



# **Fulton County Health Center Implementation Plan**

# A LETTER FROM Fulton County Health Center

Fulton County Health Center (FCHC) strives to bring together people and organizations to improve community wellness. The community health needs assessment and implementation strategy process is one way we can live out our mission. In order to fulfill this mission, we must be intentional about understanding the health issues that impact residents and work together to create a healthy community.



A primary component of creating a healthy community is assessing and prioritizing needs for impact, and then addressing those needs. In 2022, Fulton County conducted a comprehensive community health needs assessment to identify priority health issues and evaluate the overall current health status of the health system's service area. In early 2023, these findings were then used to develop an implementation strategy to describe the response to the needs identified in the CHNA report.

The 2023 Fulton County Health Center Implementation Strategy report is the fourth of these reports released, all following a CHNA. We want to provide the best possible care for our residents, and we can use this report to guide us in our strategic planning and decision making concerning future programs, clinics, and health resources.

The Fulton County Health Center Implementation Strategy would not have been possible without the help of numerous organizations. It is vital that assessments such as this continue so that we can know where to direct our resources and use them in the most advantageous ways.

More importantly, the possibility of this report relies solely on the participation of individuals in our community who committed to participating in interviews and completing health need prioritization surveys. We are grateful for those individuals who are committed to the health of the community, as we are, and take the time to share their health concerns, needs, praises, and behaviors.

The work of public health is a community job that involves individual facets, including our community members, working together to be a thriving community of health and well-being at home, work, and play.

Sincerely,

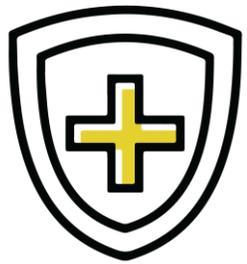
**Patti Finn**  
CEO

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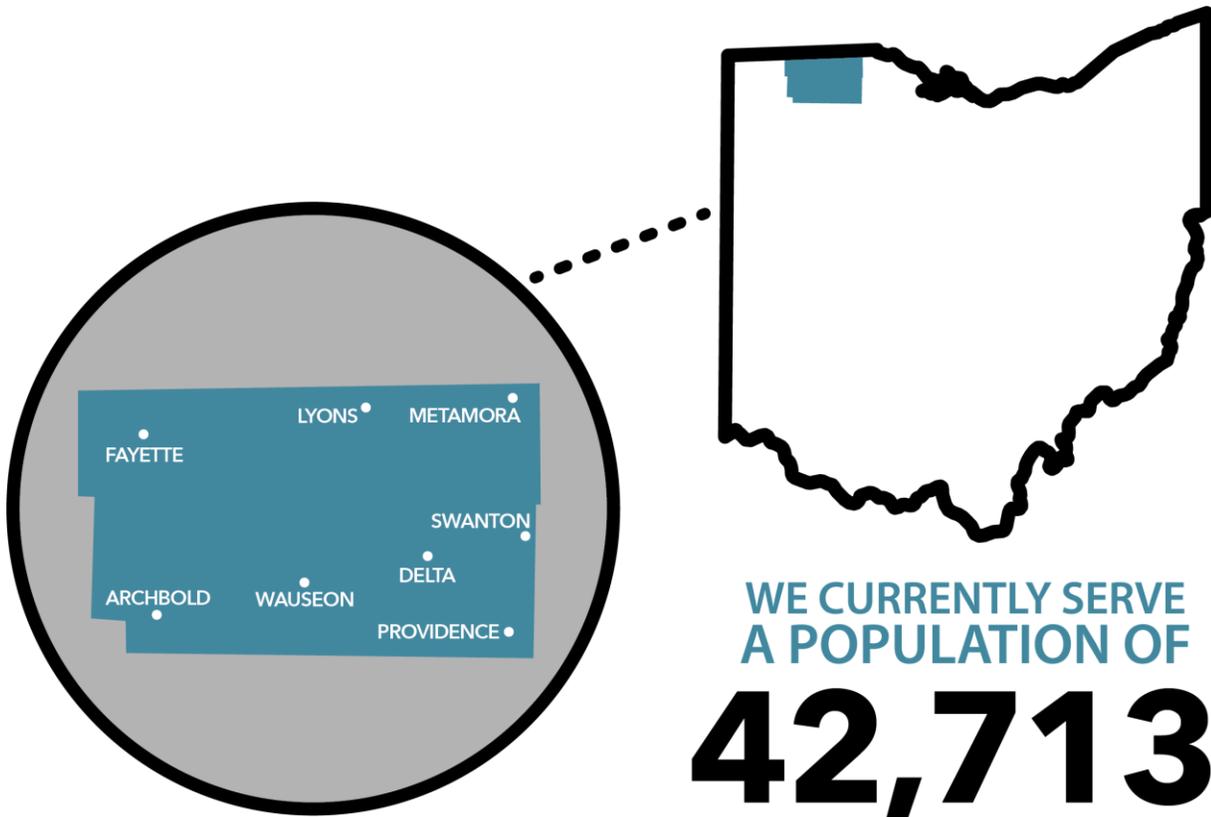
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# DEFINING THE FULTON COUNTY HEALTH CENTER SERVICE AREA



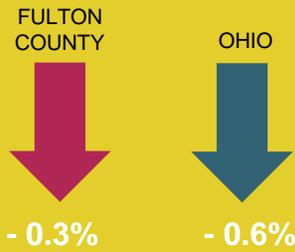
For the purposes of this report, Fulton County Health Center defines its' primary service area as being made up of Fulton County.



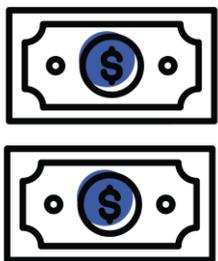
The CHNA and this resulting Implementation Strategy identify and address significant community health needs and help guide community benefit activities. This Implementation Strategy explains how FCHC plans to address the selected priority health needs identified by the CHNA.

# FULTON COUNTY AT-A-GLANCE

THE POPULATION OF FULTON COUNTY HEALTH CENTER'S SERVICE AREA HAS DECREASED, AS HAS OHIO'S POPULATION

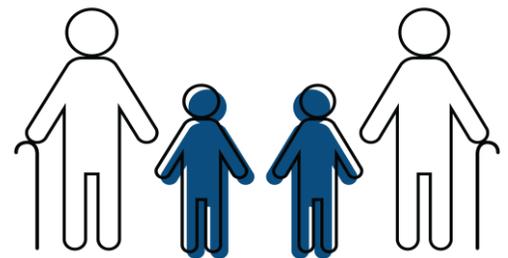


YOUTH AGES 0-17 AND SENIORS 65+ MAKE UP 42.4% OF THE POPULATION IN THE FCHC SERVICE AREA

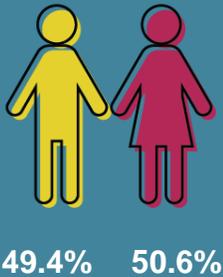


FULTON COUNTY HEALTH CENTER SERVICE AREA HAS **LOWER POVERTY RATES** THAN OHIO OVERALL

10% CHILDREN	7.3% SENIORS	10.4% FEMALE
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THE % OF MALES AND FEMALES IS ABOUT EQUAL



FULTON COUNTY SERVES 2,405 VETERANS OR 5.7% OF THE POPULATION

THE SERVICE AREA HAS LESS MENTAL HEALTH CARE ACCESS THAN OHIO OVERALL:

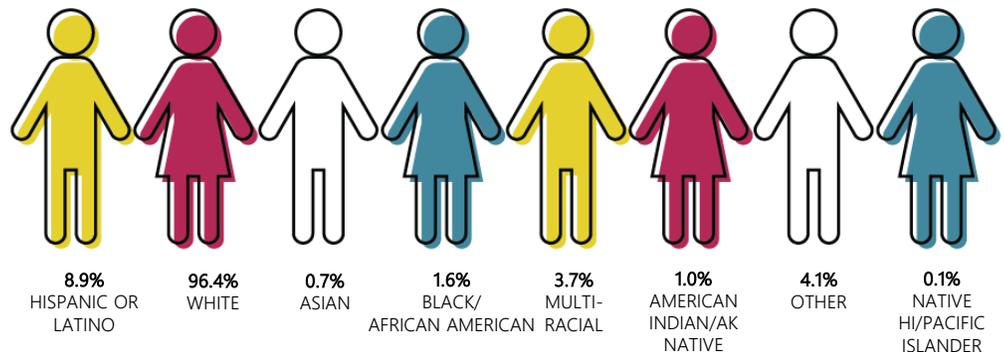
POPULATION TO MENTAL HEALTH PROVIDERS

FULTON COUNTY  
730:1

OHIO  
350:1



A MAJORITY OF THE COUNTY'S RESIDENTS IDENTIFY AS WHITE



# PRIORITY HEALTH NEEDS FOR FULTON COUNTY HEALTH CENTER

1



## PHYSICAL ACTIVITY 18% OF ADULTS

REPORT NO PHYSICAL ACTIVITY IN PAST WEEK

2



## TOBACCO/NICOTINE USE 21% OF ADULTS

WERE CONSIDERED SMOKERS

3



## ROUTINE CHECKUP 68% OF ADULTS

HAD A ROUTINE CHECKUP WITH THEIR PROVIDER IN PAST YEAR

4



## DEPRESSION & SUICIDE

ADULTS IN OUR REGION  
REPORT  
4.9 MENTALLY  
UNHEALTHY DAYS  
PER MONTH VS. 5.2  
FOR OHIO

THE SERVICE AREA HAS  
A HIGHER ADULT  
SUICIDE RATE THAN  
OHIO

5



## HEART DISEASE & DIABETES

HEART DISEASE IS THE  
LEADING  
CAUSE OF DEATH  
IN THE SERVICE AREA

10% OF ADULTS  
HAVE DIABETES, WHICH IS  
EQUAL TO THE OHIO RATE  
(10%)



# INTRODUCTION

# WHAT IS AN IMPLEMENTATION STRATEGY?



An Implementation Strategy is part of a framework that is used to guide community benefit activities - policy, advocacy, and program-planning efforts. For hospitals, the Implementation Strategy describes their plan to respond to the needs identified through the previous CHNA process. The Implementation Strategy also fulfills a requirement mandated by the IRS in Section 1.501(r)(3). For health departments, the Improvement Plan (CHIP) fulfills the mandates of the Public Health Accreditation Board (PHAB).

# OVERVIEW OF THE PROCESS

In order to develop an Implementation Strategy, FCHC followed a process that included the following steps:

- STEP 1: Plan and prepare for the implementation strategy.**
- STEP 2: Develop goals/objectives and identify indicators to address health needs.**
- STEP 3: Consider approaches to address prioritized needs.**
- STEP 4: Select approaches.**
- STEP 5: Integrate implementation strategy with community and hospital plans.**
- STEP 6: Develop a written implementation strategy.**
- STEP 7: Adopt the implementation strategy.**
- STEP 8: Update and sustain the implementation strategy.**

Within each step of this process, the guidelines and requirements of both the state and federal governments are followed precisely and systematically.

## **Affordable Care Act (Federal) Requirements**

Enacted on March 23, 2010, the Affordable Care Act (ACA) provided guidance at a national level for CHNAs for the first time. Federal requirements included in the ACA stipulate that hospital organizations under 501(c)(3) status must adhere to new 501(r) regulations, one of which is conducting a community health needs assessment every three years.

## **Ohio Department of Health Requirements**

The Ohio Department of Health (ODH) is required by state law to provide guidance to hospitals and local health departments on community health needs assessments and implementation plans. In July 2016, HB 390 (ORC 3701.981) was enacted by Ohio in order to improve population health planning in the state by identifying health needs and priorities by conducting a CHNA and subsequently developing a CHIP to address those needs in the community.

**THE 2023 FULTON COUNTY HEALTH CENTER IMPLEMENTATION STRATEGY MEETS ALL OHIO DEPARTMENT OF HEALTH AND FEDERAL (IRS) REGULATIONS.**



# STEP 1 PLAN AND PREPARE FOR THE IMPLEMENTATION STRATEGY



## IN THIS STEP, FULTON COUNTY HEALTH CENTER:

- DETERMINED WHO WOULD PARTICIPATE IN THE DEVELOPMENT OF THE IMPLEMENTATION STRATEGY
- ENGAGED BOARD AND EXECUTIVE LEADERSHIP
- REVIEWED COMMUNITY HEALTH NEEDS ASSESSMENT





## PLAN AND PREPARE FOR THE 2023 FULTON COUNTY HEALTH CENTER IMPLEMENTATION STRATEGY

Secondary and primary data were collected to complete the 2022 Fulton County Community Health Needs Assessment (CHNA) report. (Available at [fultoncountyhealthcenter.org](http://fultoncountyhealthcenter.org)). Secondary data were collected from a variety of local, county and state sources to present community demographics, social determinants of health, health care access, birth characteristics, leading causes of death, chronic disease, health behaviors, mental health, substance use and misuse, and preventative practices. The analysis of secondary data yielded a preliminary list of significant health needs, which then informed primary data collection.

In August 2022, Fulton County Health Department staff collected primary data by conducting listening sessions, as additional health information from specific populations was desired. The populations identified are some of the most vulnerable: older adults, parents of children 0-11 years old, and Hispanic/Latino residents. Four listening sessions were conducted, some in person and some by zoom. There were between five to 14 participants per session.

The primary data collection process was designed to validate secondary data findings, identify additional community issues, solicit information on disparities among subpopulations, ascertain community assets potentially available to address needs and prioritize health needs.

“  
While the community health needs assessment considers the “who, what, where and why” of community health needs, the implementation strategy addresses the “how and when”.  
”

## STEP 2

# DEVELOP GOALS AND OBJECTIVES AND IDENTIFY INDICATORS FOR ADDRESSING COMMUNITY HEALTH NEEDS



### IN THIS STEP, FULTON COUNTY HEALTH CENTER:

- DEVELOPED GOALS FOR IMPLEMENTATION STRATEGY BASED ON THE FINDINGS FROM THE CHNA
- SELECTED INDICATORS TO ACHIEVE GOALS



# PRIORITY HEALTH NEEDS GOALS, OBJECTIVES, AND INDICATORS

FCHC desired to align with the priorities and indicators of the Ohio Department of Health (ODH). In order to do this, Fulton County used the following guidelines when prioritizing the health needs of their community.

First, FCHC used the same language as the state of Ohio when assessing the factors and health outcomes of their community in the 2022 Fulton County Community Health Needs Assessment.

Figure 1.2. SHIP framework

**Equity** Health equity is achieved when all people in a community have access to affordable, inclusive and quality infrastructure and services that, despite historical and contemporary injustices, allows them to reach their full health potential.

**Priorities** The SHIP identifies three priority factors and three priority health outcomes that affect the overall health and well-being of children, families and adults of all ages.

## What shapes our health and well-being?

Many factors, including these 3 SHIP priority factors\*:

### Community conditions

- Housing affordability and quality
- Poverty
- K-12 student success
- Adverse childhood experiences

### Health behaviors

- Tobacco/nicotine use
- Nutrition
- Physical activity

### Access to care

- Health insurance coverage
- Local access to healthcare providers
- Unmet need for mental health care

## How will we know if health is improving in Ohio?

The SHIP is designed to track and improve these 3 SHIP priority health outcomes:

### Mental health and addiction

- Depression
- Suicide
- Youth drug use
- Drug overdose deaths

### Chronic disease

- Heart disease
- Diabetes
- Childhood conditions (asthma, lead)

### Maternal and infant health

- Preterm births
- Infant mortality
- Maternal morbidity

## All Ohioans achieve their full health potential

- Improved health status
- Reduced premature death

**Vision**  
Ohio is a model of health, well-being and economic vitality

**Strategies** The SHIP provides state and local partners with a menu of effective policies and programs to improve Ohio's performance on these priorities.

\* These factors are sometimes referred to as the social determinants of health or the social drivers of health

Next, with the data findings from the community health needs assessment process, FCHC used the following guidelines/worksheet to choose priority factors and priority health outcomes. Using the guidance from ODH’s State Health Improvement Plan (SHIP) strengthened the ability to align with the state in order to strengthen the efforts to improve the health, well-being, and economic vitality of both the FCHC service area and the state of Ohio. (worksheet/guidelines continued to next page)

Figure 3. Alignment with priorities and indicators

**STEP 1** Identify at least one priority factor and at least one priority health outcome

PRIORITY FACTORS	PRIORITY HEALTH OUTCOMES
<input type="checkbox"/> Community Conditions (strongly recommended)	<input checked="" type="checkbox"/> Mental Health and Addiction
<input checked="" type="checkbox"/> Health Behaviors	<input checked="" type="checkbox"/> Chronic Disease
<input checked="" type="checkbox"/> Access to Care	<input type="checkbox"/> Maternal and Infant Health

**STEP 2** Select at least 1 indicator for each identified priority factor

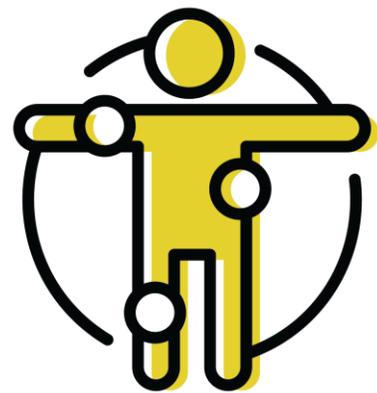
PRIORITY FACTORS	
<b>COMMUNITY CONDITIONS</b>	
TOPIC	INDICATOR NAME*
Housing affordability and quality	<input type="checkbox"/> CC1. Affordable and Available Housing Units
Poverty	<input type="checkbox"/> CC2. Child Poverty
	<input type="checkbox"/> CC3. Adult Poverty
K-12 student success	<input type="checkbox"/> CC4. Chronic Absenteeism (K-12 students)
	<input type="checkbox"/> CC5. Kindergarten Readiness
Adverse childhood experiences	<input type="checkbox"/> CC6. Adverse Childhood Experiences (ACEs)
	<input type="checkbox"/> CC7. Child Abuse and Neglect
<b>HEALTH BEHAVIORS</b>	
TOPIC	INDICATOR NAME*
Tobacco/nicotine use	<input checked="" type="checkbox"/> HB1. Adult Smoking
	<input type="checkbox"/> HB2. Youth All-Tobacco/Nicotine Use
Nutrition	<input type="checkbox"/> HB3. Youth Fruit Consumption
	<input type="checkbox"/> HB4. Youth Vegetable Consumption
Physical Activity	<input type="checkbox"/> HB5. Child Physical Activity
	<input checked="" type="checkbox"/> HB6. Adult Physical Activity
<b>ACCESS TO CARE</b>	
TOPIC	INDICATOR NAME*
Health Insurance Coverage	<input checked="" type="checkbox"/> AC1. Uninsured Adults
	<input checked="" type="checkbox"/> AC2. Uninsured Children
Local Access to Healthcare Services	<input checked="" type="checkbox"/> AC3. Primary Care Health Professional Shortage Areas
	<input checked="" type="checkbox"/> AC4. Mental Health Professional Shortage Areas
Unmet Need for Mental Health Care	<input type="checkbox"/> AC5. Youth Depression Treatment Unmet Need
	<input checked="" type="checkbox"/> AC6. Adult Mental Health Care Unmet Need

**STEP 2 CONTINUED** Select at least 1 indicator for each identified priority factor

PRIORITY HEALTH OUTCOMES	
MENTAL HEALTH AND ADDICTION	
TOPIC	INDICATOR NAME*
Depression	<input type="checkbox"/> MHA1. Youth Depression
	<input checked="" type="checkbox"/> MHA2. Adult Depression
Suicide Deaths	<input type="checkbox"/> MHA3. Youth Suicide Deaths
	<input type="checkbox"/> MHA4. Adult Suicide Deaths
Youth Drug Use	<input type="checkbox"/> MHA5. Youth Alcohol Use
	<input type="checkbox"/> MHA6. Youth Marijuana Use
Drug Overdose Deaths	<input checked="" type="checkbox"/> MHA7. Unintentional drug overdose deaths
CHRONIC DISEASE	
TOPIC	INDICATOR NAME*
Heart Disease	<input checked="" type="checkbox"/> CD1. Coronary Heart Disease
	<input checked="" type="checkbox"/> CD2. Premature Death - Heart Disease
	<input checked="" type="checkbox"/> CD3. Hypertension
Diabetes	<input checked="" type="checkbox"/> CD4. Diabetes
Harmful Childhood Conditions	<input type="checkbox"/> CD5. Child Asthma Morbidity
	<input type="checkbox"/> CD6. Child Lead Poisoning
MATERNAL AND INFANT HEALTH	
TOPIC	INDICATOR NAME*
Preterm Births	<input type="checkbox"/> MIH1. Uninsured Adults
Infant Mortality	<input type="checkbox"/> MIH2. Infant Mortality
Maternal Morbidity/Mortality	<input type="checkbox"/> MIH3. Severe Maternal Morbidity



# ADDRESSING THE HEALTH NEEDS



The 2022 CHNA identified the following significant health needs from an extensive review of the primary and secondary data. From the significant health needs, FCHC chose health needs that considered the health system's capacity to address community needs, the strength of community partnerships, and those needs that correspond with the health system's priorities.

## THE THREE PRIORITY HEALTH NEEDS THAT WILL BE ADDRESSED IN THE 2023 IMPLEMENTATION STRATEGY ARE:

### Priority Area 1: CHRONIC DISEASE

- ✓ Improve Adult Nutrition & Physical Activity
- ✓ Reduce Heart Disease & Diabetes

### Priority Area 2: MENTAL HEALTH & ADDICTION

- ✓ Decrease Adult Tobacco/Nicotine Use
- ✓ Decrease Drug Overdoses

### Priority Area 3: ACCESS TO CARE

- ✓ Increase Local Access & Preventive Services



# STEPS 3 & 4 SELECT STRATEGIES & ACTION STEPS TO ADDRESS PRIORITIZED HEALTH NEEDS



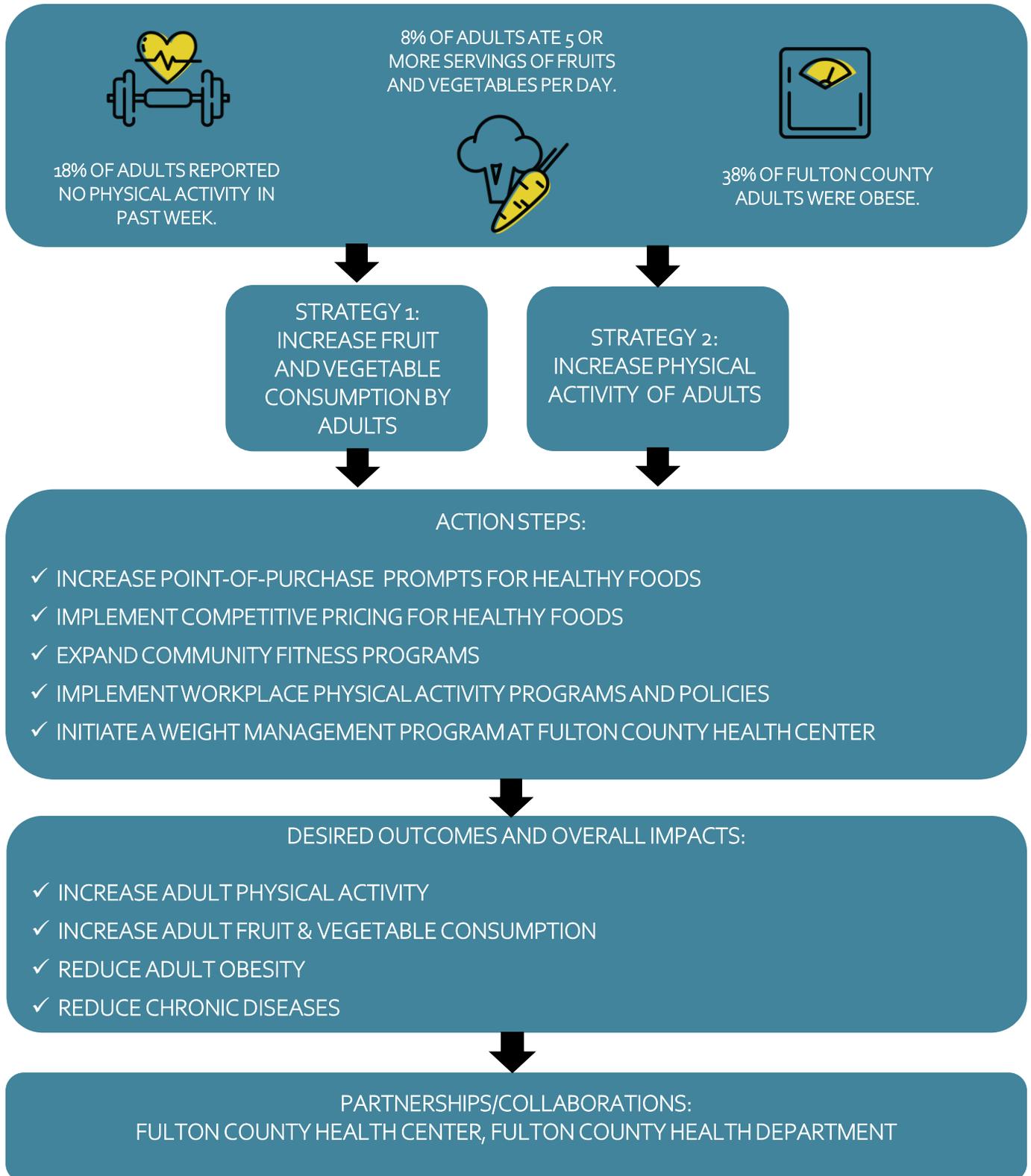
## IN THESE STEPS, FULTON COUNTY HEALTH CENTER:

- SELECTED APPROACHES TO ADDRESS FULTON COUNTY HEALTH CENTER'S SERVICE AREA PRIORITIZED HEALTH NEEDS



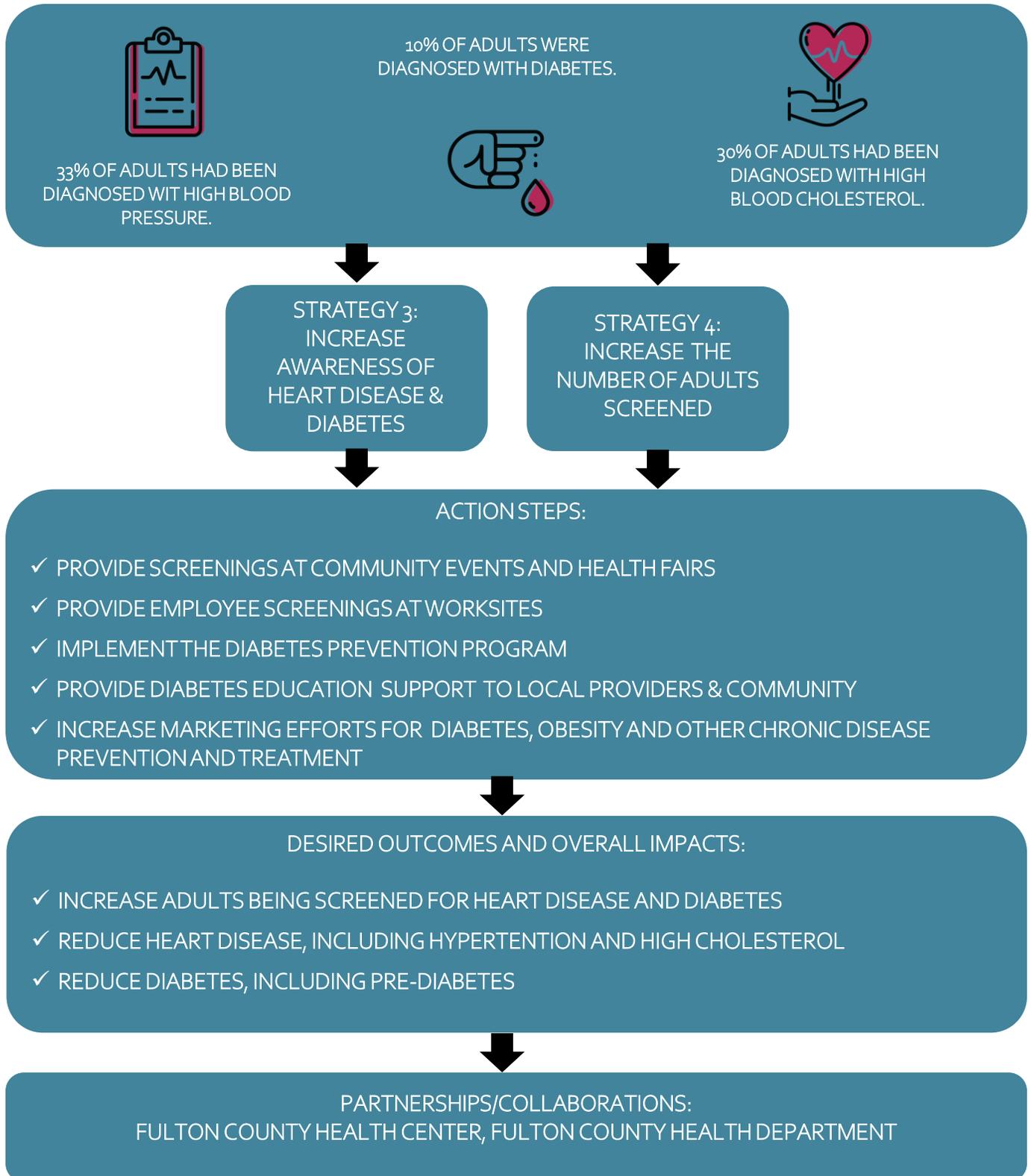
# CHRONIC DISEASE

## IMPROVE ADULT NUTRITION & PHYSICAL ACTIVITY



# CHRONIC DISEASE

## REDUCE HEART DISEASE & DIABETES



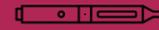
# MENTAL HEALTH & ADDICTION

## DECREASE ADULT TOBACCO/NICOTINE USE



21% OF FULTON COUNTY ADULTS WERE CURRENT SMOKERS.

49% OF SMOKERS HAD TRIED QUITTING FOR AT LEAST ONE DAY IN THE PAST YEAR.



2% OF ADULTS USED E-CIGARETTES OR OTHER ELECTRONIC VAPOR PRODUCTS IN THE PAST YEAR.

STRATEGY 1:  
IMPLEMENT  
POLICIES IN  
WORKSITES

STRATEGY 2:  
INCREASE THE  
NUMBER OF ADULTS  
SCREENED &  
REFERRED

### ACTION STEPS:

- ✓ INCREASE SCREENINGS IN PROVIDER OFFICES AND HOSPITAL
- ✓ INCREASE REFERRALS BY PROVIDERS TO OHIO QUIT LINE AND/OR CESSATION SPECIALISTS
- ✓ IMPLEMENT WORKSITE POLICIES SUCH AS NOT HIRING NICOTINE USERS AND/OR SURCHARGERS
- ✓ PROVIDE CESSATION SERVICES TO COMMUNITY AND EMPLOYEES

### DESIRED OUTCOMES AND OVERALL IMPACTS:

- ✓ DECREASE ADULT TOBACCO/NICOTINE USE
- ✓ DECREASE CARDIOVASCULAR DISEASE

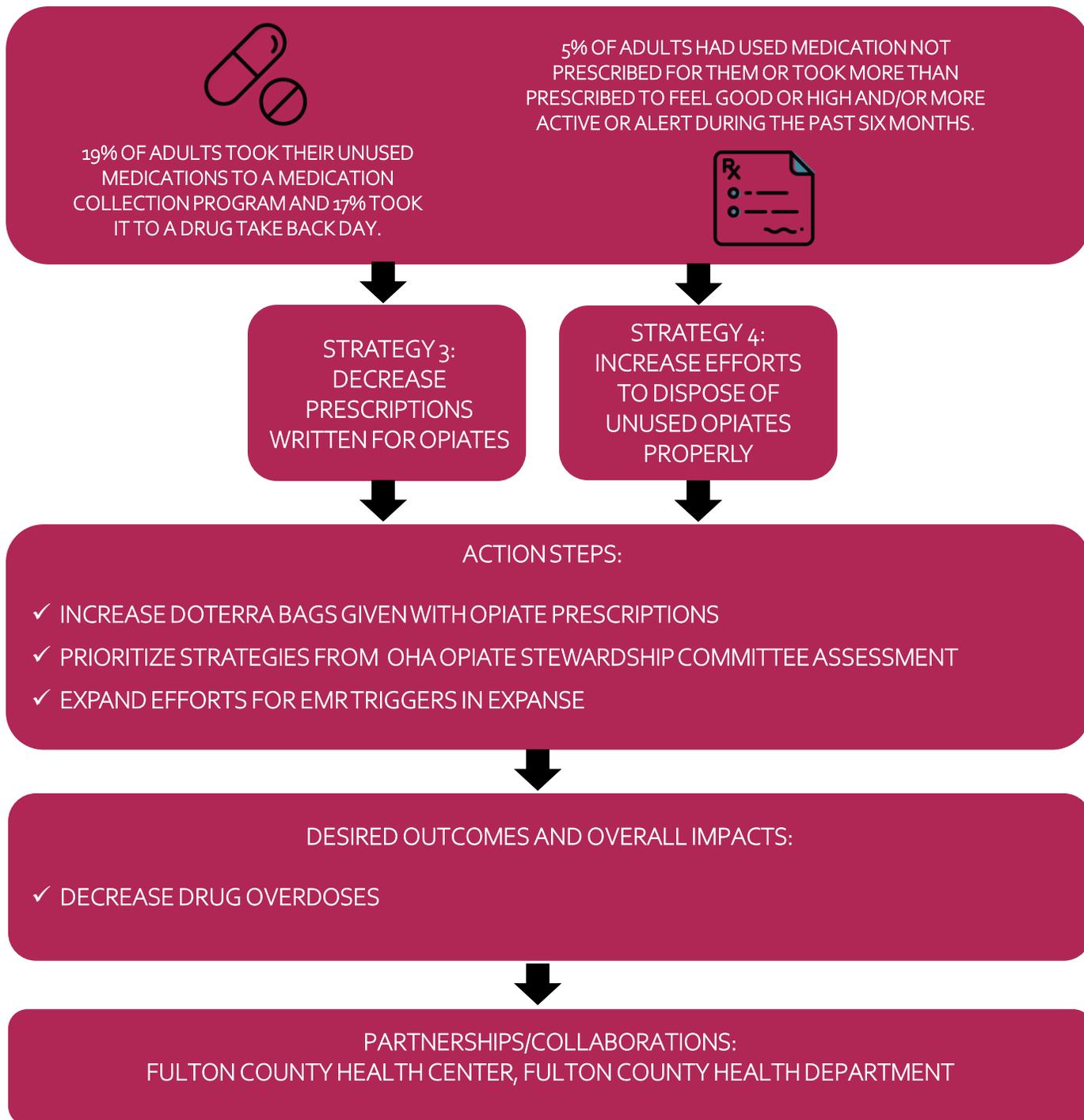
### PARTNERSHIPS/COLLABORATIONS:

FULTON COUNTY HEALTH CENTER, FULTON COUNTY HEALTH DEPARTMENT



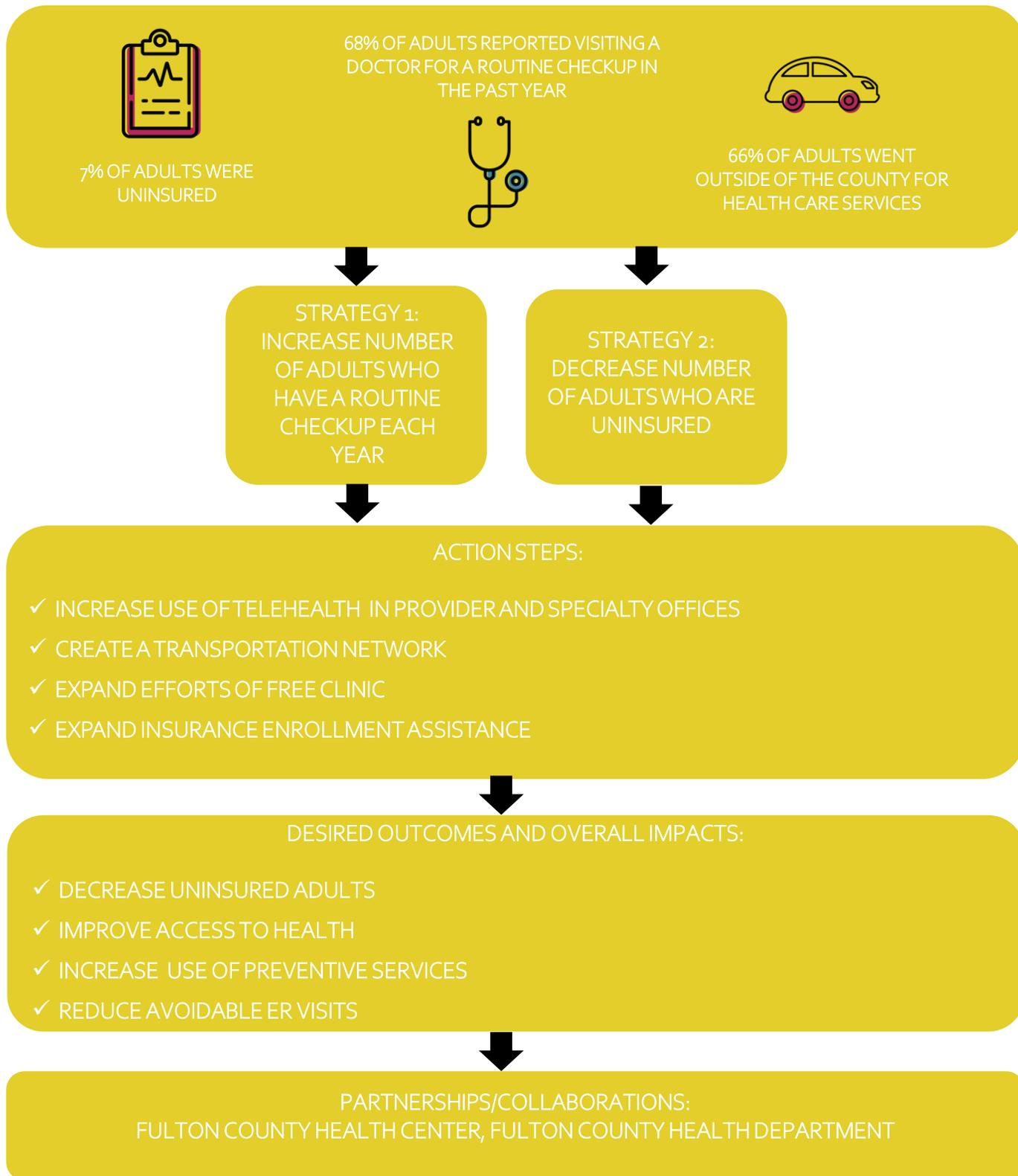
# MENTAL HEALTH & ADDICTION

## DECREASE DRUG OVERDOSES



# ACCESS TO CARE

## INCREASE LOCAL ACCESS AND PREVENTIVE SERVICES



# STEPS 5-8 INTEGRATE, DEVELOP, ADOPT, AND SUSTAIN IMPLEMENTATION STRATEGY



## IN THIS STEP, FULTON COUNTY HEALTH CENTER WILL:

- INTEGRATE IMPLEMENTATION STRATEGY WITH COMMUNITY AND HOSPITAL PLANS
- DEVELOP A WRITTEN IMPLEMENTATION STRATEGY
- ADOPT THE IMPLEMENTATION STRATEGY
- UPDATE AND SUSTAIN THE IMPLEMENTATION STRATEGY



# FULTON COUNTY HEALTH CENTER NEXT STEPS



## ADOPTION OF IMPLEMENTATION STRATEGY

The CHNA and this resulting Implementation Strategy identify and address significant community health needs and help guide community benefit activities. This Implementation Strategy explains how FCHC plans to address the selected priority health needs identified by the CHNA. This Implementation Strategy was adopted by the FCHC Board of Directors on April 24, 2023. This report is widely available to the public on the Fulton County Health Center's website at [fultoncountyhealthcenter.org](http://fultoncountyhealthcenter.org). Written comments on this report can be submitted to [bward@fulhealth.org](mailto:bward@fulhealth.org)

## EVALUATION OF IMPACT

FCHC will monitor and evaluate the programs and actions outlined above. FCHC anticipates the actions taken to address significant health needs will improve health knowledge, behaviors, and status, increase access to care, and overall help support good health. FCHC is committed to monitoring key indicators to assess impact. Our reporting process includes the collection and documentation of tracking measures, such as the number of people reached/served and collaborative efforts to address health needs. A review of the impact of the Fulton County Health Center's actions to address these significant health needs will be reported in the next scheduled CHNA.



## ADDITIONAL HEALTH NEEDS NOT DIRECTLY ADDRESSED

Since FCHC cannot directly address all the health needs present in the community, we will concentrate our resources on those health needs where we can effectively impact our county given our areas of focus and expertise. Taking existing organization and community resources into consideration, FCHC will not directly address the remaining health needs identified in the CHNA including youth nutrition, physical activity, and substance use, as other partners already address these issues. In addition, FCHC will not directly address infant mortality, as our data does not support this health need. FCHC will continue to look for opportunities to address community needs where we can make a meaningful contribution. Community partnerships may support other initiatives that the hospital cannot independently lead in order to address the other health needs identified in the 2022 CHNA.





Fulton County  
**PARTNERS  
FOR HEALTH**

*Building a Healthy Community*



*Moxley*  
PUBLIC HEALTH

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