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

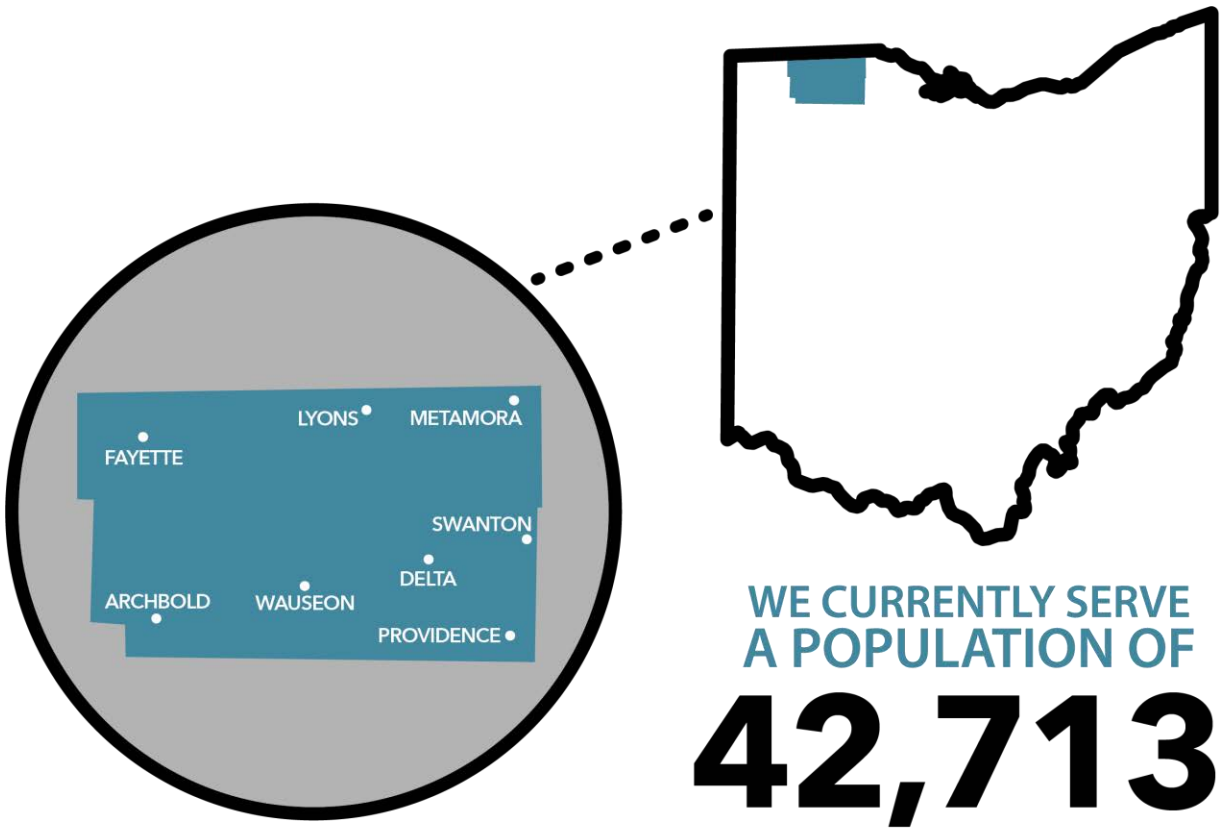
TABLE OF CONTENTS

Service Area.....4
Fulton County At-A-Glance.....5
Priority Health Needs.....6
Introduction: What Is An Implementation Strategy?.....7
Overview of the Process.....8
Step 1: Plan And Prepare For The Implementation Strategy.....9-10
Step 2: Develop Goals, Objectives And Indicators.....11-15
Steps 3 & 4: Select Strategies And Action Steps.....16
Priority Area 1: Chronic Disease.....17-18
Priority Area 2: Mental Health And Addiction.....19-20
Priority Area 3: Access to Care.....21
Steps 5-8: Integrate, Develop, Adopt, And Sustain Implementation Strategy.....22-23

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.



WE CURRENTLY SERVE
A POPULATION OF

42,713

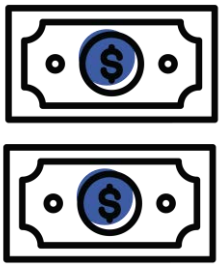
The CHNA and this resulting Implementation Strategy identify and address significant community health needs and help guide community benefit activities. This Implementation Strategy explains how FCHC plans to address the selected priority health needs identified by the CHNA.

FULTON COUNTY AT-A-GLANCE

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

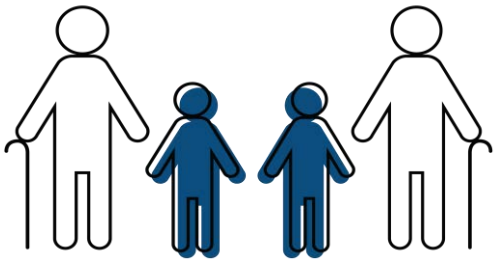
FULTON COUNTY	OHIO
- 0.3%	- 0.6%

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%	7.3%	10.4%
CHILDREN	SENIORS	FEMALE



THE % OF MALES AND FEMALES IS ABOUT EQUAL

49.4% 50.6%

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

8.9% HISPANIC OR LATINO	96.4% WHITE	0.7% ASIAN	1.6% BLACK/ AFRICAN AMERICAN	3.7% MULTI-RACIAL	1.0% AMERICAN INDIAN/AK NATIVE	4.1% OTHER	0.1% NATIVE HI/PACIFIC ISLANDER

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).

Fulton County PARTNERS FOR HEALTH

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

Fulton County PARTNERS FOR HEALTH

Building a Healthy Community

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). 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

Fulton County PARTNERS FOR HEALTH

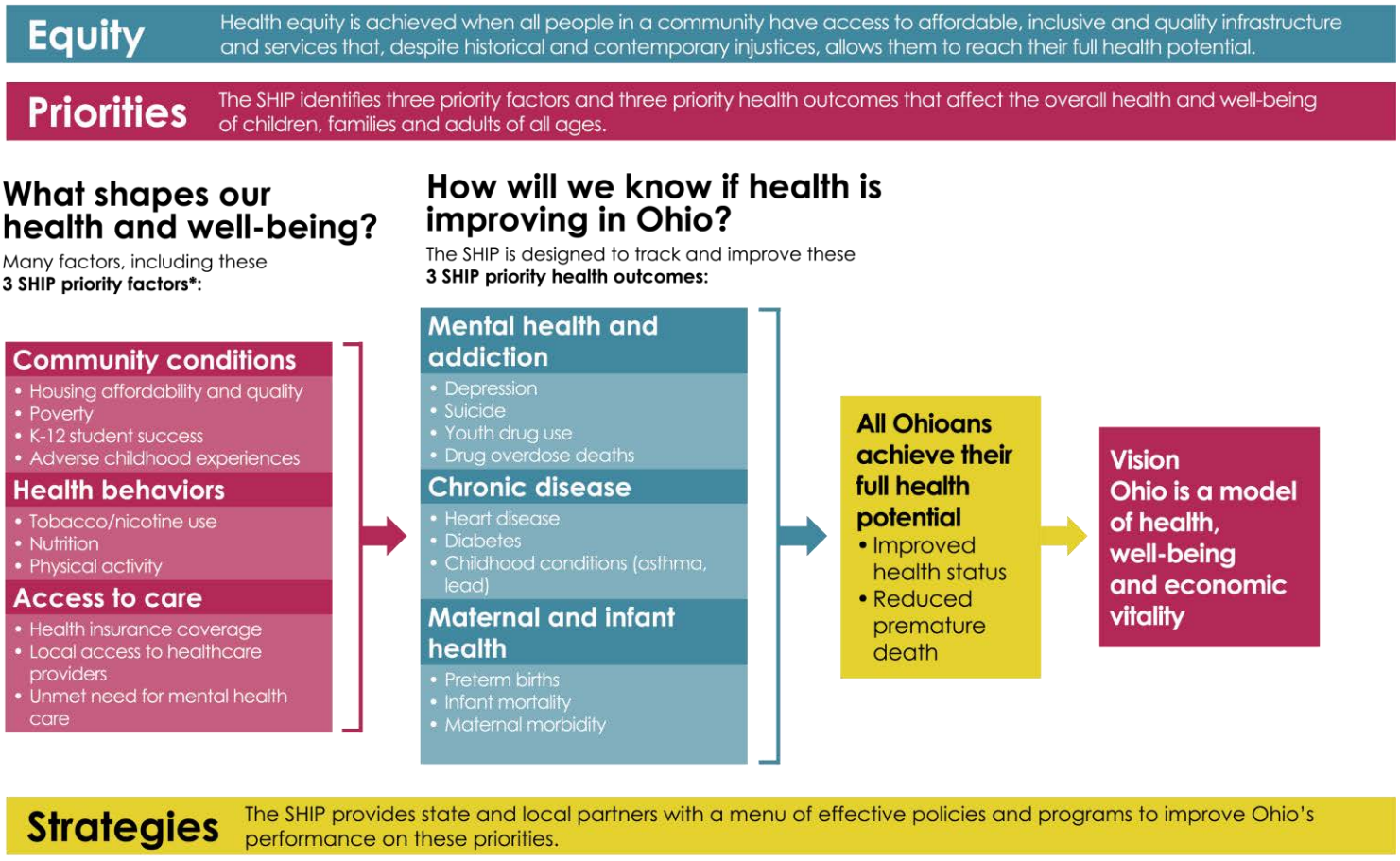
Building a Healthy Community

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**



* 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
☐ Community Conditions (strongly recommended)	☑ Mental Health and Addiction
☑ Health Behaviors	☑ Chronic Disease
☑ Access to Care	☐ Maternal and Infant Health

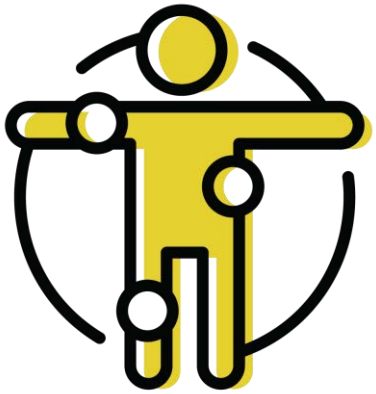
STEP 2 Select at least 1 indicator for each identified priority factor

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

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

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

Fulton County PARTNERS FOR HEALTH

Building a Healthy Community

CHRONIC DISEASE

IMPROVE ADULT NUTRITION & PHYSICAL ACTIVITY

18% OF ADULTS REPORTED NO PHYSICAL ACTIVITY IN PAST WEEK.

8% OF ADULTS ATE 5 OR MORE SERVINGS OF FRUITS AND VEGETABLES PER DAY.

38% OF FULTON COUNTY ADULTS WERE OBESE.

STRATEGY 1: INCREASE FRUIT AND VEGETABLE CONSUMPTION BY ADULTS

STRATEGY 2: INCREASE PHYSICAL ACTIVITY OF ADULTS

ACTION STEPS:

- ✓ INCREASE POINT-OF-PURCHASE PROMPTS FOR HEALTHY FOODS
- ✓ IMPLEMENT COMPETITIVE PRICING FOR HEALTHY FOODS
- ✓ EXPAND COMMUNITY FITNESS PROGRAMS
- ✓ IMPLEMENT WORKPLACE PHYSICAL ACTIVITY PROGRAMS AND POLICIES
- ✓ INITIATE A WEIGHT MANAGEMENT PROGRAM AT FULTON COUNTY HEALTH CENTER

DESIRED OUTCOMES AND OVERALL IMPACTS:

- ✓ INCREASE ADULT PHYSICAL ACTIVITY
- ✓ INCREASE ADULT FRUIT & VEGETABLE CONSUMPTION
- ✓ REDUCE ADULT OBESITY
- ✓ REDUCE CHRONIC DISEASES

PARTNERSHIPS/COLLABORATIONS:
FULTON COUNTY HEALTH CENTER, FULTON COUNTY HEALTH DEPARTMENT

CHRONIC DISEASE

REDUCE HEART DISEASE & DIABETES

33% OF ADULTS HAD BEEN DIAGNOSED WIT HIGH BLOOD PRESSURE.

10% OF ADULTS WERE DIAGNOSED WITH DIABETES.

30% OF ADULTS HAD BEEN DIAGNOSED WITH HIGH BLOOD CHOLESTEROL.

STRATEGY 3: INCREASE AWARENESS OF HEART DISEASE & DIABETES

STRATEGY 4: INCREASE THE NUMBER OF ADULTS SCREENED

ACTION STEPS:

- ✓ PROVIDE SCREENINGS AT COMMUNITY EVENTS AND HEALTH FAIRS
- ✓ PROVIDE EMPLOYEE SCREENINGS AT WORKSITES
- ✓ IMPLEMENT THE DIABETES PREVENTION PROGRAM
- ✓ PROVIDE DIABETES EDUCATION SUPPORT TO LOCAL PROVIDERS & COMMUNITY
- ✓ INCREASE MARKETING EFFORTS FOR DIABETES, OBESITY AND OTHER CHRONIC DISEASE PREVENTION AND TREATMENT

DESIRED OUTCOMES AND OVERALL IMPACTS:

- ✓ INCREASE ADULTS BEING SCREENED FOR HEART DISEASE AND DIABETES
- ✓ REDUCE HEART DISEASE, INCLUDING HYPERTENTION AND HIGH CHOLESTEROL
- ✓ REDUCE DIABETES, INCLUDING PRE-DIABETES

PARTNERSHIPS/COLLABORATIONS:
FULTON COUNTY HEALTH CENTER, FULTON COUNTY HEALTH DEPARTMENT

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

19% OF ADULTS TOOK THEIR UNUSED MEDICATIONS TO A MEDICATION COLLECTION PROGRAM AND 17% TOOK IT TO A DRUG TAKE BACK DAY.

5% OF ADULTS HAD USED MEDICATION NOT PRESCRIBED FOR THEM OR TOOK MORE THAN PRESCRIBED TO FEEL GOOD OR HIGH AND/OR MORE ACTIVE OR ALERT DURING THE PAST SIX MONTHS.

STRATEGY 3: DECREASE PRESCRIPTIONS WRITTEN FOR OPIATES

STRATEGY 4: INCREASE EFFORTS TO DISPOSE OF UNUSED OPIATES PROPERLY

ACTION STEPS:

- ✓ INCREASE DOTERRA BAGS GIVEN WITH OPIATE PRESCRIPTIONS
- ✓ PRIORITIZE STRATEGIES FROM OHA OPIATE STEWARDSHIP COMMITTEE ASSESSMENT
- ✓ EXPAND EFFORTS FOR EMR TRIGGERS IN EXPANSE

DESIRED OUTCOMES AND OVERALL IMPACTS:

- ✓ DECREASE DRUG OVERDOSES

PARTNERSHIPS/COLLABORATIONS:
FULTON COUNTY HEALTH CENTER, FULTON COUNTY HEALTH DEPARTMENT

ACCESS TO CARE

INCREASE LOCAL ACCESS AND PREVENTIVE SERVICES

7% OF ADULTS WERE UNINSURED

68% OF ADULTS REPORTED VISITING A DOCTOR FOR A ROUTINE CHECKUP IN THE PAST YEAR

66% OF ADULTS WENT OUTSIDE OF THE COUNTY FOR HEALTH CARE SERVICES

STRATEGY 1: INCREASE NUMBER OF ADULTS WHO HAVE A ROUTINE CHECKUP EACH YEAR

STRATEGY 2: DECREASE NUMBER OF ADULTS WHO ARE UNINSURED

ACTION STEPS:

- ✓ INCREASE USE OF TELEHEALTH IN PROVIDER AND SPECIALTY OFFICES
- ✓ CREATE A TRANSPORTATION NETWORK
- ✓ EXPAND EFFORTS OF FREE CLINIC
- ✓ EXPAND INSURANCE ENROLLMENT ASSISTANCE

DESIRED OUTCOMES AND OVERALL IMPACTS:

- ✓ DECREASE UNINSURED ADULTS
- ✓ IMPROVE ACCESS TO HEALTH
- ✓ INCREASE USE OF PREVENTIVE SERVICES
- ✓ REDUCE AVOIDABLE ER VISITS

PARTNERSHIPS/COLLABORATIONS:
FULTON COUNTY HEALTH CENTER, FULTON COUNTY HEALTH DEPARTMENT

STEPS 5-8

INTEGRATE, DEVELOP, ADOPT, AND SUSTAIN IMPLEMENTATION STRATEGY

IN THIS STEP, FULTON COUNTY HEALTH CENTER WILL:

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

Fulton County PARTNERS FOR HEALTH

Building a Healthy Community

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. Written comments on this report can be submitted to 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

Fulton County
PARTNERS
FOR HEALTH
Building a Healthy Community

Moxley
PUBLIC HEALTH

Template provided by
www.moxleypublichealth.com
stephanie@moxleypublichealth.com