (7%) Income: <\$25K (10%) | Female |
| Marijuana use in past 6 months | 2% | Age: 30-64 (4%) Income: <\$25K (3%) | Male |
| Lack of Exercise (2.25 ranking with lowest number indicating highest priority) | | | |
| Adults reporting no physical activity in past week | 18% | -- | -- |
| Adults reporting some type of physical activity or exercise for at least 30 minutes 3 or more days per week; | 61% | -- | -- |

| | | | |
|--|-----|----|----|
| Adults reporting exercising 5 or more days per week; | 33% | -- | -- |
| Adults reporting unable to exercise | 4% | -- | -- |

NEEDS ASSESSMENT, *continued*

What are the most significant factors impacting quality of life for a healthy community?

Religious or spiritual values (1.2 ranking with lowest number indicating highest priority)

Strong family lifestyle (1.25 ranking with lowest number indicating highest priority)

Good jobs and healthy economy (1.66 ranking with lowest number indicating highest priority)

Low crime/safe neighborhoods (2.0 ranking with lowest number indicating highest priority)

Access to health care (2.5 ranking with lowest number indicating highest priority)

Healthy behaviors and lifestyles (2.5 ranking with lowest number indicating highest priority)

NEEDS ASSESSMENT, *continued*

What are the most significant **YOUTH** health issues or concerns identified in the 2016 assessment report?

| Key Issue or Concern | Percent of Population At risk | Age Group (or Income Level) Most at Risk | Gender Most at Risk |
|--|-------------------------------|--|---------------------|
| Obesity (18 votes) | | | |
| Obese | 18% | Age: 14-16 | Male |
| Overweight | 14% | Age: 14-16, 17+ | Female |
| Ate 1-4 servings of fruits and vegetables per day | 88% | -- | -- |
| Described themselves as slightly or very overweight | 32% | -- | -- |
| No physical activity in past week | 11% | -- | -- |
| Went to bed hungry on at least one day in past week because their family could not afford food | 13% | -- | -- |
| Mental Health (18 votes) | | | |
| Felt sad or hopeless almost every day for two or more weeks in a row | 22% | Age: 17+ | Female |
| Contemplated suicide | 10% | -- | -- |
| Attempted suicide | 6% | Age: 14-16 | Female |
| Did not seek help because did not know where to go | 21% | -- | -- |
| Did not seek help because their family would not support them | 11% | -- | -- |
| Substance Abuse (18 votes) | | | |
| Current drinker | 9% | Age: 17+ | Male |
| Binge drinker (of current drinkers) | 50% | Age: 17+ | Male |
| Obtained alcohol by a parent giving it to them | 30% | -- | -- |
| Driven a car after drinking alcohol in past month | 5% | -- | -- |
| Ever misused medications | 6% | -- | -- |
| Marijuana use in past month | 7% | Age: 17+ | Male |
| Used electronic vapor products in past year | 11% | -- | -- |
| Perceived there was no risk to using electronic vapor products | 16% | -- | -- |
| Current smoker | 6% | Age: 17+ | Female |
| Bullying (7 votes) | | | |
| Bullied in past year | 38% | -- | -- |
| Bullied on school property in past year | 27% | -- | -- |
| Electronically/cyber bullied in past year | 10% | -- | -- |
| Texting and Driving (7 votes) | | | |
| Texted while driving in past month | 30% | -- | -- |
| Sexing/Risky Social Media (6 votes) | | | |
| Sexted | 16% | Age: 17+ | -- |
| Received a sexually revealing photo in past month | 11% | -- | -- |

NEEDS ASSESSMENT, *continued*

What are the most significant **CHILD** health issues or concerns identified in the 2016 assessment report?

| Key Issue or Concern | Percent of Population at risk | Age Group (or Income Level) Most at Risk | Gender Most at Risk |
|--|-------------------------------|---|---------------------|
| Obesity (18 votes) | | | |
| Obese | 21% | -- | -- |
| Overweight | 17% | -- | -- |
| Ate fruit or drank 100% fruit juice at least once per day during past week | 61% | -- | -- |
| Parent Reading to Child (13 votes) | | | |
| Read to their 0-5-year-old child every day | 29% | -- | -- |
| Read to their 6-11-year-old child every day | 12% | -- | -- |
| Asthma (8 votes) | | | |
| Diagnosed with asthma | 12% | Age: 6-11 | -- |
| Dental Care (6 votes) | | | |
| Dental care visit in past year | 69% | -- | -- |
| No dental care in past year because parent did not know where to go | 6% | -- | -- |
| No dental care in past year because parent could not find dentist who accepted their insurance | 6% | -- | -- |
| Screen Time/Social Media (5 votes) | | | |
| Had a social network account (6-11-year-old) | 15% | -- | -- |
| Smoking During Pregnancy (4 votes) | | | |
| Smoked during pregnancy | 8% | -- | -- |
| Vaccination Rates (2 votes) | | | |
| Did not get all of their recommended vaccinations | 11% | -- | -- |

PRIORITIES CHOSEN

Based on the 2019 Adult Fulton County Health Assessment, key issues were identified for adults. Committee members then completed a ranking exercise, giving a score for magnitude, seriousness of the consequence and feasibility of correcting, resulting in an average score for each issue identified. Each committee member then ranked the issues from 1-10 , discussed their ranking with sector partners and submitted their scores. Additional the FCHD staff reviewed the 2018 Youth Health Assessment data and priorities selected.

Lowest number (1 – 3) indicates highest priority

The results were as follows:

SELECTION OF PRIORITIES

Through the analysis of the data collected through the Community Health Assessment, Fulton County Partners for Health members have selected the following a priority focuses in our community.

MENTAL HEALTH

| Adult Mental Health | | | |
|---|--------------|--|-----------------------|
| Felt sad or hopeless two or more weeks in a row | 10% | Age: 30-64 (10%) Income < \$25K (16%) | Female (14%) (14%) |
| Considered attempting suicide | 4% | ----- | ----- |
| Attempted suicide | 1% | ----- | ----- |
| Completed suicide | 5% (2017) | ----- | ----- |
| Youth Mental Health | | | |
| Felt Sad or Hopeless For Two Weeks or More in a Row | 29% | Age: 17 and older (36%) | Female (41%) |
| Had Seriously Considered Attempting Suicide in the Past 12 Months | 15% | Age: 17 and older (18%) | Female (22%) |
| Attempted suicide | 7% | Age: 17 and older (10%) | Female (9%) |

OBESITY

| Adult Obesity | | | |
|-----------------------------------|-----|--|--------------|
| Obese | 36% | Age: < 30 Income: >\$25K | Male |
| Overweight | 36% | Age: 65+ Income: < \$25K | Male |
| No physical activity in past week | 18% | -- | -- |
| Youth Obesity | | | |
| Obese | 19% | Age: 14 – 16 (20%) 17 – above (19%) | Male (21%) |
| Overweight | 13% | Age: 14 – 16 (14%) | Female (15%) |
| No physical activity in past week | 15% | ----- | ----- |

SUBSTANCE USE

| Adult Substance Use | | | |
|---|--|--|--------------------------|
| Binge drinker (current drinkers) | 18% | ----- | -- |
| Frequent drinker (drank 3 + days/week) | 36% | Age: <30 (57%) Income: >\$25K (42%) | Male (42%) |
| Of those who drank in the past month, reported at least one episode of binge drinking | 35% | ----- | ----- |
| Alcohol or Drug Related Total Crashes | 6 City of Wauseon | 55 Fulton County | ----- |
| Current smoker | 12% | Age: 30 – 64 (13%) Income: < \$25 K (20%) | Female (13%) |
| Youth Substance Use | | | |
| Current Smoker | 6% | Age: 17 + (14%) | Male (7%) Female (6%) |
| Vape use in past 12 months | 17% | -- | -- |
| Perception of harm of vape use | 24% reported belief in great risk in harming themselves with use | Age: 17 + (14%) | --- |

PRIORITY FACTORS

| Access to Care – unmet need for mental health care | | | |
|---|-----|----------------------------|-----------------------------|
| Youth experiencing 3 + ACE's | 23% | | |
| Youth Behaviors Experienced 3 or More ACEs | | Experienced 3 or More ACEs | Did Not Experience Any ACEs |
| Bullied (in the past 12 months) | | 67% | 21% |
| Seriously considered attempting suicide (in the past 12 months) | | 36% | 4% |
| Attempted suicide (in the past 12 months) | | 21% | 2% |
| Smoked cigarettes (in the past 30 days) | | 15% | 3% |

Note: Caution should be used when interpreting subgroup results as the margin of error for any subgroup is higher than that of the overall survey

PRIORITIES SELECTED

FULTON COUNTY WILL FOCUS ON THE FOLLOWING THREE PRIORITIES OVER THE NEXT 3 YEARS:

Mental Health and Addiction:

(Mental Health: female adults, ages 30 – 64, with emphasis on individuals with incomes below \$25,000 and high school females)

Substance Use:

(Addiction: high school youth who are using vape/e-cigarette products)

Chronic Disease

(Obesity: males under age 30, with an emphasis on individuals with incomes above \$25,000 and high school age males)

FORCES OF CHANGE

Fulton County Partners for Health were asked to identify positive and negative forces which could impact community health improvement and overall health of this community over the next three to five years. This group discussion covered many local, state, and national issues and change agents which could be factors in Fulton County in the near future. The table below summarizes the forces of change agent and its potential impacts.

| Force of Change | Impact |
|--|--|
| Political | |
| Decrease trust in media | Potential for issues awareness/discussion to be lost |
| Environmental Concerns (increase awareness of pollution including light, water, air) | Unknown impact on public health |
| Increased youth awareness/involvement in social justice | Youth voice could influence what issues are addressed and how resources are used |
| Legalization of medical use of marijuana | Possible increase in youth/adult use; possible movement towards recreational drug legalization |
| Policies to restrict availability of pain relievers | Over time, should decrease access to prescription pain medications and decrease youth misuse |
| Polarizing of political alignment | Resources spent on polarization vs. issues at hand |
| Tobacco 21 Policy | Over time, should decrease youth access and decrease youth tobacco use |
| Upcoming presidential election | Unclear what direction our new leader might focus his/her efforts |
| Economic | |
| COVID 19 | Shift in funding to response to pandemic Decreased tax revenue |
| Decrease in giving to charitable organizations | Decrease in privately funded programs |
| “Entrepreneurial Spirit” | Potential for innovation/creative out of the box thinking |
| Economic/Workforce Expansion (Delta Industrial Corridor) | Potential for increased revenue/taxes/community-focused businesses |
| Lower unemployment rates | Availability of workers is unknown due to COVID-19 –re-entry process is unclear? |
| Market instability | Decrease in funding available (both public/private) |
| Shift from college education to skilled labor/Career Centers/certifications ODE shifting to “whole child” – creating different career paths | Mental health challenges for those who have education but can’t find employment within their degree industry. Many have excessive college debt |
| Technology | |
| Significant increase in use of social media across all age groups | Impact on mental health Sensationalism of hot topics (regardless of whether based in fact) |
| Increase in social media platforms that require “short periods of consumption” | Impact on ability to sustain attention |
| Increase use/availability of technology in schools | Unknown impact to public health; could be both positive or negative |
| Increased social isolation | Affects life balance |

Government

| | |
|--|--|
| Availability of Prescription Drug Plans for Senior Citizens | Potential in decrease access to needed prescription medications |
| Changes in public funded insurance (Medicaid, Medicare etc.) | Potential for decrease access to care |
| Decrease in number of mental health providers | Decreased access to care, especially for those disparate populations |
| Decrease in public funding for behavioral health | Decrease in access to care |
| Decrease in public trust | Impact to public health unknown |
| New ADAMhs Board CEO | Potential for shift in funding targets/recipients |
| OH House Bill 502– Mental Health & Schools Funding | Providing schools additional op/funding Professional development – staff for public health issues |
| OH House Bill 318 – Increase in funding for Behavior Health within schools | Provides opportunity for funding for SEL programs by building/districts PBIS funding |
| Policy differences between state/federal Tobacco and Marijuana | Mixed messages to youth and adults about impact on health/safety. |

Social

| | |
|---|---|
| Availability of affordable housing | <p>MH: difficult for those with limited income – unstable housing/finances increases risk for mental health issues/suicide</p> <p>Many landlords unwilling to rent to those with mental health/disability challenges</p> <p>Accessible housing – for elderly and DD population</p> <p>Housing for seniors – due to accessibility/too much physical space for them to care for</p> <p>ADAMhs Bd collecting data (via providers) which will be mandatory starting 7/1/20 which will help identify housing situation for those who are challenged. Will provide more complete data picture.</p> |
| Availability of public transportation | <p>Unable to go to work/appointments/social events</p> <p>Rural community really struggle</p> <p>Mental health illness at ED – look to family for transportation to special care</p> |
| COVID 19 | <p>Potential for increase in substance use, mental health, family violence, access to services etc.</p> <p>Potential for social isolation</p> |
| Decrease in positive coping mechanisms | <p>Potential for increase in substance use, mental health, family violence, access to services etc.</p> <p>Potential for social isolation</p> |
| Decrease in youth resiliency; youth have unrealistic expectations | <p>Increase in need for respite for multi-systematic youth (to avoid loss of parental custody)</p> <p>Additional needs for kids (usually receive during school day)</p> <p>Summer months: a lot of youth programming is unavailable...</p> <p>Virtually – for youth activities – concern with lack of available technology, funds for programming</p> <p>A lot of pressure for schools to provide multiple needs of our young people</p> <p>Increase mental health treatment needs (lack of available providers)</p> <p>Need for parent education (recognizing needs of their youth) – connect to resources</p> |
| Human Trafficking | <p>Trauma to affected victims, families, communities</p> |
| Increase in awareness/acceptance of sharing mental health challenges | <p>A lot of pressure for schools to provide multiple needs of our young people/adults</p> <p>Increase mental health treatment needs (lack of available providers)</p> <p>Need for parent education (recognizing needs of their youth) – connect to resources</p> |
| Increasing conversations about mental health challenges decreasing the significance of more serious chronic mental health diagnosis | <p>A lot of pressure for schools to provide multiple needs of our young people/adults</p> <p>Increase mental health treatment needs (lack of available providers)</p> <p>Need for parent education (recognizing needs of their youth) – connect to resources</p> |

Demographical

| | |
|---|--|
| Aging population | Strain on resources |
| Decrease youth alcohol use | Potentially using other substances |
| Increase in youth vaping use | Long-term health impacts unknown |
| Shift in values; younger generations more open to legalization of drugs | Increase in number of states seeking legalization of rec MJ |
| Increase in reliance on CNP and Nurse specialists for both mental health and physical health. | Increase availability of providers/increased access to health care. |
| Neonatal | Impact of maternal use of substances on infants – impact on school system/mental health/ grandparents raising children – mental health and impact resource |

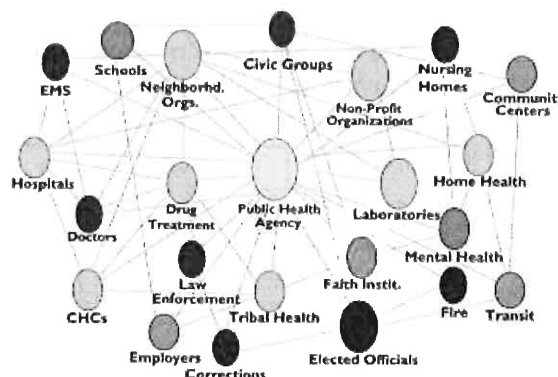
LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT

The Local Public Health System

Public health systems are commonly defined as “all public, private, and voluntary entities that contribute to the delivery of essential public health services within a jurisdiction.” This concept ensures that all entities’ contributions to the health and well-being of the community or state are recognized in assessing the provision of public health services.

The public health system includes:

- Public health agencies at state and local levels
- Healthcare providers
- Public safety agencies
- Human service and charity organizations
- Education and youth development organizations
- Recreation and arts-related organizations
- Economic and philanthropic organizations
- Environmental agencies and organizations

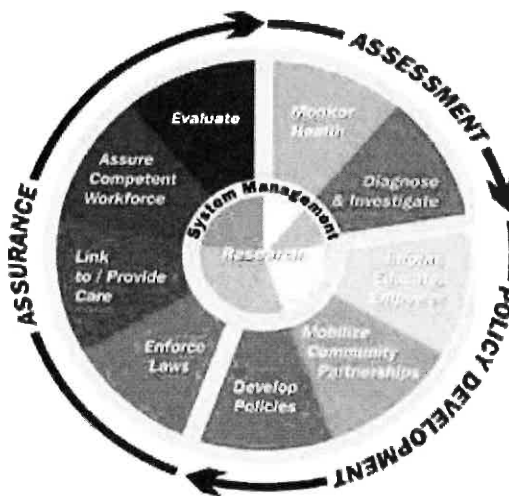


The 10 Essential Public Health Services

The 10 Essential Public Health Services describe the public health activities that all communities should undertake and serve as the framework for the NPHPS instruments.

Public health systems should:

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and action to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure competent public and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.



LOCAL PUBLIC HEALTH SYSTEM, *continued*

The Local Public Health System Assessment (LPHSA) answers the questions, "What are the components, activities, competencies, and capacities of our local public health system?" and "How are the Essential Services being provided to our community?"

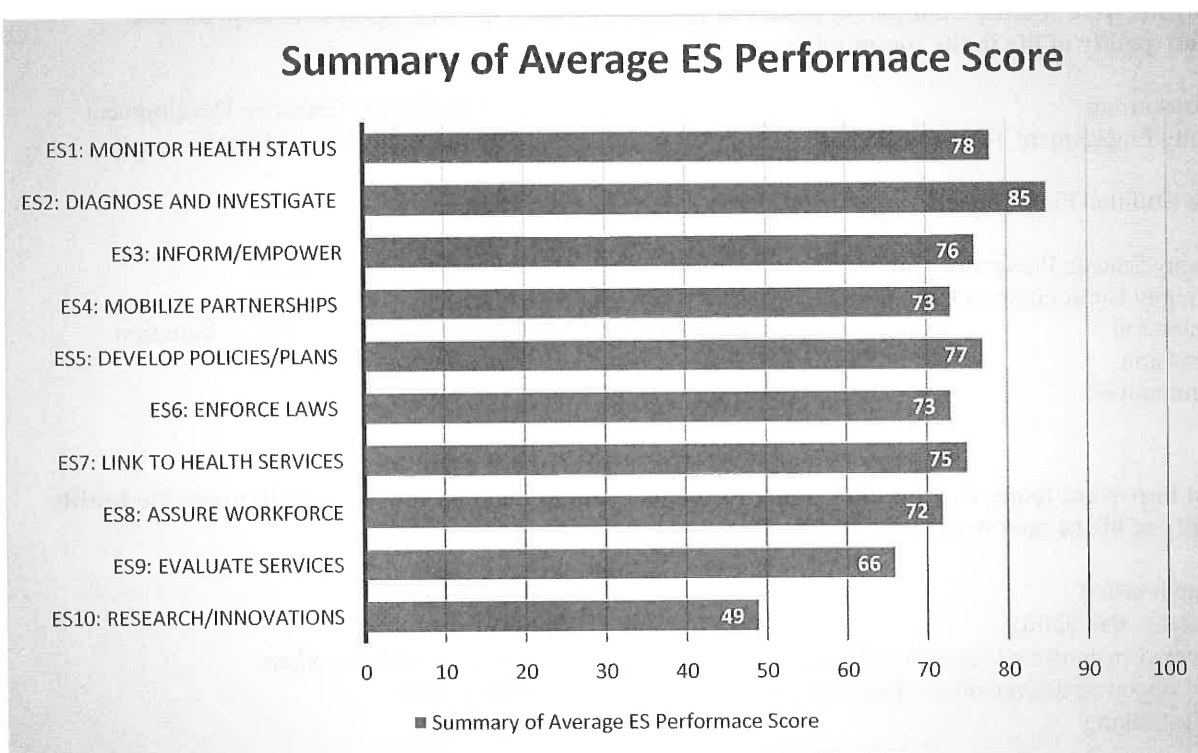
This assessment involves the use of a nationally recognized tool called the **National Public Health Performance Standards Local Instrument**.

Members of the Fulton County Health Department completed the performance measures instrument. The LPHSA results were then shared with Partners for Health members for feedback and discussion.

As part of minimum standards, local health departments are required to complete this assessment at least once every five years.

To view the full results of the LPHSA, please contact Kim Cupp from the Fulton County Health Department at kcupp@fultoncountyoh.com.

Fulton County Local Public Health Assessment 2020 Summary



COMMUNITY THEMES AND STRENGTHS

Fulton County Partners for Health participated in an exercise to discuss community themes and strengths. The results were as follows:

Fulton County community members believed the most important characteristics of a healthy community were:

| | |
|--|---------------------------------------|
| Access to Health Care | Low Vacancy of buildings/storefronts |
| Building/strengthening infrastructure | Population Diversity |
| Engaged parents/community adults | Strong Employment |
| Green Space | Visibility of people in the community |
| Intergenerational relationships/events | |

Community members were most proud of the following regarding their community:

| | |
|-----------------------------------|---------------------|
| Community partnerships/networking | Safe communities |
| Fulton County Fair | Strong schools |
| Multiple generations of families | Strong employers |
| Strong faith values | Youth leadership |
| Youth involvement | Youth opportunities |

The following were specific examples of people or groups who have worked together to improve the health and quality of life in the community:

| | |
|--|-------------------------------------|
| Aging Consortium | Fulton County Economic Development |
| Community Engagement Team (NSBS) | Fulton County Senior Center |
| CORE | JFS |
| Family & Children First Council | HC3 |
| 4-H | LOSS Team |
| Four County Suicide Prevention Coalition | Ministerial Associations |
| Fulton County Children Services | |
| Ohio Means Job | School Administration Collaboration |
| OSU Extension | United Way |
| Safe Communities | |

The most important issues that Fulton County residents believed must be addressed to improve the health and quality of life in their community were:

| | |
|---|------------------------------|
| Affordable housing | Mental Health |
| Agricultural sustainability | Obesity |
| Balance between consumers and contributors | Retention of skilled workers |
| Economic opportunities/retention of employees | Substance abuse |
| Human Trafficking | Transportation |

The following were barriers that have kept the community from doing what needs to be done to improve health and quality of life:

Affordable/available daycare
Community awareness of efforts/resources
Funding
Mutually reinforcing strategies
Resource collaboration
Source of higher education within county

Fulton County residents believed the following actions, policies, or funding priorities would support a healthier community:

Celebration/publicizing positive community events/progress/accomplishments
Increase taxes to fund:
Schools
Senior Centers
Arts/Cultural Activities
Community Family Center
List of community groups/central resource list for new and existing community members
Support for community engaged business

Fulton County residents were most excited to get involved or become more involved in improving the community through

Basic parenting classes offered
Early intervention
Free Family Events
Innovation
Multiple generational/senior center events

QUALITY OF LIFE SURVEY

In 2016, community members, at the request of Fulton County Partners for Health, completed a short Quality of Life Survey via Survey Monkey. There were 468 Fulton County community members who completed the survey. The anchored Likert scale responses were converted to numeric values ranging from 1 to 5, with 1 being lowest and 5 being highest. For example, an anchored Likert scale of “Very Satisfied” = 5, “Satisfied” = 4, “Neither Satisfied or Dissatisfied” = 3, “Dissatisfied” = 2, and “Very Dissatisfied” = 1. For all responses of “Don’t Know,” or when a respondent left a response blank, the choice was a non-response, was assigned a value of 0 (zero) and the response was not used in averaging response or calculating descriptive statistics. In June 2020, representatives from the Fulton County Health Center and the Fulton County Health Department met to review and discuss the 2016 results. Due to COVID -19, a decision was made to utilize this previous Quality of Life survey results as we felt data gathered now would be strongly impacted by the current epidemic.

| Quality of Life Questions | Likert Scale Average Response 2013 | Likert Scale Average Response 2017 |
|---|---|---|
| 1. Are you satisfied with the quality of life in our community? (Consider your sense of safety, well-being, participation in community life and associations, etc.) [IOM, 1997] | 3.9 | 3.9 |
| 2. Are you satisfied with the health care system in the community? (Consider access, cost, availability, quality, options in health care, etc.) | 3.6 | 3.4 |
| 3. Is this community a good place to raise children? (Consider school quality, day care, after school programs, recreation, etc.) | 4.2 | 4.1 |
| 4. Is this community a good place to grow old? (Consider elder-friendly housing, transportation to medical services, churches, shopping; elder day care, social support for the elderly living alone, meals on wheels, etc.) | 3.7 | 3.8 |
| 5. Is there economic opportunity in the community? (Consider locally owned and operated businesses, jobs with career growth, job training/higher education opportunities, affordable housing, reasonable commute, etc.) | 3.0 | 3.3 |
| 6. Is the community a safe place to live? (Consider residents’ perceptions of safety in the home, the workplace, schools, playgrounds, parks, and the mall. Do neighbors know and trust one another? Do they look out for one another?) | 4.0 | 4.0 |
| 7. Are there networks of support for individuals and families (neighbors, support groups, faith community outreach, agencies, or organizations) during times of stress and need? | 3.9 | 3.9 |
| 8. Do all individuals and groups have the opportunity to contribute to and participate in the community’s quality of life? | 3.7 | 3.7 |
| 9. Do all residents perceive that they — individually and collectively — can make the community a better place to live? | 3.3 | 3.4 |
| 10. Are community assets broad-based and multi-sectoral? (There are a variety of resources and activities available county-wide) | 3.2 | 3.3 |
| 11. Are levels of mutual trust and respect increasing among community partners as they participate in collaborative activities to achieve shared community goals? | 3.4 | 3.4 |
| 12. Is there an active sense of civic responsibility and engagement, and of civic pride in shared accomplishments? (Are citizens working towards the betterment of their community to improve life for all citizens?) | 3.4 | 3.5 |

QUALITY OF LIFE SURVEY, *continued*

In 2016, Fulton County Partners for Health added 20 additional questions at the end of the Quality of Life survey to address various social determinants of health-related issues that may be affecting economic development and other growth within the county.

Housing

9% of survey respondents indicated they rented their housing unit. 91% of respondents owned their home.

11% of renters planned to purchase a home within the next year. 44% planned to purchase a home within the next three years.

When asked what percent of their household income goes to housing, renters responded: less than 30% (35%), 30-50% (45%), and 50% or higher (8%). 12% did not know what percent of their household income went to their housing.

57% of renters indicated they had problems finding affordable housing.

When asked how many people lived in their housing unit, renters responded: one (43%), two (22%), three (8%), and four or more (27%).

4% of home owners planned to sell their home within the next year. 13% planned to sell within the next three years.

When asked what percent of their household income goes to housing, home owners responded: less than 30% (62%), 30-50% (25%), and 50% or higher (6%). 7% did not know what percent of their household income went to their housing.

10% of home owners indicated they had problems finding affordable housing.

When asked how many people lived in their housing unit, home owners responded: one (10%), two (43%), three (13%), and four or more (34%).

Childcare

61% of residents indicated that they had 0 children, under 18 years old, living in their home. 12% had one, 15% had two, and 12% had three or more living in their home.

63% of residents indicated that they had 0 children, under 6 years old, living in their home. 22% had one, 12% had two, and 3% had three or more living in their home.

Of those with children under 6 years old, 66% indicated their child attended daycare or preschool.

QUALITY OF LIFE SURVEY, *continued*

When asked why their child(ren) under 6 years old did not attend daycare or preschool the following were common responses:

"Too young/not age eligible"

"I work from home and take care of my children while I work" "Too expensive, and lack of resources for childcare in our area"

"The only preschools in Wauseon are Christian-based. Our family is Jewish" "Relative watches"

22% of parents, with children under six years old, reported daycare or babysitting expenses have prevented them from full-time employment.

Commute

When asked how long it takes Fulton County residents to get to work, they stated: less than 10 minutes (33%), 10-14 minutes (13%), 15-19 minutes (10%), 20-24 minutes (9%), 25-29 minutes (5%), 30-34 minutes (4%), 35-44 minutes (2%), 45-59 minutes (3%), and 90 or more minutes (<1%). 3% of respondents worked from home and 17% of respondents did not work.

Survey respondents commuted to work by: car, truck or van (98%), walked (4%), bicycle (2%), motorcycle (1%), public transportation (<1%), and other means (1%).

Of residents who commuted to work, 29% would consider employment opportunities that would decrease their commute time.

Education

21% of Fulton County residents were considering furthering their education.

When asked what was prohibiting Fulton County residents from furthering their education, the following were common responses:

"Debt/Cost"

"My age and children in college" "Work schedule"

"Limited time with my children"

"Time and no tuition reimbursement"

"Cost and workload with full time job and family" "Availability of programs locally"

"Health and age concerns"

QUALITY OF LIFE SURVEY, *continued*

Of residents who were considering furthering their education, the following were common responses regarding what type of education they would seek:

"Workshops and sessions" "Finishing my degree" "Continuing education"

"Associate's/Bachelor's/Graduate/Doctoral degrees"

"Classes to allow me to keep my job"

"Specific career enhancement certification" "Paramedic and FF-II"

"Learning a foreign language" "Computer skills"

"Law enforcement"

"Online college"

RESOURCE ASSESSMENT

Based on the chosen priorities, Fulton County Partners for Health was asked to complete a resource inventory for each priority. The resource inventory allowed Fulton County Partners for Health to identify existing community resources, such as programs, exercise opportunities, free or reduced cost health screenings, and more. Fulton County Partners for Health were then asked to determine whether a program or service was evidence-based, a best practice, or had no evidence indicated based on the following parameters:

An **evidence-based** practice has compelling evidence of effectiveness. Participant success can be attributed to the program itself and have evidence that the approach will work for others in a different environment. A **best practice** is a program that has been implemented and evaluation has been conducted. While the data supporting the program is promising, its scientific rigor is insufficient. A **non-evidence based** practice has neither no documentation that it has ever been used (regardless of the principals it is based upon) nor has been implemented successfully with no evaluation.

The resource assessment can be found in the appendix starting on page 67 and at the following links:

<http://fultoncountyhealthdept.com/>

<https://www.fultoncountyhealthcenter.org/>

Priority #1 I Mental Health and Addiction

Mental Health and Addiction Indicators

**Additional data can be found in the full 2019 Fulton County Community Health Assessment*

Adult and Youth Substance Abuse

| Adult Comparisons | Fulton County 2012 | Fulton County 2016 | Fulton County 2019 | Ohio 2017 | U.S. 2017 |
|---|--------------------|--------------------|-------------------------------------|-----------|-----------|
| Drank alcohol at least once in past month | 44% | 43% | 55% | 54% | 55% |
| Binge drinker (drank 5 or more drinks for males and 4 or more for females on an occasion) | 17% | 15% | 18% | 19% | 17% |
| Adults who used marijuana in the past 6 months | 2% | 2% | 2% recreational 1% medicinal use | N/A | N/A |
| Adults who misused prescription drugs in the past 6 months | 6% | 11% | 5% | N/A | N/A |

Red – Fulton County worse than Ohio

Green- Fulton County better than Ohio

N/A – not available

| Youth Comparisons | Fulton County 2012 (6 th -12 th) | Fulton County 2014 (6 th -12 th) | Fulton County 2016 (6 th -12 th) | Fulton County 2018 (6 th -12 th) | Fulton County 2018 (9 th -12 th) | Ohio 2014 (9 th -12 th) | U.S. 2017 (9 th -12 th) |
|--|---|---|---|---|---|--|--|
| Current drinker | 15% | 15% | 9% | 11% | 18% | 30% | 30% |
| Binge drinker (of all youth) | 9% | 10% | 4% | 8% | 13% | 16% | 14% |
| Drank and drove (of youth drivers) | 3% | 6% | 5% | 6% | 8% | 4% | 6% |
| Obtained the alcohol they drank by someone giving it to them | N/A | N/A | 38% | 30% | 38% | 38% | 44% |
| Youth who used marijuana in the past month | 4% | 6% | 7% | 7% | 12% | 21% | 20% |
| Ever misused medications | 6% | 8% | 6% | 7% | 11% | N/A | N/A |

Red-Fulton County worse than Ohio

Green- Fulton County better than Ohio

N/A – not available

| Youth Comparisons | Fulton County 2012 (6 th -12 th) | Fulton County 2014 (6 th -12 th) | Fulton County 2016 (6 th -12 th) | Fulton County 2018 (6 th -12 th) | Fulton County 2018 (9 th -12 th) | Ohio 2011 (9 th -12 th) | U.S. 2017 (9 th -12 th) |
|--|---|---|---|---|---|--|--|
| Ever tried cigarettes | 20% | 23% | 18% | 25% | N/A | 52%** | N/A |
| Current smokers | 7% | 8% | 6% | 6% | 10% | 15% | 9% |
| Usually obtained their own cigarettes by buying them in a store or gas station | 23% | 16% | 13% | 11% | N/A | N/A | N/A |

Red-Fulton County worse than Ohio

*Green- Fulton County better than Ohio **Comparative YRBS data for Ohio is 2011*

N/A – not available

Priority #1 I Mental Health and Addiction

Mental Health and Addiction Indicators, *continued*

Adult Mental Health

10% of Fulton County adults felt so sad or hopeless almost every day for two weeks or more in a row⁷

16 % of Fulton County adults, with incomes less than \$25,000, reported feeling sad or hopeless for two weeks or more in a row.

| Adult Comparisons | Fulton County 2012 | Fulton County 2016 | Fulton County 2019 | Ohio | U.S. |
|---|--------------------|--------------------|--------------------|------|------|
| Considered attempting suicide in the past year | 1% | 3% | 4% | N/A | N/A |
| Two or more weeks in a row felt sad or hopeless | 10% | 8% | 10% | N/A | N/A |

N/A – not available

Youth Mental Health

29% of youth in Fulton County reported they felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities in the past 12 months

41% of Fulton County **female** youth reported they felt so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities in the past 12 months

37% of youth reported they would seek help if they were dealing with anxiety, stress, depression, or thoughts of suicide. This is a decrease of 9% reported in 2016 (48%)

Of youth who reported they would not seek help, the following reasons were reported: they can handle it themselves (31%), worried what others might think (27%), would not know where to go (10%), cost (8%), their family would not support them in getting help (6%), their friends would not support them in getting help (5%), transportation (5%). 3% indicated they were currently in treatment which is an 8% decrease from the 11% who reported they were in treatment in 2016.

| Youth Comparisons | Fulton County 2012 (6 th -12 th) | Fulton County 2014 (6 th -12 th) | Fulton County 2016 (6 th -12 th) | Fulton County 2018 (6 th -12 th) | Fulton County 2018 (9 th -12 th) | Ohio 2013 (9 th -12 th) | U.S. 2017 (9 th -12 th) |
|---|---|---|---|---|---|--|--|
| Youth who had seriously considered attempting suicide in the past year | 10% | 12% | 10% | 15% | 17% | 14% | 17% |
| Youth who had attempted suicide in the past year | 4% | 5% | 6% | 7% | 9% | 6% | 7% |
| Youth who felt sad or hopeless almost every day for 2 or more weeks in a row. | 17% | 19% | 22% | 29% | 35% | 26% | 32% |

Red- Fulton County worse than Ohio

Green- Fulton County better than Ohio

Priority #1 I Mental Health and Addiction

County Profile: 2014-2018

Fulton County, OH

Drug Overdose Mortality Rate

28.8 Deaths per 100k population
(Ages 15-64)

52.1 Ohio Drug Overdose Mortality Rate

27.1 U.S. Drug Overdose Mortality Rate

33

42,305

Total Deaths Population

Note: Sociodemographic and economic data are provided to show composition of the total population; they DO NOT reflect the proportions of individuals who died as a result of overdose.

SOCIO-DEMOGRAPHIC

| | Fulton County | Ohio | United States |
|---|---------------|-------|---------------|
| Race/Ethnicity | | | |
| White (non-Hispanic) | 88.2% | 79.2% | 61.5% |
| African American (non-Hispanic) | 9.4% | 12.2% | 12.3% |
| Hispanic or Latino | 8.6% | 3.7% | 17.6% |
| Asian (non-Hispanic) | 8.4% | 2.1% | 5.3% |
| Native Hawaiian/Pacific Islander (non-Hispanic) | 0.9% | 0.0% | 0.2% |
| American Indian/Alaska Native (non-Hispanic) | 0.3% | 0.2% | 0.7% |
| Age | | | |
| Under 15 | 19.8% | 18.5% | 19.0% |
| 15-64 | 63.8% | 65.2% | 68.1% |
| 65+ | 16.7% | 16.3% | 14.9% |
| Educational Attainment | | | |
| At least High School Diploma (25+) | 91.2% | 90.1% | 87.3% |
| Bachelor's Degree or more (25+) | 17.2% | 27.8% | 30.9% |
| Disability Status | | | |
| % Residents with a disability (18-64) | 11.2% | 11.9% | 10.3% |

ECONOMIC

| | | | |
|---|----------|----------|----------|
| Broadband Access (3 or more providers) | 97.8% | 94.9% | 93.3% |
| Median Household Income | \$40,231 | \$54,533 | \$57,662 |
| Poverty Rate | 9.4% | 14.5% | 14.8% |
| Unemployment Rate | 4.8% | 5.8% | 6.8% |
| Injury-prone Employment | | | |
| Construction | 4.1% | 3.9% | 4.8% |
| Mining and Natural Resources | 1.7% | 0.5% | 1.4% |
| Manufacturing | 38.7% | 12.9% | 8.8% |
| Trade, Transportation, & Utilities | 15.7% | 19.0% | 19.1% |

This data is from the Opioid Community Assessment Tool created by NORC at the University of Chicago and can be found at opioidmisusetool.norc.uchicago.edu

NORC at the University of Chicago

USDA

Priority #1 I Mental Health and Addiction

Gaps and Potential Strategies- Substance Abuse

| Gaps | Potential Strategies |
|---|--|
| 1. Youth support groups | Development and implementation of county or regional support group for young people |
| 2. No comprehensive screening mechanism at schools | Electronic screening method in every district at multiple grade levels Program to refer students after screening identification |
| 3. Stigma for getting help | Education Comprehensive and broad screening of substance use |
| 4. School and community prevention programming is not comprehensive and intentionally planned | Consistent and comprehensive evidence based programs across the board Require schools to report their programming efforts Increase school –based youth led programming efforts |

Gaps and Potential Strategies- Mental Health

| Gaps | Potential Strategies |
|--|---|
| 1. Stigma of getting help | Primary care physicians as access point to educate and refer patients Ensure that all primary care physicians are using PHQ-9 |
| 2. No comprehensive mechanism for screening at schools, community locations or physician offices | More primary care intervention to rule out medical conditions Electronic screening method in every district at multiple grade levels Program to refer students after screening identification |
| 3. Lack of general education of signs and symptoms | Educate community/raise awareness on signs and symptoms |
| 4. School and community prevention programming is not comprehensive and intentionally planned | Consistent and comprehensive evidence based programs across the board Require schools to report their programming efforts Consider the expansion and additional programs- Incredible years, PAX, SOS, Youth led programming |

Priority #1 I Mental Health and Addiction

The following programs and policies have been reviewed and have proven strategies to **improve mental health and decrease addiction:**

Mental Health Best Practices

1. **PHQ-9:** The PHQ-9 is the nine-item depression scale of the Patient Health Questionnaire. The PHQ-9 is a powerful tool for assisting primary care clinicians in diagnosing depression as well as selecting and monitoring treatment. The primary care clinician and/or office staff should discuss with the patient the reasons for completing the questionnaire and how to fill it out. After the patient has completed the PHQ-9 questionnaire, it is scored by the primary care clinician or office staff.

- There are two components of the PHQ-9:
- Assessing symptoms and functional impairment to make a tentative depression diagnosis, and
- Deriving a severity score to help select and monitor treatment

The PHQ-9 is based directly on the diagnostic criteria for major depressive disorder in the Diagnostic and Statistical Manual Fourth Edition (DSM-IV).

For more information go to:

<http://www.integration.samhsa.gov/clinical-practice/screening-tools#depression>

2. **SOS Signs of Suicide®:** The Signs of Suicide Prevention Program is an award-winning, nationally recognized program designed for middle and high school-age students. The program teaches students how to identify the symptoms of depression and suicidality in themselves or their friends, and encourages help-seeking through the use of the ACT® technique (Acknowledge, Care, Tell).

The SOS High School program is the only school-based suicide prevention program listed on the Substance Abuse and Mental Health Services Administration's National Registry of Evidence-based Programs and Practices that addresses suicide risk and depression, while reducing suicide attempts. In a randomized control study, the SOS program showed a reduction in self-reported suicide attempts by 40% (BMC Public Health, July 2007).

For more information go to:

<http://www.mentalhealthscreening.org/programs/youth-prevention-programs/sos/>

3. **The Incredible Years®:** The Incredible Years programs for parents and teachers reduce challenging behaviors in children and increase their social and self-control skills. The Incredible Years programs have been evaluated by the developer and independent investigators. Evaluations have included randomized control group research studies with diverse groups of parents and teachers. The programs have been found to be effective in strengthening teacher and parent management skills, improving children's social competence and reducing behavior problems. Evidence shows that the program have turned around the behaviors of up to 80 percent of the children of participating parents and teachers. If left unchecked these behaviors would mean those children are at greater risk in adulthood of unemployment, mental health problems, substance abuse, early pregnancy/early fatherhood, criminal offending, multiple arrests and imprisonment, higher rates of domestic violence and shortened life expectancy. Incredible Years training programs give parents and teachers strategies to manage behaviors such as aggressiveness, ongoing tantrums, and acting out behavior such as swearing, whining, yelling, hitting and kicking, answering back, and refusing to follow rules. Through using a range of strategies, parents and teachers help children regulate their emotions and improve their social skills so that they can get along better with peers and adults, and do better academically. It can also mean a more enjoyable family life.

For more information go to: For more information go to: <http://www.incredibleyears.com/>

4. PAX (Good Behavior Game)

The PAX Good Behavior Game (PAX GBG) teaches children to work together for common goals, and to focus on a positive future they co-create with others. These are core cognitive, emotional, and behavioral skills required for peaceful, productive, healthy and happy lives.

For more information, go to: <https://www.goodbehaviorgame.org/>

5. Youth Led Programs

Youth led programming is an evidence-based community process, utilizing two frameworks, Youth Empowerment Conceptual Framework and the Strategic Prevention Framework. Occurring in both school and community settings, young people are encouraged by Adult Allies to actively look at their surroundings, gather information, and then address community topics that are relevant to their lives. Youth led programs provide a platform to effectively engage youth voice and youth action, equipping young people with the knowledge, skills, and attitudes required to impact their community.

For more information, go to: <http://www.ohioadultallies.co>

Youth Substance (Drug) Use Prevention Best Practices

Too Good For Drugs: Too Good for Drugs (TGFD) is a school-based prevention program for kindergarten through 12th grade that builds on students' resiliency by teaching them how to be socially competent and autonomous problem solvers. The program is designed to benefit everyone in the school by providing needed education in social and emotional competencies and by reducing risk factors and building protective factors that affect students in these age groups. TGFD focuses on developing personal and interpersonal skills to resist peer pressures, goal setting, decision making, bonding with others, having respect for self and others, managing emotions, effective communication, and social interactions. The program also provides information about the negative consequences of drug use and the benefits of a nonviolent, drug-free lifestyle. TGFD has developmentally appropriate curricula for each grade level through 8th grade, with a separate high school curriculum for students in grades 9 through 12. The K-8 curricula each include 10 weekly, 30- to 60-minute lessons, and the high school curriculum includes 14 weekly, 1-hour lessons plus 12 optional, 1-hour "infusion" lessons designed to incorporate and reinforce skills taught in the core curriculum through academic infusion in subject areas such as English, social studies, and science/health. Ideally, implementation begins with all school personnel (e.g., teachers, secretaries, janitors) participating in a 10-hour staff development program, which can be implemented either as a series of 1-hour sessions or as a 1- or 2-day workshop.

Five studies conducted by an independent evaluator have examined TGFD's effectiveness in reducing adolescents' intention to use tobacco, alcohol, and marijuana; reducing fighting; and strengthening protective and resiliency factors. Each of the five studies showed positive effects on risk and protective factors relating to alcohol, tobacco, illegal drug use, and violence, including significant positive effects on the following:

- ☐ Attitudes toward drugs
- ☐ Attitudes toward violence
- ☐ Perceived peer norms
- ☐ Peer disapproval of use
- ☐ Emotional competence
- ☐ Social and resistance skills
- ☐ Goals and decision making
- ☐ Perceived harmful effects

For more information go to: <http://www.mendezfoundation.org/>

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For more information, go to: <http://www.ohioadultallies.com>

Priority #1 I Mental Health and Addiction Action Step Recommendations & Action Plan

To work toward **improving mental health and decreasing addiction** the following actions steps are recommended:


1. Continue to coordinate with Four County ADAMHs Board and regional health departments to implement mental health wellness media campaign
2. Increase Youth & Adult Mental Health First Aid Training
3. Expand our school based Screening, Brief Intervention and Referral to Treatment Model
4. Expand our Universal School-Based Suicide Awareness and Education Program
5. Build community cessation partners to increase opportunities for tobacco cessation for youth and adults
6. Provide vaping presentations to middle school students in schools annually
7. Ensure our current School-Based social and emotional instruction continues to be sustainable (capacity and funding)
8. Implement telephonic tobacco cessation programs

| 1. Priority Health Outcomes: Mental Health and Addiction | | | |
|--|---------------------------------------|--|--------------|
| Priority Factors: Healthcare System and Access (unmet need for mental health care) | | | |
| Strategy: Media Campaign | | | |
| Priority Outcome: Reduce Drug Dependence or Abuse and Reduce Depression | | | |
| Priority Indicator: A. Reduce past-year illicit drug dependence or abuse among ages 12+ B. Percent of youth who experienced a major depressive episode within the past year | | | |
| Short-Term Outcomes: Increase by 5% the number of Fulton County female youth (grades 9th-12th) and female adults (ages 30-64) who report willingness to seek help if dealing with anxiety, stress, depression or thoughts of suicide as reported on 2021 Youth Health Status Report and 2022 FC Health Status Report | | | |
| Long-Term Outcomes: Decrease by 5% the number of Fulton County female youth (grades 9th – 12th) and female adults (ages 30-64) reporting that they felt sad or hopeless two or more weeks in a row as reported on the 2025 Health Status Report | | | |
| Action Step | Output | Person/Agency Responsible | Timeline |
| Year 1: Continue to coordinate with the ADAMHs Board, Defiance, Henry and Williams County health departments to develop and implement a media campaign to promote mental wellness, recognize signs of mental health issues, and understand value of referral/treatment. Distribution within Fulton County should focus on priority population | Mental Health Wellness Media Campaign | Fulton County Health Department, Jaime Fogarty | Dec. 1, 2021 |
| Year 2: Evaluate effectiveness of campaign in reaching priority population. | | | Dec. 1, 2022 |
| Year 3: Based on evaluation, adjust media campaign to increase reach to focus population. | | | Dec. 1, 2023 |


| | | | |
|---|---|---|-----------------|
| 2. Priority Health Outcomes: Mental Health and Addiction | | | |
| Priority Factors: Healthcare System and Access (unmet need for mental health care) | | | |
| Strategy: Youth & Adult Mental Health First Aid Training | | | |
| Priority Outcome: Reduce Drug Dependence or Abuse and Reduce Depression | | | |
| Priority Indicator: A. Reduce past-year illicit drug dependence or abuse among ages 12+ | | | |
| B. Percent of youth who experienced a major depressive episode within the past year | | | |
| Short-Term Outcomes: Increase by 5% the number of Fulton County female youth (grades 9th-12th) and female adults (ages 30-64) who report willingness to seek help if dealing with anxiety, stress, depression or thoughts of suicide as reported on 2021 Youth Health Status Report and 2022 FC Health Status Report | | | |
| Long-Term Outcomes: Decrease by 5% the number of Fulton County female youth (grades 9th – 12th) and female adults (ages 30-64) reporting that they felt sad or hopeless two or more weeks in a row as reported on the 2025 Health Status Report | | | |
| Action Step | Output | Person/Agency Responsible | Timeline |
| Year 1: Provide Opportunity for Youth & Adult Mental Health First Aid Training by determining target audience for training and building capacity around benefit for training to professionals. Provide 4 opportunities for FC adults to be trained. | Professionals and community adults trained in Youth and Adult Mental Health First Aid | Karen VonDeylen Maumee Valley Guidance | Dec. 1, 2021 |
| Year 2: Provide 4 opportunities for FC adults to be trained. | | | Dec 1, 2022 |
| Year 3: Provide 4 opportunities for FC adults to be trained. | | | Dec 1, 2023 |

3. Priority Health Outcomes: Mental Health and Addiction

Priority Factors: Healthcare System and Access (unmet need for mental health care), Health Behaviors – Tobacco/Nicotine Use

| Strategy: Screening, Brief Intervention and Referral to Treatment  | | | |
|--|--|---|------------------|
| Priority Outcomes: Reduce Drug Dependence or Abuse and Reduce Depression | | | |
| Priority Indicator: A. Reduce past-year illicit drug dependence or abuse among ages 12+ B. Percent of youth who experienced a major depressive episode within the past year | | | |
| Short-Term Outcomes: Increase by 10% the number of Fulton County youth being screened for mental health issues by September 2022 by behavioral health agency conducting SBIRT Screenings | | | |
| Long-Term Outcomes: Decrease by 5% the number of Fulton County youth (grades 6 th – 12 th) reporting that they felt sad or hopeless two or more weeks in a row as reported on the 2025 Health Status Report | | | |
| Action Step | Output | Person/Agency Responsible | Timeline |
| Year 1: Expand capacity for increased use of routine SBIRT (Screening, Brief Intervention, and Referral to Treatment) process in school setting to identify individuals in need of services. | Increased opportunities for youth being screened for drug and alcohol/depression/mental health issues in a school setting. | FCHD - Beth Thomas Behavioral Health Agency Four County ADAMHS Board (funder) | December 1, 2022 |
| Year 2: Recruit at least one additional school district (or expand to additional grade within participating district) to implement the SBIRT process routinely | Increase in number of youth routinely being screened for drug and alcohol/depression/mental health issues from baseline. | | December 1, 2022 |
| Year 3: Continue efforts from Years 1 and 2. | | | December 1, 2023 |

4. Priority Topic: Mental Health and Addiction (Mental Health)
Priority Factors: Healthcare System and Access (unmet need for mental health care)

| Strategy: Implement a Universal School-Based Suicide Awareness and Education Program  | | | |
|--|--|---|--|
| Priority Outcomes: Reduce Depression | | | |
| Priority Indicator: A. Reduce past-year illicit drug dependence or abuse among ages 12+ B. Percent of youth who experienced a major depressive episode within the past year | | | |
| Short-Term Outcomes: Increase by 5% the number of Fulton County female youth (grades 9th-12th) and female adults (ages 30-64) who report willingness to seek help if dealing with anxiety, stress, depression or thoughts of suicide as reported on 2021 Youth Health Status Report and 2022 FC Health Status Report | | | |
| Long-Term Outcomes: Decrease by 5% the number of Fulton County female youth (grades 9th – 12th) and female adults (ages 30-64) reporting that they felt sad or hopeless two or more weeks in a row as reported on the 2025 Health Status Report | | | |
| Action Step | Output | Person/Agency Responsible | Timeline |
| Year 1: Continue to introduce Signs of Suicide (SOS) Program to school administration (superintendents, principals, and guidance counselors). For school district consistency, determine to which grade levels the program will be offered. Collect pre/post data to determine what skills are gained. Track number of youth who self-refer or trigger assessment for referral. Determine method for follow up. | HS and MS students trained in Signs of Suicide. MS students self-refer for mental health issues HS students screened for suicide intention | Karen VonDeylen Maumee Valley Guidance | May 1, 2021 September 30, 2022 May 1, 2023 |
| Year 2: Implement the SOS program in 2 additional schools or additional grade levels within participating school district | | | |
| Year 3: Continue efforts from Years 1 and 2. | | | |

5. Priority Topic: Mental Health and Addiction (Mental Health)
Priority Factors: Health Behaviors – Tobacco Nicotine Use

| Strategy: Build community cessation partners to increase opportunities for tobacco cessation for youth and adults | | | |
|--|---|------------------------------------|--------------------|
| Priority Outcome: Reduce Heart Disease | | | |
| Priority Indicator: A. Reduce past-year illicit drug dependence or abuse among ages 12+ B. Youth/Adult tobacco/nicotine use | | | |
| Short-Term Outcomes: Increase by 5% the number of Fulton County youth that use the My Life, My Quit line in 12 months | | | |
| Long-Term Outcomes: Decrease by 5% the number of Fulton County youth (grades 6th – 12th) who report e-cig/vape use in the past 12 months by 2025 as reported by the Fulton County Health Status Report. | | | |
| Decrease by 5% the number of Fulton County adults who report tobacco use in the past 12 months by 2025 as reported by the Fulton County Health Status Report. | | | |
| Action Step | Output | Person/Agency Responsible | Timeline |
| Year 1: Identify possible community partners to provide support and referral to cessation opportunities for youth | Increase in number of community partners addressing youth tobacco cessation | Beth Thomas, FCHD HC3 Coalition | May 1, 2021 |
| Year 2: Partner with at least 2 identified community partners to provide support and referral for youth tobacco cessation. | | | September 30, 2022 |
| Year 3: Continue efforts from Years 1 and 2. | | | May 1, 2023 |

**6. Priority Topic: Mental Health and Addiction (Mental Health)
Priority Factors: Health Behaviors – Tobacco Nicotine Use**

Strategy: Provide vaping presentations to middle school students in schools annually

Priority Outcome: Reduce Heart Disease

**Priority Indicator: A. Reduce past-year illicit drug dependence or abuse among ages 12+
B. Youth/Adult tobacco/nicotine use**

Short-Term Outcomes: Increase by 5% the number of Fulton County youth (ages 11 - 16) who report great risk for e-cig/vape use by 2021 as reported by the Fulton County Health Status Report.

Long-Term Outcomes: Decrease by 5% the number of Fulton County youth (grades 6th – 12th) who report e-cig/vape use in the past 12 months by 2025 as reported by the Fulton County Health Status Report.

| Action Step | Output | Person/Agency Responsible | Timeline |
|---|--|------------------------------------|--------------------|
| Year 1: Identify Fulton County school districts willing to partner for vaping/e-cig presentations to middle school students. | Middle school youth receive annual education about vaping/e-cigarette products | Beth Thomas FCHD/HCC3 Coalition | May 31, 2021 |
| Year 2: Implement vaping presentations in 2/7 districts | | | September 30, 2022 |
| Year 3: Continue efforts from Years 1 and 2. | | | May 1, 2023 |

7. Priority Topic: Mental Health and Addiction (Mental Health)
Priority Factors: Healthcare System and Access (unmet need for mental health care), Health Behaviors

Strategy: Ensure our current School-Based social and emotional instruction continues to be sustainable (capacity and funding)

Priority Outcomes: Reduce Depression

Priority Indicator: A. Reduce past-year illicit drug dependence or abuse among ages 12+

B. Percent of youth who experienced a major depressive episode within the past year

Shorter-Term Outcomes: Increase by 5% the number of Fulton County female youth (grades 9th-12th) and female adults (ages 30-64) who report willingness to seek help if dealing with anxiety, stress, depression or thoughts of suicide as reported on 2021 Youth Health Status Report and 2022 FC Health Status Report

Longer-Term Outcomes: Decrease by 5% the number of Fulton County female youth (grades 9th – 12th) and female adults (ages 30-64) reporting that they felt sad or hopeless two or more weeks in a row as reported on the 2025 Health Status Report

| Action Step | | Person/Agency | Timeline |
|---|--------------------|--|----------------------------|
| As a result of previous Community Health Improvement Plans, we have established strong and sustainable school and community-based programming for youth to address mental health, substance use and other high risk behaviors. Fulton County Partners for Health will continue to monitor these programs annually to ensure appropriate outcomes and secured funding. | Output | Beth Thomas/FCHD | May 1, 2022 |
| | Too Good for Drugs | Ruth Peck, Recovery Services of NWO | May 1, 2022 May 1, 2023 |

**8. Priority Topic: Mental Health and Addiction (Tobacco)
Priority Factor: Health Behavior- Tobacco/Nicotine Use**

Strategy: Implement Telephonic Tobacco Cessation Programs

Priority Outcome: Reduce Heart Disease

Priority Indicator: Adult tobacco/nicotine use

Short-Term Outcomes: Increase by 5% the number of Fulton County adults that use the Ohio Quit Line

Long-Term Outcomes: Decrease by 5% the number of Fulton County adults who smoke or use other tobacco products as reported on the 2025 Health Status Report

| Action Step (Activities) | Output | Person/Agency Responsible | Timeline |
|---|----------------------------------|---|--------------------|
| Year 1: Partner with the Fulton County Health Department and the Ohio Quit Line to offer education and referral information to Fulton County Health Center Employees through the Wellness Plan and Health Fairs | Ohio Tobacco Quit Line Referrals | Britney Ward Fulton County Health Center | May 30, 2021 |
| Year 2: Continue efforts from Year 1 and expand education and referral information to events throughout the county | | | September 30, 2022 |
| Year 3: Continue efforts from Years 1 and 2 and expand education and referral information to other large employers in the county | | | May 30, 2023 |

Priority #2 I Chronic Disease

Chronic Disease Indicators

**Additional data can be found in the full 2019 Fulton County Community Health Assessment*

Adult Obesity

In Fulton County, 18% of adults did not participate in any physical activity in the past week, including 4% who were unable to exercise. This is a decrease of 12% from 30% reported in 2016.

In 2019, 31% of adults ate 1-to-2 servings of fruits and vegetables per day, 47% ate 3-to-4 servings per day, and 8% ate 5 or more servings per day. Four percent (4%) of adults ate no servings of fruits and vegetables per day.

The table below indicates the number of sugar-sweetened beverages Fulton County adults consumed daily.

| Type of beverage | 5 or more servings | 3-4 servings | 1-2 servings | 0 servings |
|---------------------------|--------------------|--------------|--------------|------------|
| Sugar sweetened beverages | 3% | 7% | 42% | 48% |

| Adult Comparisons | Fulton County 2005 | Fulton County 2012 | Fulton County 2016 | Fulton County 2019 | Ohio 2017 | U.S. 2017 |
|-------------------|--------------------|--------------------|--------------------|--------------------|-----------|-----------|
| Obese | | 34% | 36% | 43% | 36% | 34% |
| Overweight | | 35% | 35% | 32% | 36% | 35% |

*Red- Fulton County worse than Ohio
Green- Fulton County better than Ohio*

Youth Obesity

Five percent (5%) of youth drank 5 or more servings of sugar-sweetened beverages per day; 21% of youth drank 3-4 servings; and 61% of youth drank 1-2 servings. Thirteen percent (13%) of youth drank zero servings of sugar-sweetened beverages per day.

| Youth Comparisons | Fulton County 2012 (6 th -12 th) | Fulton County 2014 (6 th -12 th) | Fulton County 2016 (6 th -12 th) | Fulton County 2018 (6 th -12 th) | Fulton County 2019 (9 th -12 th) | Ohio 2013 (9 th -12 th) | U.S. 2017 (9 th -12 th) |
|---|--|--|--|--|--|---|---|
| Obese | 14% | 13% | 18% | 19% | 20% | 13% | 15% |
| Overweight | 12% | 13% | 14% | 15% | 14% | 16% | 16% |
| Described themselves as slightly or very overweight | 30% | 28% | 32% | 35% | 38% | 28% | 32% |

| | | | | | | | |
|---|-----|-----|-----|-----|-----|-----|-----|
| Ate 1 to 4 servings of fruits and vegetables per day | 78% | 84% | 88% | 88% | N/A | N/A | N/A |
| Physically active at least 60 minutes per day on every day in past week | 34% | 37% | 34% | 32% | N/A | 26% | 27% |
| Did not participate in at least 60 minutes of physical activity on any day in past week | 7% | 8% | 11% | 15% | N/A | 13% | 14% |

Red- Fulton County worse than Ohio Green- Fulton County better than Ohio N/A- Not Available

Child Obesity

21% of children were classified as obese by Body Mass Index (BMI) calculations. 17% of children were classified as overweight, 51% were normal weight, and 11% were underweight as reported in the 2016 Fulton County Health Status Report.

64% of Fulton County children ate vegetables at least once per day during the past week. 5% of children had not eaten any vegetables in the past week as reported in the 2016 Fulton County Health Status Report.

Priority #2 I Chronic Disease

Chronic Disease Indictors, continued Adult Cardiovascular Health

Four percent (4%) of adults reported they had angina or coronary heart disease, increasing to 14% of those over the age of 65 and 16% of those with incomes less than \$25,000

Nearly one-third (30%) of Fulton County adults had been diagnosed with high blood cholesterol. The 2013 BRFSS reported that 38% of Ohio and U.S. adults had been told they have high blood cholesterol.

Fulton County adults diagnosed with high blood pressure were more likely to have:

Rated their overall health as fair or poor (61%)
 Been ages 65 years or older (60%)
 Incomes less than \$25,000 (58%)
 Been classified as obese by body mass index (42%)

Thirty percent (30%) of adults had been diagnosed with high blood cholesterol.

More than four-fifths (84%) of adults had their blood cholesterol checked within the past five years.

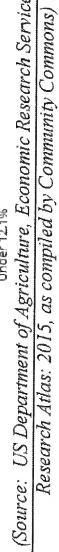
Fulton County adults with high blood cholesterol were more likely to have:

Been ages 65 years or older (57%)
 Rated their overall health as fair or poor (49%)
 Incomes less than \$25,000 (37%)

| Adult Comparisons | Fulton County 2005 | Fulton County 2012 | Fulton County 2016 | Fulton County 2019 | Ohio 2017 | U.S. 2017 |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------|--------------|
| Had angina or coronary heart disease | N/A | 1% | 4% | 4% | 5% | 4% |
| Had a heart attack | 5% | 2% | 5% | 3% | 6% | 4% |
| Had a stroke | 2% | 1% | 4% | 2% | 4% | 3% |
| Had high blood pressure | 26% | 32% | 37% | 33% | 35% | 32% |
| Had high blood cholesterol | 24% | 29% | 32% | 30% | 33% | 33% |
| Had blood cholesterol checked within past 5 years | 61% | 77% | 81% | 84% | 85% | 86% |

Red- Fulton County worse than Ohio
Green- Fulton County better than Ohio
N/A- Not Available

Food Insecure Population, Percent by County, Feeding America 2014



(Source: ESRI Map Gallery and OpenStreetMap: 2013. OpenStreetMap: 2013, as compiled by Community Commons)

Priority #2 I Chronic Disease

Gaps and Potential Strategies- Obesity/Cardiovascular for adult males (under 30 with income > \$25,000)

| Gaps | Potential Strategies |
|---|---|
| 1. Access to indoor recreation facilities | o Promote areas community can access |
| 3. Logistical barriers | o Better transportation o Build time management skills |
| 6. Wellness opportunities | o Employer insurance incentives o Educate employers about the benefits of workplace wellness |

Gaps and Potential Strategies- Obesity/Cardiovascular (youth males ages 14 – 16)

| Gaps | Potential Strategies |
|--|--|
| 1. Lack of motivation | o Recruit champions o Promote success stories o Lifestyle activities (vs. school sports) |
| 2. Access to indoor recreation facilities | o Promote areas community can access |
| 3. Parents not educated about what their children are learning | o Educate and engage parents in school activities o Expand potential opportunities (churches, etc.) |
| 4. Logistical barriers | o Better transportation o Build time management skills |
| 5. Family opportunities | o Engage families in non-competitive opportunities o Parents and children exercising opportunities |

Priority #2 | Chronic Disease

Best Practices

The following programs and policies have been reviewed and have proven strategies to improve chronic disease:

1. Serving Up MyPlate: A Yummy Curriculum (USDA Nutritional Guidelines): Serving Up MyPlate is a collection of classroom materials that helps elementary school teachers integrate nutrition education into Math, Science, English Language Arts, and Health. This “yummy curriculum” introduces the importance of eating from all five food groups using the MyPlate icon and a variety of hands-on activities. Students also learn the importance of physical activity to staying healthy. Serving Up MyPlate provides teacher lesson plans, activities, posters, parent education handouts, and additional games and resources.

For more information go to: <http://www.fns.usda.gov/tn/serving-myplate-yummy-curriculum>

2. Ohio Tobacco Quit Line: The Ohio Tobacco Quit Line provides personal quit coaching and telephone counseling free of charge to ALL Ohioans, regardless of insurance status or income. There is also a special protocol for pregnant women. Nicotine patches, gum, or lozenges are provided for up to eight weeks at no charge to eligible participants. Quit Line: 1-800-QUIT-NOW

For more information go to: <https://ohio.quitlogix.org/en-US/>

3. Point-of-Purchase Prompts Point-of-purchase or point-of-decision prompts are motivational messages such as signs, posters, front of package labels or shelf labels placed near fruits, vegetables and other items to encourage individuals to purchase these healthier food options. Point-of-purchase prompts can provide specific nutrition information, use symbols to rate or indicate healthy items, or promote selection of specific types of healthy foods. Point-of-purchase prompts for healthy food choices can be implemented in cafeterias, vending machines, grocery stores, or retail locations in worksites, hospitals, schools, or other community venues. Point-of-purchase prompts are often implemented as part of a multi-component approach to improving food environments.

For more information go to: <https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/point-of-purchase-prompts-for-healthy-foods>

4. Competitive Pricing for Healthy Foods Competitive pricing assigns higher costs to non-nutritious foods than nutritious foods. Competitive pricing can include incentives, subsidies, or price discounts for healthy foods and beverages as well as disincentives or price increases for unhealthy foods and beverages. Competitive pricing can be implemented in various settings, including schools, worksites, grocery stores or other food retail outlets, cafeterias, and vending machines.

For more information go to: <https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/competitive-pricing-for-healthy-foods>

5. Community Fitness Programs Fitness programs can be offered in a variety of public settings including community, senior, fitness, and community wellness centers and outdoor settings such as parks. Program offerings vary by location, but often include exercise classes such as aerobic dance classes, Zumba, Pilates, yoga, Tai Chi, and spinning/indoor cycling.

For more information go to: <https://www.countyhealthrankings.org/take-action-to-improve-health/what-works-for-health/strategies/community-fitness-programs>

6. Diabetes Prevention Program The National Diabetes Prevention Program—or National DPP—was created in 2010 to address the increasing burden of prediabetes and type 2 diabetes in the United States. This national effort created partnerships between public and private organizations to offer evidence-based, cost-effective interventions that help prevent type 2 diabetes in communities across the United States. One key feature of the National DPP is the CDC-recognized lifestyle change program, a research-based program focusing on healthy eating and physical activity which showed that people with prediabetes who take part in a structured lifestyle change program can cut their risk of developing type 2 diabetes by 58% (71% for people over 60 years old).

For more information go to: <https://www.cdc.gov/diabetes/prevention/index.htm>

Priority #2 I Chronic Disease Action Plan

Action Step Recommendations & Action Plan

To work toward **decreasing chronic disease**, the following actions steps are recommended:

1. Social Support Interventions for Healthy Eating in the Community
2. Continue to Implement a School-Based Nutrition Education Program
4. Social Support Interventions for Physical Activity in the Community
5. Increase Point-of-Purchase Prompts for Healthy Foods
6. Implement Competitive Pricing for Healthy Foods
7. Implement Farm-to-Institution Program
8. Expand Community Fitness Programs
9. Expand Individually-Adapted Physical Activity Programs
10. Implement Diabetes Prevention Program

| 1. Priority Health Outcomes: Chronic Disease (Heart Disease-Cardiovascular Health, Diabetes) | | | |
|---|---|---------------------------|--------------------|
| Priority Factor: Health Behavior- Nutrition | | | |
| Strategy: Social Support Interventions for Healthy Eating in the Community | | | |
| Shorter-Term Outcomes: Decrease by 5% the number of Fulton County adults and youth, grades 6 th -12 th , reporting consumption of sugary beverages in the past week as reported on the 2021 Fulton County Youth Health Status Report and 2022 Fulton County Health Status Report (adult) | | | |
| Longer-Term Outcomes: Decrease by 5% the number of Fulton County children, youth, grades 6 th – 12 th and adults who are obese as reported on the 2025 Fulton County Health Status Report | | | |
| Action Step (Activities) | Output | Person/Agency Responsible | Timeline |
| Year 1: Identify school districts/organizations who are willing to partner to decrease access to sugar-sweetened beverages at sport concession stands through price/promotion | Decrease sugar-sweetened beverages at schools | Rachel Kinsman, FCHD | May 31, 2021 |
| Identify school districts/organizations who are willing to partner to increase access to non-sugary beverages at sport concession stands through price/promotion | | | |
| Year 2: Partner with at least 2 identified school districts/organizations to work together to decrease/increase access. Devise plan to track beverage sales | | | September 30, 2021 |
| Year 3: Evaluate data and modify strategies as informed by the data. | | | May 31, 2022 |

2. Priority Topic: Chronic Disease-Cardiovascular Health

| | | | |
|---|---|---|--------------------|
| Strategy: Increase Community, Workplace and High School Screening Events and Data Tracking | | | |
| Priority Outcome: Reduce Heart Disease | | | |
| Priority Indicator: Percent of adults ever diagnosed with coronary heart disease/ Percent of adults ever diagnosed with hypertension | | | |
| Short-Term Outcomes: Improve data collection system for tracking number of adults being screened for blood pressure and blood cholesterol and number of adults whose rates fall in an unhealthy range. Increase by 5% the number of Fulton County adults who are screened for blood pressure and cholesterol levels. | | | |
| Long-Term Outcomes: Decrease by 5% the number of Fulton County adults diagnosed with high blood pressure by 2028. Decrease by 5% the number of Fulton County adults diagnosed with high blood cholesterol by 2028. | | | |
| Action Step (Activities) | Output | Person/Agency Responsible | Timeline |
| Year 1: Establish baseline of number of adults being screened. Develop tool for tracking the number of people who fall in unhealthy range for blood pressure and cholesterol. | Increased # of screening opportunities Increased data access | Britney Ward Fulton County Health Center | May 31, 2021 |
| Year 2: Engage area employers through Fulton County Economic Group as well as area medical insurance providers to increase opportunities for community adults to be screened. | | | September 30, 2021 |
| Year 3: Implement collection methods and determine way to organize data for easier access for all community partners | | | May 31, 2022 |


3. Priority Topic: Chronic Disease (Heart Disease-Cardiovascular Health and Obesity)

Priority Factor: Health Behavior- Nutrition

| Strategy: Implement a School-Based Nutrition Education Program | | | |
|--|---|---------------------------------------|--------------------|
| Priority Outcome: Reduce Heart Disease | | | |
| Priority Indicator: Youth fruit and vegetable consumption | | | |
| Short-Term Outcomes: Increase by 5% the number of Fulton County adults, youth and children eating 1-2 servings of fruits and vegetables per day as reported on the 2021 Fulton County Youth Health Status Report and 2022 Fulton County Health Status Report (adult and child) | | | |
| Long-Term Outcomes: Decrease by 5% the number of Fulton County children, youth, grades 6 th – 12 th and adults who are obese as reported on the 2028 Fulton County Health Status Report. | | | |
| Action Step (Activities) | Output | Person/Agency Responsible | Timeline |
| Year 1: Continue the Serving up My Plate program in Third grade classrooms in Fulton County Schools (& Crunch Out Obesity – Fourth Grade physical education classes in Fulton County). | More students will have nutrition education using best practice programs. | Rachel Kinsman, FCHD | May 30, 2021 |
| Year 2: Select and implement strategies. | Increased fruit consumption | Fulton County Schools | September 30, 2022 |
| Year 3: Evaluate data and modify strategies as informed by the data. | Increased vegetable consumption | Elementary Physical Education Program | May 30, 2023 |

4. Priority Health Outcomes: Chronic Disease (Heart Disease-Diabetes)

Priority Factor: Health Behavior- Physical Activity

Strategy: Social Support Interventions for Physical Activity in Community Settings 

Priority Health Outcome: Heart Disease, Diabetes

Priority Indicator: Adult and child physical activity

Short-Term Outcomes: Increase by 5% the number of Fulton County adults and youth, grades 6th -12th, reporting physical activity in the past week as reported on the 2021 Fulton County Youth Health Status Report and 2025 Fulton County Health Status Report (adult)

Long-Term Outcomes: Decrease by 5% the number of Fulton County children, youth, grades 6th – 12th and adults who are obese as reported on the 2025 Fulton County Health Status Report.

| Action Step (Activities) | Output | Person/Agency Responsible | Timeline |
|--|--|---------------------------|---|
| <p>Year 1: Contact organized physical activities in the county (local races such as Relay for Life, etc.) to encourage child and family components to their activities. Promote activities through social media outlets.</p> <p>Update existing Walking Guides and push them out through social media outlets on a quarterly basis.</p> <p>Year 2: Implement strategies and evaluate effectiveness.</p> <p>Year 3: Determined by Years 1 and 2.</p> | Increase youth and adult physical activity | Rachel Kinsman, FCHD | <p>May 31, 2021</p> <p>September 30, 2022</p> <p>May 31, 2023</p> |

5. Priority Topic: Chronic Disease (Heart Disease-Cardiovascular Health and Obesity)

Priority Factor: Health Behavior- Nutrition

Strategy: Increase Point of Purchase Prompts for Healthy Food 

Priority Outcome: Reduce Heart Disease

Priority Indicator: Adult fruit and vegetable consumption

Short-Term Outcomes: Increase by 5% the number of Fulton County adults eating fruits and vegetables as reported on the 2022 Fulton County Health Status Report

Long-Term Outcomes: Decrease by 5% the number of Fulton County adults who are obese as reported on the 2028 Fulton County Health Status Report

| Action Step (Activities) | Output | Person/Agency Responsible | Timeline |
|--|---|---|--------------------|
| Year 1: Complete an environmental scan of current cafeteria choices and point of purchase prompts. Complete a staff survey regarding support of changes in cafeteria. Meet with Food & Nutrition Services director to discuss feasibility of implementing point of purchase prompts. | Highlight healthier choices at point of purchase. | Britney Ward Fulton County Health Center | May 30, 2021 |
| Year 2: Implement point of purchase prompts in Fulton County Health Center cafeteria. | Increased fruit consumption | | September 30, 2022 |
| Year 3: Expand point of purchase prompts to other large employer cafeterias in the county. | Increased vegetable consumption | | May 30, 2023 |

**6. Priority Topic: Chronic Disease (Heart Disease-Cardiovascular Health and Obesity)
Priority Factor: Health Behavior- Nutrition**

Strategy: Implement Competitive Pricing for Healthy Foods 🍎

Priority Outcome: Reduce Heart Disease

Priority Indicator: Adult fruit and vegetable consumption

Short-Term Outcomes: Increase by 5% the number of Fulton County adults eating fruits and vegetables as reported on the 2022 Fulton County Health Status Report

Long-Term Outcomes: Decrease by 5% the number of Fulton County adults who are obese as reported on the 2028 Fulton County Health Status Report.

| Action Step (Activities) | Output | Person/Agency Responsible | Timeline |
|---|---|---|--------------------|
| Year 1: Complete an environmental scan of current cafeteria choices and pricing. Complete a staff survey regarding support of changes in cafeteria. Meet with Food & Nutrition Services director to discuss feasibility of implementing pricing changes. | Decrease pricing for healthy foods and/or increase pricing for foods that are not healthy | Britney Ward Fulton County Health Center | May 30, 2021 |
| Year 2: Implement pricing changes in Fulton County Health Center cafeteria. | Increased fruit consumption | | September 30, 2022 |
| Year 3: Expand pricing changes for healthy foods to other large employer cafeterias in the county. | Increased vegetable | | May 30, 2023 |

7. Priority Topic: Chronic Disease (Heart Disease-Cardiovascular Health and Obesity)

Priority Factor: Health Behavior- Nutrition

Strategy: Implement Farm-to-Institution Program 

Priority Outcome: Reduce Heart Disease

Priority Indicator: Adult fruit and vegetable consumption

Short-Term Outcomes: Increase by 5% the number of Fulton County adults eating fruits and vegetables as reported on the 2022 Fulton County Health Status Report

Long-Term Outcomes: Decrease by 5% the number of Fulton County adults who are obese as reported on the 2028 Fulton County Health Status Report.

| Action Step (Activities) | Output | Person/Agency Responsible | Timeline |
|--|--|---|--------------------|
| Year 1: Complete a staff survey regarding support of Farm-to-Institution program. Meet with local Community Supported Agriculture (CSA) groups to discuss feasibility of partnering with the Fulton County Health Center. | Partner with local farmers to provide fresh fruits and vegetables to employees | Britney Ward Fulton County Health Center | May 30, 2021 |
| Year 2: Implement Farm-to-Institution program at Fulton County Health Center | Increased fruit and vegetable consumption | | September 30, 2022 |
| Year 3: Expand Farm-to-Institution program to other large employers in the county. | | | May 30, 2023 |

8. Priority Topic: Chronic Disease (Heart Disease-Cardiovascular Health and Obesity)
Priority Factor: Health Behavior- Physical Activity

| | | | |
|---|--|---|--------------------|
| Strategy: Expand Community Fitness Programs | | | |
| Priority Outcome: Reduce Heart Disease | | | |
| Priority Indicator: Adult and youth physical activity | | | |
| Short-Term Outcomes: Increase by 5% the number of Fulton County adults and youth who are physically active reported on the 2022 Fulton County Health Status Report | | | |
| Long-Term Outcomes: Decrease by 5% the number of Fulton County adults and youth who are obese as reported on the 2028 Fulton County Health Status | | | |
| Action Step (Activities) | Output | Person/Agency Responsible | Timeline |
| Year 1: Reach out to locations in communities within the county that would be willing to host community fitness classes. Hire additional fitness instructors if needed. Continue to offer various types of classes at various times. | Partner with local farmers to provide fresh fruits and vegetables to employees | Britney Ward Fulton County Health Center | May 30, 2021 |
| Year 2: Expand Community Fitness Programs to at least 3 communities in the county. | Increased fruit and vegetable consumption | | September 30, 2022 |
| Year 3: Expand Community Fitness Programs to at least 4 communities in the county. | | | May 30, 2023 |

9. Priority Topic: Chronic Disease (Heart Disease-Cardiovascular Health and Obesity)
Priority Factor: Health Behavior- Physical Activity


| | | | |
|---|--|---|--------------------|
| Strategy: Expand Individually-Adapted Physical Activity Programs | | | |
| Priority Outcome: Reduce Heart Disease | | | |
| Priority Indicator: Adult and youth physical activity | | | |
| Short-Term Outcomes: Increase by 5% the number of Fulton County adults and youth who are physically active reported on the 2022 Fulton County Health Status Report | | | |
| Long-Term Outcomes: Decrease by 5% the number of Fulton County adults and youth who are obese as reported on the 2028 Fulton County Health Status | | | |
| Action Step (Activities) | Output | Person/Agency Responsible | Timeline |
| Year 1: Continue to offer senior classes such as SilverSneakers, Silver & Fit, and Renew Active. Explore the feasibility of adding programs for youth, disabled adults and youth, and other special populations. Explore the feasibility of offering programs to FCHC employees through the wellness plan. | Offer physical activity programs to special populations that can be individually adapted to meet their needs | Britney Ward Fulton County Health Center | May 30, 2021 |
| Year 2: Expand programs above to offsite locations. | Increased physical activity | | September 30, 2022 |
| Year 3: Continue efforts from Years 1 and 2. | | | May 30, 2023 |

10. Priority Topic: Chronic Disease (Diabetes)**Priority Factor: Health Behavior- Physical Activity and Nutrition****Strategy: Implement Diabetes Prevention Program****Priority Outcome: Reduce Diabetes and Pre-Diabetes****Priority Indicator: Adult diabetes and prediabetes****Short-Term Outcomes: Increase by 5% the number of Fulton County adults who are enrolled in a diabetes prevention program.****Long-Term Outcomes: Decrease by 5% the number of Fulton County adults who were diagnosed as diabetic or pre-diabetic as reported on the 2028 Fulton County Health Status Report.**

| Action Step (Activities) | Output | Person/Agency Responsible | Timeline |
|---|--|---|--------------------|
| Year 1: Contact CDC to become a certified Diabetes Prevention Program (DPP) location. Dietitians will be trained through CDC DPP Program. Work with FCHC Finance Department and Physician Offices to set up process to bill insurance for reimbursement. Pilot DPP program with first cohort | Enroll community members and FCHC staff into the Diabetes Prevention Program | Britney Ward Fulton County Health Center | May 30, 2021 |
| Year 2: Offer at least quarterly DPP cohorts and one for FCHC employees | | | September 30, 2022 |
| Year 3: Continue efforts from Years 1 and 2. | | | May 30, 2023 |

PROGRESS AND MEASURING OUTCOMES

The progress of achieving the priority outcomes of reducing heart disease, depression and drug dependence/abuse will be monitored with measurable short-term and long-term outcomes (indicators) identified for each strategy found within the action plans within each of the priority sections. Many short-term and long-term outcomes (indicators) align directly with the State Health Improvement Plan (SHIP). The individuals that are working on action steps (activities) will meet on an as needed basis. The full committee will meet at least quarterly to report out the progress. The committee will form a plan to disseminate the Community Health Improvement Plan to the community. Action steps (activities), responsible person/agency, and timelines will be reviewed at the end of each year by the committee. Edits and revisions will be made accordingly.

Fulton County will continue facilitating a Community Health Assessment at least every 3 years to collect and track data. Primary data will be collected for adults and youth using national sets of questions to not only compare trends in Fulton County, but also be able to compare to the state, the nation, and Healthy People 2030. This data will serve as measurable outcomes for each of the priority areas. Outcomes (indicators) that are common to the SHIP have been defined throughout this report and are identified with the  icon.

In addition to outcome evaluation, process evaluation will also be used on an ongoing basis to focus on how well action steps (activities) are being implemented. Areas of process evaluation that the CHIP work group members will monitor will include the following: number of participants, location(s) where services are provided, number of policies implemented, economic status and racial/ethnic background of those receiving services (when applicable), and intervention delivery (quantity and fidelity). Work groups will share challenges faced with larger Fulton County Partners for Health group to utilize expertise to move work forward.

Twice yearly, the Fulton County Partners for Health will hear progress updates from the various workgroups and offer support and expertise to address any challenges faced in the implementation of strategies.

Contact Us

For more information about any of the agencies, programs, and services described in this report, please contact:

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Fulton County Partners for Health Community Resource Assessment 2020

Priority #1: Mental Health
Focus Population ~ Adult – Female 30-64 with
emphasis on individuals with income <25K

| Program/Strategy/ Service | Responsible Agency | Continuum of Care prevention, early intervention, treatment and Evidence of Effectiveness |
|--|--|--|
| Parent Cafe | Maumee Valley Guidance Center | Prevention / Early Intervention |
| Support Group | ADAMhs Board | Post Intervention |
| NAMI Support Groups | www.namifourcounty.org | Intervention |
| Outpatient Counseling Services | Recovery Services of Northwest Ohio Maumee Valley Guidance Center FCHC AJA Behavioral Shalom Ministries Lutheran Social Services | Treatment Best Practice |
| Crisis Stabilization and Inpatient | Fulton County Health Center | Treatment Evidence based |
| Patient Health Questionnaire (PHQ9) Screening at PCP offices | Four County Suicide Prevention Coalition | Prevention Evidence based |
| Mental Health First Aid | Maumee Valley Guidance | Prevention / Early Intervention |
| Serenity Haven | Recovery Services of Northwest Ohio | Early Intervention / Treatment |
| Family Help | National Alliance on Mental Illness (NAMI) | Treatment Best Practice |
| Counseling | Churches | Early Intervention / Treatment Best Practice |
| Screenings & Referrals | Fulton County Health Dept | Early Intervention Best Practice |

Priority #1: Mental Health
Focus Population ~ Youth – Female / 17 Years Old & Older

| Program/Strategy/ Service | Responsible Agency | Continuum of Care prevention, early intervention, treatment and Evidence of Effectiveness |
|--|---|--|
| Signs of Suicide program (SOS) | Maumee Valley Guidance | Prevention Evidence based |
| Four County Suicide Prevention Coalition | Four County ADAMhs Board | Prevention / Early Intervention |
| Outpatient Counseling Services | Recovery Services of Northwest Ohio Maumee Valley Guidance Center FCHC AJA Behavioral Lutheran Social Services Shalom Ministries | Treatment Best Practice |
| Suicide Prevention Awareness | Maumee Valley Guidance Center | Prevention |
| Counseling | School Guidance Counselors | Early Intervention & treatment Best Practice |
| Patient Health Questionnaire (PHQ9) Screening at PCP offices | Four County Suicide Prevention Coalition | Prevention Evidence based |
| Counseling | Churches | Early Intervention & treatment Best Practice |
| Screenings & Referrals | Fulton County Health Dept | Early Intervention Best Practice |
| Teen Line | Comprehensive Crisis Care | Early intervention Best practice |
| Youth Mental Health First Aid | Maumee Valley Guidance Center | Prevention Evidence Based |
| RoX Ruling Our Experiences | Fulton County Health Dept / JFS | Prevention Evidence Based |
| YAC Youth Advisory Council | HC3: Healthy Choices Caring Communities | Youth Led Prevention Best Practice |
| SBIRT – School Screenings | HC3: Healthy Choices Caring Communities | Prevention Evidence Based |
| School Support Prevention Programs | Fulton County Schools | Prevention Evidence Based |

Priority #2: Healthy Weight
Focus Population ~ Adult-Male < 30 with an emphasis on
individuals with income > 25K

| Program/Strategy/ Service | Responsible Agency | Continuum of Care prevention, early intervention, treatment and Evidence of Effectiveness |
|---|--|--|
| Lifestyle Management Session/Training | Fulton County Health Center | Prevention / Early Intervention / Education |
| Healthy Cooking 101 | Fulton County Health Center | Prevention / Education |
| Salt Sense | Fulton County Health Center | Early Intervention / Treatment / Education |
| Eat For Life | Fulton County Health Center | Prevention / Early Intervention / Education |
| Low Cholesterol Living | Fulton County Health Center | Early intervention / Treatment / Education |
| Lifestyle for Lower Cholesterol | Fulton County Health Center | Early intervention / Treatment / Education |
| Let's Eat | Fulton County Health Center | Early intervention / Treatment / Education |
| Healthy Holiday Eating | Fulton County Health Center | Early intervention / Treatment / Education |
| Adult Church Sports Leagues | Fulton County Villages | Prevention / Early Intervention |
| Dave's Running Shop Training Programs | Dave's Running Shop | Prevention / Early Intervention Best practice |
| 15 and 15 | Fulton County Health Center | Prevention / Early Intervention / Support / Education |
| Fulton County Employee Wellness Program | Insurance Company / Corporate Wellness | Prevention/Early Intervention Best practice |
| Healthy Living/Lifestyles | OSU Extension | Prevention |
| Rails to Trails | Northwestern Ohio Trails Association | Prevention/early intervention Best practice |
| Weight Watchers | Weights Watchers | Prevention/ treatment Evidence based |
| Learn to be: Debt and Diet Free | Fulton County Health Center | Prevention / Early Intervention / Education |

Priority #2: Healthy Weight
Focus Population ~ Adult-Male < 30 with an emphasis
on individuals with income > 25K

| Program/Strategy/ Service | Responsible Agency | Continuum of Care prevention, early intervention, treatment and Evidence of Effectiveness |
|---|--|--|
| Nutrition Counseling | Fulton County Health Center | Early intervention / Treatment / Education |
| Dinner with the Docs | Fulton County Health Center | Prevention / Early Intervention / Education |
| Land Based Fitness Classes | Fulton County Health Center | Prevention / Education |
| Water Based Fitness Classes | Fulton County Health Center | Prevention / Education |
| Exercise | FC Wellness Center Marshall Fitness Anytime Fitness Temple Delta & Wauseon Cardio Drumming Balance Cycle & Wellness, Fusion Training New Heights | Prevention / Early Intervention / Treatment Best practice |
| High School Weight Rooms | Fulton County High Schools | Prevention / Early Intervention |
| Park Trails, Basketball Courts, Tennis Courts, Volleyball Courts | Fulton County Villages | Prevention / Early Intervention |

Priority #2: Healthy Weight
Focus Population ~ Youth – Male / 14 – 16 Years Old

| Program/Strategy/ Service | Responsible Agency | Continuum of Care prevention, early intervention, treatment and Evidence of Effectiveness |
|--|---|--|
| Land Based Fitness Classes | Fulton County Health Center | Prevention / Education |
| Water Based Fitness Classes | Fulton County Health Center | Prevention / Education |
| Parks & Recreation Sports Programs | Parks & Recreation | Prevention/early intervention Best practice |
| Exercise | FC Wellness Center Marshall Fitness Anytime Fitness Temple Delta & Wauseon Cardio Drumming Balance Cycle & Wellness, Fusion Training New Heights | Prevention / Early Intervention / Treatment Best practice |
| High School Weight Rooms | Fulton County High Schools | Prevention / Early Intervention |
| Park Trails, Basketball Courts, Tennis Courts, Volleyball Courts | Fulton County Villages | Prevention / Early Intervention |
| Rails to Trails | Northwestern Ohio Trails Association | Prevention/early intervention Best practice |
| Lifestyle Management Session/Training | Fulton County Health Center | Prevention / Early Intervention / Education |
| Cholesterol Screenings | Fulton Co High Schools / Fulton County Health Center | Prevention / Early Intervention / Education |
| Dave's Running Shop Training Programs | Dave's Running Shop | Prevention / Early Intervention Best practice |

Priority #3: Addiction
Focus Population ~ Youth / 6 – 12 Grade

| Program/Strategy/ Service | Responsible Agency | Continuum of Care prevention, early intervention, treatment and Evidence of Effectiveness |
|--|--|--|
| RoX Ruling Our Experiences | Fulton County Health Dept JFS | Prevention Evidence Based |
| Youth Led Programming Youth Advisory Council(YAC) | HC3: Healthy Choices Caring Communities | Prevention Evidence Based |
| SBIRT – School Screenings | HC3: Healthy Choices Caring Communities | Prevention Evidence Based |
| YLP Youth Led Prevention (BOSS) | Fulton County Health Dept | Prevention Evidence Based |
| Youth Mental Health First Aid | Maumee Valley Guidance Center | Prevention Evidence Based |
| Too Good for Drugs | Recovery Services of Northwest Ohio | Prevention Evidence Based |

Fulton County Partners for Health
2017 Mental Health Strategic Plan Map
 ** updated in 2020 with new data

Updated 2020 with 2018 Health Status Report Data

| Community Logic Model | | | Measurable Outcomes | | |
|--|--|---|--|--|---|
| Problem Statement | Root Causes | Strategy | Outputs Results of Activities | Shorter-Term Outcomes (3 years) | Longer-Term Outcomes (5 years) |
| <p><i>Perceived mental health stigma prevents individuals from seeking referral/treatment.</i></p> <p>Adult:</p> <ul style="list-style-type: none"> 14% of Fulton County adults used a program or service for themselves or a loved one to help with depression, anxiety, or emotional problems 57% of adults indicated they did not need such a program Reasons for not using such a program included: 7% stigma of seeking mental health services 7% fear <p>FC Health Status Report, 2019</p> <p><i>Too many Fulton County residents under the age of 30 are experiencing mental health issues</i></p> | <p><i>Perceived mental health stigma prevents individuals from seeking referral/treatment.</i></p> <p>Adult:</p> <ul style="list-style-type: none"> 14% of Fulton County adults used a program or service for themselves or a loved one to help with depression, anxiety, or emotional problems 57% of adults indicated they did not need such a program Reasons for not using such a program included: 7% stigma of seeking mental health services 7% fear <p>FC Health Status Report, 2019</p> <p>Youth (grades 6th -12th)</p> <ul style="list-style-type: none"> Only 37% reported they would seek help if dealing with anxiety, stress, depression or thoughts of suicide** (decrease from 48% reported in 2016***) Of those not seeking help, 27% worried what others might think ** (decrease from 39% in 2016***) Of those not seeking help, 6% reported their families would not support them ** (decrease from 11% in 2016***) 14% reported they talk with no one when dealing with feelings of depression or suicide** (increase from 12% reported in | <p>ADAMH's Board-Health Dept. Driven Media Campaign</p> <p>Provide Information:</p> <ul style="list-style-type: none"> will help residents understand value of referral/treatment <p>Build Skills:</p> <ul style="list-style-type: none"> help residents recognize signs/symptoms of mental health issues <p>Youth & Adult Mental Health First Aid Training</p> <p>Build Skills:</p> <ul style="list-style-type: none"> Provide opportunity for professional and community adults working with youth and adults to recognize mental health wellness and signs/symptoms of mental health issues. <p>School based Signs of Suicide Program</p> <p>Build Skills:</p> <ul style="list-style-type: none"> Provide opportunity for county MS/HS students to recognize mental health wellness and signs/symptoms of mental health issues in their peers. <p>Enhance Access/Reduce Barriers:</p> <ul style="list-style-type: none"> Provide opportunity for MS students to self-refer for assessment/treatment Provide opportunity for HS students to be screened for mental health wellness. | <p>Provide Information: Mental Health Wellness Media Campaign</p> <p>Build Skills:</p> <p>Professionals and community adults trained in Youth and Adult Mental Health First Aid</p> <p>HS and MS students trained in Signs of Suicide.</p> <p>Enhance Access/Reduce Barriers</p> <p>MS students self-refer for mental health issues</p> <p>HS students screened for suicide intention</p> | <p><i>Perceived mental health stigma prevents individuals from seeking referral/treatment.</i></p> <p>Increase by 5% the number of Fulton County youth, grades 6th - 12th, who report willingness to seek help if dealing with anxiety, stress, depression or thoughts of suicide as reported on 2021 Youth Health Status Report.</p> <p>Increase by 5% the number of Fulton County young adults, ages 19 - 30 who report willingness to seek help if dealing with anxiety, stress, depression or thoughts of suicide as reported on 2022 FC Health Status Report.</p> | <p>Decrease by 5% the number of Fulton County youth, grades 6th - 12th reporting that they felt sad or hopeless two or more weeks in a row as reported on the 2025 Health Status Report.</p> <p>Decrease by 5% the number of Fulton County young adults, ages 19 - 30 reporting that they felt sad or hopeless two or more weeks in a row as reported on the 2025 Health Status Report.</p> |
| <p>Data to Support Problem Statement:</p> <p>Adult:</p> <ul style="list-style-type: none"> 10% reported two or more weeks in a row felt sad or hopeless. Increases to 16% for those with incomes under \$25,000 4% considered suicide in past year <p>FC Health Status Report, 2019</p> | | | | | |

| | | | | |
|---|---|---|---|--|
| <p>Youth: (grades 6th –12th)</p> <ul style="list-style-type: none"> • 29% reported two or more weeks in a row felt sad or hopeless.** (increase from 22% reported in 2016*** • Increases to 41% for female youth ** Increase from 32% in 2016***) • 15% reported considered suicide** (increase from 10% in 2016*** • Increased to 22% for female youth** (increase from 13% in 2016*** • 6% reported attempted suicide** <p>** 2018 Fulton County Health Status Report</p> <p>*** 2016 Fulton County Health Status Report</p> | <p><i>Lack of promotion of Mental Health Wellness</i></p> <p>Adults:</p> <p>rated their mental health as not good on four or more days in the previous month</p> <ul style="list-style-type: none"> • 21 % (2016, HSR) • 17% (2014 HSR) <p>Average days that mental health not good in past month</p> <ul style="list-style-type: none"> • 3.2 (2016 HSR) • 2.6 days (2012 HSR) <p>Youth (grades 6th – 12th)</p> <p>Youth who felt sad or hopeless almost every day for 2 or more weeks in a row</p> <ul style="list-style-type: none"> • 29% 2018 HSR • 22% 2016 HSR • 18% 2014 HSR • 17% 2012 HSR • 14% 2010 HSR <p>Child:</p> <p>2 or more Adverse Childhood Experiences</p> <ul style="list-style-type: none"> • 6% 2016 HSR | <p>Develop community screening program</p> <p>Modify Policy</p> <ul style="list-style-type: none"> • Build capacity for increased use of routine SBIRT (Screening, Brief Intervention, and Referral to Treatment) Process in clinical, community and school setting to identify individuals in need of service <p>Expand School-based Mental Health Wellness Programs</p> <p>Build Skills</p> <ul style="list-style-type: none"> • Utilize ROX and Incredible Years programs to increase youth mental wellness. | <p>Establish baseline for current screenings numbers of adults and youth for mental health issues.</p> <p>Increase in number community members routinely being screened for mental health issues.</p> <p>Establish indicated data baselines and plans for gathering, compiling, analyzing, and tracking data</p> <p>Annual collaborative report of mental health wellness skills/indicators present in youth involved in school based program.</p> <p>Increase in number of youth receiving school based programming through either ROX</p> | <p>Increase by 10% the number of adults/youth being screened for mental health issues by May 2023 as reported behavioral health agency conducting screenings</p> |
|---|---|---|---|--|

| Fulton County Partners for Health Chronic Disease Strategic Plan Map 2017 ** updated in 2020 with new data | | | | |
|---|--|--|---|---|
| Community Logic Model | | Measurable Outcomes | | |
| Problem Statement | Root Causes | Strategy | Shorter-Term Outcomes (2 year) Longer-Term Outcomes (5 years) | |
| <p><i>Too many Fulton County residents are obese.</i></p> <p>Data to Support Problem Statement:</p> <p>Adult:</p> <ul style="list-style-type: none"> 36% are Obese (HSR, 2019) Decrease from 43% reported in 2016 36% are Overweight (HSR, 2019) <p>Youth:</p> <ul style="list-style-type: none"> 19% are Obese (HSR, 2018) 13% are Overweight (HSR, 2018) <p>Child (Ages 0-11 years):</p> <ul style="list-style-type: none"> 21% are Obese (HSR, 2016) 17% are Overweight (HSR, 2016) 31% are Head Start FC participants are over the 95 percentile for BMI (2016 FC Head Start Program) | <p>Sedentary Life Style.</p> <p>Adult:</p> <ul style="list-style-type: none"> 18% of Adults did not participate in physical activity in the past week, including those who are unable to exercise. (HSR, 2019) <p>Youth:</p> <ul style="list-style-type: none"> 15% of youth did not participate in at least 60 minutes of physical activity on any day in the past week. (HSR, 2018) Child (Ages 0-11 years): 93% are active for 60 min. on 3+ days / week. (HSR, 2016) 75% are active for 60 min. on 5+ days / week. (HSR, 2016) 1% report no activity (HSR, 2016) <p>Food Choice.</p> <p>Adult:</p> <ul style="list-style-type: none"> 31% eating 1-2 servings of fruits and vegetables per day. ** (decrease from 63% reported in 2016***) 47% eat 3-4 servings per day** (increase from 29 % reported in 2016***) Only 8% eat 5 or more servings per day. (HSR, 2019 Increase from 4% reported in 2016***) <p>Adult Barriers - why they choose foods they eat:**</p> <ul style="list-style-type: none"> Taste – 65% Enjoyment – 65% Cost – 45% Ease of preparation – 46% Healthiness of food – 55% Foods they are used to – 47% Availability – 30% | <p>Provide social supports to increase physical activity</p> | <p>Enhance access/reduce barriers:</p> <p>Community promotion of available opportunities to engage in physical activity individually as well as in families</p> <p>Enhance access/reduce barriers:</p> <p>Decrease access to surgery beverages at local sport concession stands</p> <p>Increase incentive/decrease disincentive</p> <p>Increase cost of sugary beverages while decreasing cost of non-sugary beverages</p> | <p>Increase by 5% the number of Fulton County youth, grades 6th – 12th, reporting physical activity in the past week as reported on the 2021 FC Youth Health Status Report.</p> <p>Increase by 5% the number of Fulton County adults, reporting physical activity in the past year as reported on the 2023 FC Health Status Report.</p> <p>Decrease by 2% the number of Fulton County youth, grades 6th – 12th and adults who are obese as reported on the 2028 Fulton County Health Status Report.</p> |

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| | <ul style="list-style-type: none"> • What family prefers – 39% • Nutritional content – 31% • Calorie content – 26% • If organic – 6% • If genetically modified – 6% • If lactose free – 4% • Health care provider's advice – 2% • Gluten free – 3% • Food sensitivities – 2% (HSR, 2019) <p>Barriers to consuming Fruits and Vegetables:</p> <ul style="list-style-type: none"> • Too expensive – 11% • Did not like the taste – 8% • Did not know how to prepare – 2% • Did not take electronic benefit transfer – <1% • No access – 1% • No variety – 2% (HSR, 2019) <p>Youth:</p> <ul style="list-style-type: none"> • 38% eat 1-2 servings of fruits and vegetables per day. (decrease from 57% in 2016*** • 36% eat 3-4 servings of fruits and vegetables per day.** • 20% eat 5 or more servings of fruits and vegetables per day. ** <p>Child (Ages 0-11 years):</p> <ul style="list-style-type: none"> • 64% ate vegetables at least once per day in the past week. • 5% had not eaten any vegetables in the past week. • 61% ate fruit or drank 100% fruit juice at least once per day. • 3% had not eaten any fruit in the past week. (HSR, 2016) | | | | <p>Continue school-based programming in FC elementary schools: My Plate- 3rd graders across county Crunch out Obesity-4th graders across county</p> |
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| <p>Too many Fulton County residents are experiencing cardiovascular disease</p> <p>Heart disease and stroke accounted for 32% of all Fulton County adult deaths in the 2018 Coroners' Report.</p> <p>Hypertension</p> <ul style="list-style-type: none"> • (33%) of adults had been diagnosed with high blood pressure • 39% of males • 28% of females • 60% of those 65 years and older. • 58% of those with an income below \$25,000 (FC HSR, 2019) <p>Hypercholesterolemia</p> <ul style="list-style-type: none"> • (30%) of Fulton County adults had • been diagnosed with high blood cholesterol (FC HSR, 2019) <p>Coronary Artery Disease</p> <ul style="list-style-type: none"> • 4% of Fulton County adults reported they had angina or coronary/heart disease; increases to 14% for those over age 65 and 16% for those with an income below \$25,000 • (2019 FC HSR) | <p>Root Causes Cardiovascular Health</p> <p>Obesity / lack of exercise / poor diet</p> <ul style="list-style-type: none"> • 36% of FC adults are Obese (HSR, 2019) • 36% of FC adults are Overweight (HSR, 2019) <p>Stress</p> <ul style="list-style-type: none"> • 16% of FC adults have spoken with a physician about depression, anxiety, or emotional problems. • 23% of FC adults were limited in some way due to a physical, mental or emotional • problem; increasing to 35% of those with incomes less than \$25,000 (FC HSR, 2016) <p>Smoking</p> <ul style="list-style-type: none"> • 11% of adult males are current smokers • 13% of adult females are current smokers • (FC HSR, 2019) <p>Local Conditions</p> <p>Obesity</p> <ul style="list-style-type: none"> • Access to unhealthy foods • 2 parents working (lack of time/time management) • Family value/activity or lack of recreational/work • Technology (increase use) • Stress • Job • 2 parent working • Technology • Weather • Kids in a lot of activities • Smoking • Cultural / farm community • Work environment • Stress • Coping • Peer pressure | <p>Develop system to track the amount of people who are in an unhealthy range for blood pressure and cholesterol during health screenings.</p> <p>Enhance access/reduce barriers</p> <p>Community Health screenings for blood pressure and cholesterol.</p> <p>Workplace health screenings for blood pressure and cholesterol.</p> <p>Health screenings for freshman and senior high school students for cholesterol.</p> <p>Recognize the potential contribution of stress and smoking to the issue of cardiovascular disease; as additional data is gathered, we will work to address these local conditions in the future.</p> | <p>Short Term Goals Improve data collection system for tracking number of adults being screened for blood pressure and blood cholesterol and number of adults whose rates follow in an unhealthy range.</p> <p>Increase by 10% the number of Fulton County adults who are screened for blood pressure and cholesterol levels.</p> | <p>Long Term Goals</p> <p>Decrease by 5% the number of Fulton County adults diagnosed with high blood pressure by 2028.</p> <p>Decrease by 5% the number of Fulton County adults diagnosed with high blood cholesterol by 2028.</p> |
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