2020-2023

Fulton County

Community Health Improvement Plan

Adopted
12/9/20
Reviewed
12/14/21

TABLE OF CONTENTS

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.

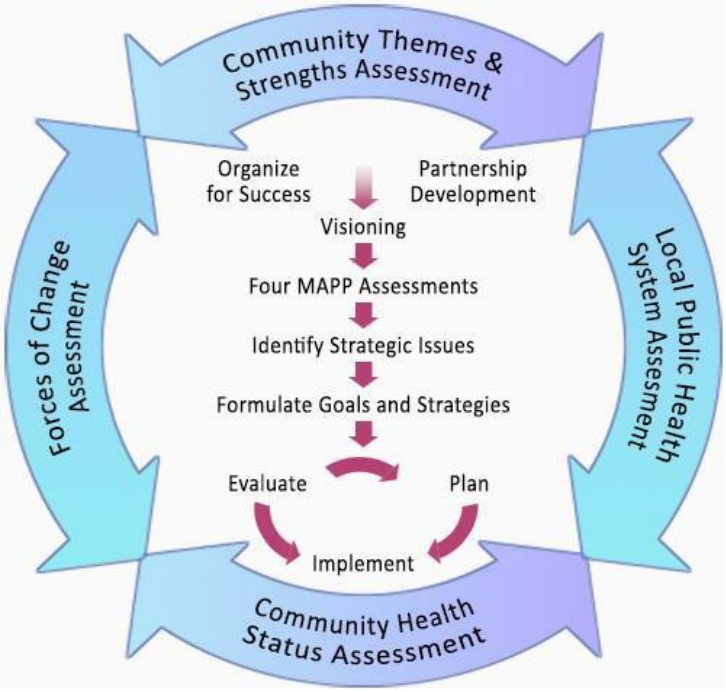
Fulton County Partners for Health utilized Fulton County Health Department and Fulton County Health Center staff to facilitate the MAPP process. Key Community leaders were invited to participate in an organized process of strategic planning to improve the health of residents of the county. The National 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 date 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	
Mental Health and Addiction	*Obesity*
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:

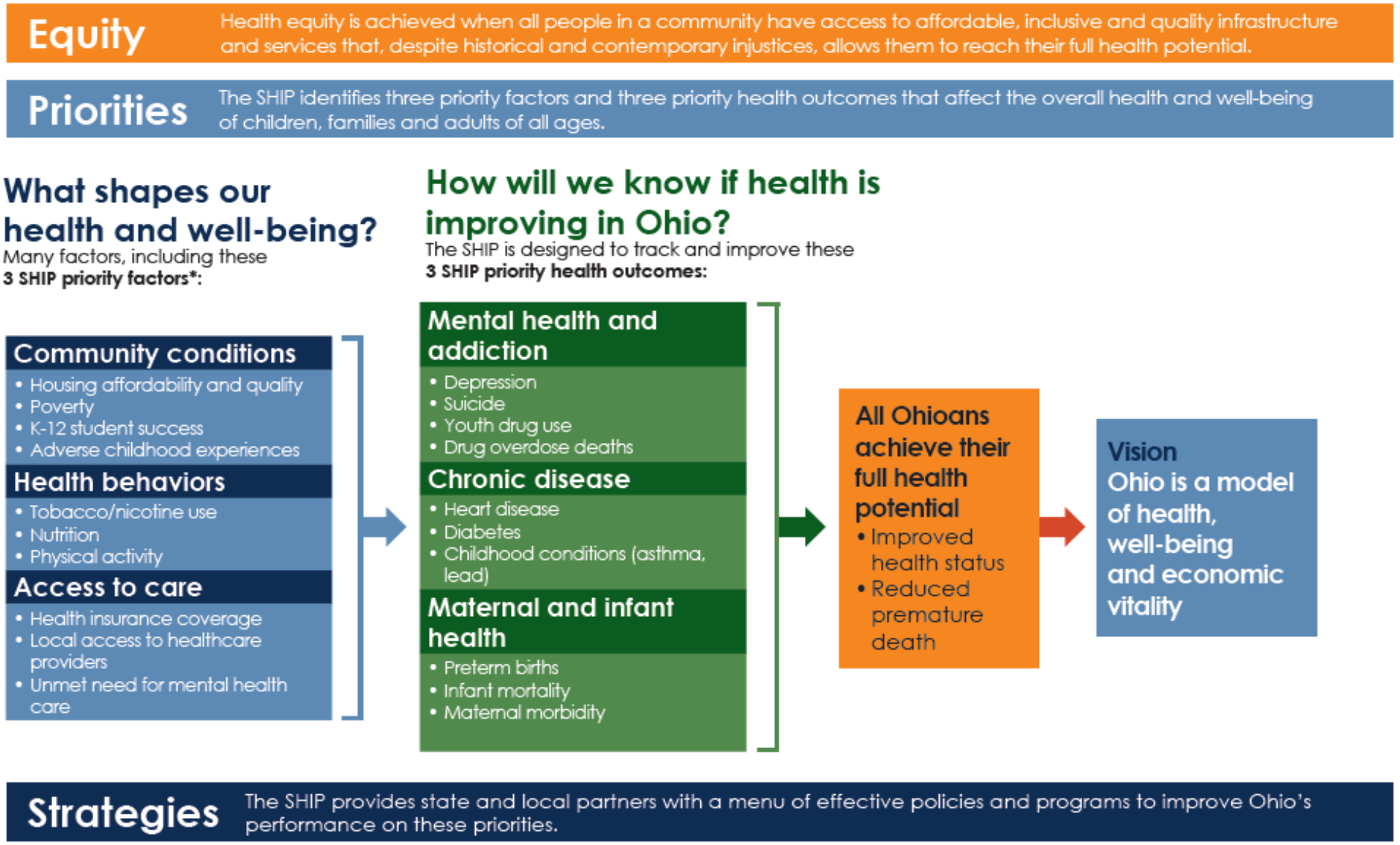
Figure 1.2: 2020-2023 Fulton County CHIP Alignment with the 2020-2022 SHIP

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

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

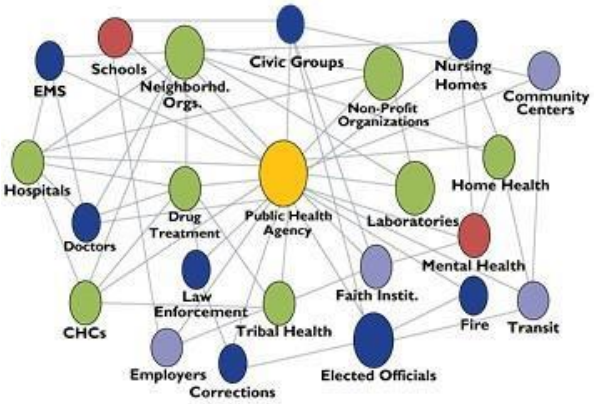
LOCAL PUBLIC HEALTH SYSTEM ASSESSMENT

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 i n 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.

(Source: Centers for Disease Control; National Public Health Performance Standards; The Public Health System and the 10 Essential Public Health Services; http://www.cdc.gov/nphpsp/essentialservices.html)

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?"

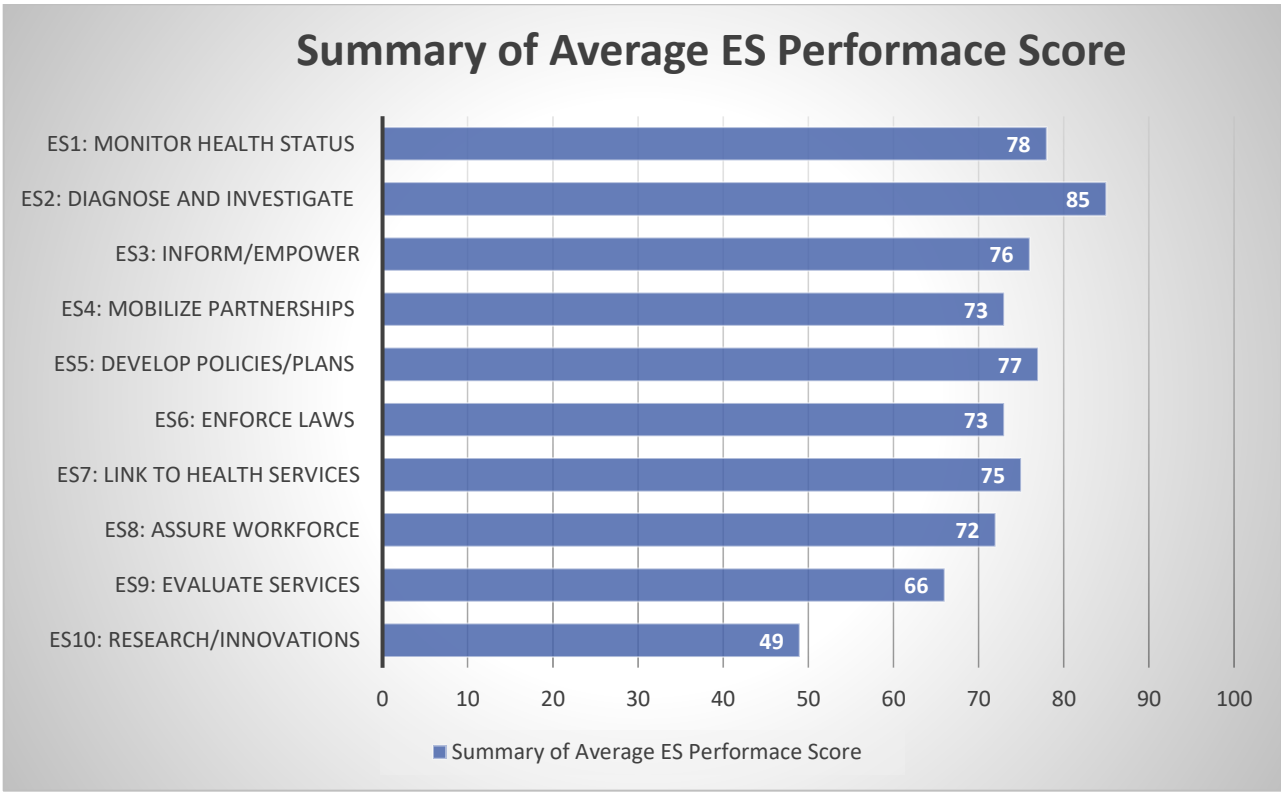
This assessment involves the use of a nationally recognized tool called the **National Public Health Performance Standards Local Instrument**.

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

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

Community partnerships/networking
Fulton County Fair
Multiple generations of families
Strong faith values
Youth involvement
Safe communities
Strong schools
Strong employers
Youth leadership
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
Community Engagement Team (NSBS)
CORE
Family & Children First Council
4-H
Four County Suicide Prevention Coalition
Fulton County Children Services
Ohio Means Job
OSU Extension
Safe Communities
Fulton County Economic Development
Fulton County Senior Center
JFS
HC3
LOSS Team
Ministerial Associations
School Administration Collaboration
United Way

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
Agricultural sustainability
Balance between consumers and contributors
Economic opportunities/retention of employees
Human Trafficking
Mental Health
Obesity
Retention of skilled workers
Substance abuse
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 (6th-12th)	Fulton County 2014 (6th-12th)	Fulton County 2016 (6th-12th)	Fulton County 2018 (6th – 12th)	Fulton County 2018 (9th–12th)	Ohio 2014 (9th–12th)	U.S. 2017 (9th–12th)
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 (6th-12th)	Fulton County 2014 (6th-12th)	Fulton County 2016 (6th-12th)	Fulton County 2018 (6th-12th)	Fulton County 2018 (9th-12th)	Ohio 2011 (9th -12th)	U.S. 2017 (9th -12th)
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 row'

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

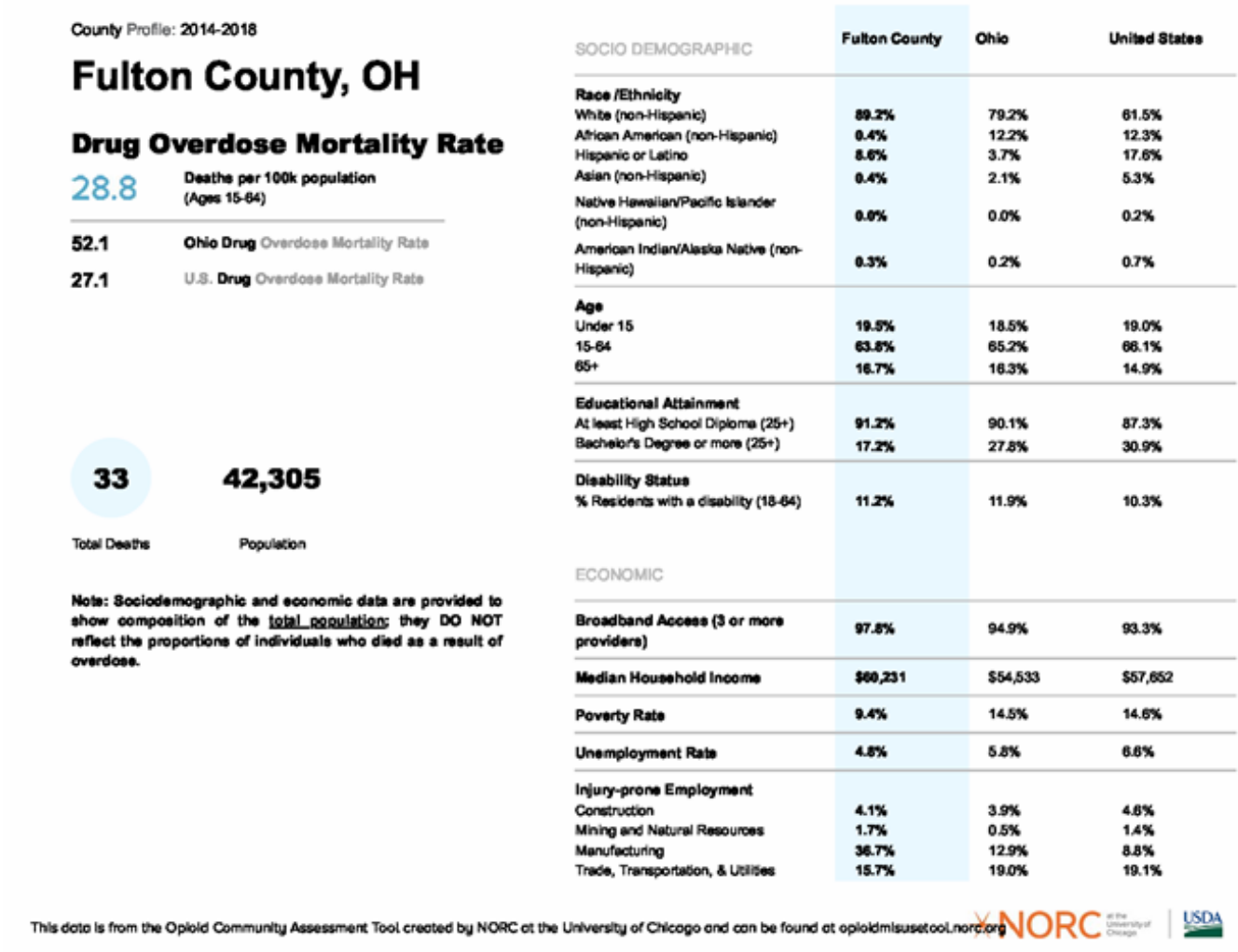
37% of youth reported they would seek help if they were dealing with anxiety, stress, depression, or thoughts of suicide. This is a decrease of 9% reported in 2016 (48%)

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 (6th-12th)	Fulton County 2014 (6th-12th)	Fulton County 2016 (6th-12th)	Fulton County 2018 (6th-12th)	Fulton County 2018 (9th-12th)	Ohio 2013 (9th-12th)	U.S. 2017 (9th-12th)
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 Total Deaths

42,305 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)	89.2%	79.2%	61.5%
African American (non-Hispanic)	6.4%	12.2%	12.3%
Hispanic or Latino	3.6%	3.7%	17.6%
Asian (non-Hispanic)	0.4%	2.1%	5.3%
Native Hawaiian/Pacific Islander (non-Hispanic)	0.0%	0.0%	0.2%
American Indian/Alaska Native (non-Hispanic)	0.3%	0.2%	0.7%
Age			
Under 15	19.5%	18.5%	19.0%
15-64	63.8%	65.2%	66.1%
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	$60,231	$54,533	$57,652
Poverty Rate	9.4%	14.5%	14.6%
Unemployment Rate	4.8%	5.8%	6.6%
Injury-prone Employment			
Construction	4.1%	3.9%	4.6%
Mining and Natural Resources	1.7%	0.5%	1.4%
Manufacturing	36.7%	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.org

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 through12. 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/**

PAX (Good Behavior Game)

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

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.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

12/14/2021 – Reviewed/On Track – Campaign ongoing

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

12/14/2021 – Reviewed / On Track -

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 6th – 12th) 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. Increase in number of youth routinely being screened for drug and alcohol/depression/mental health issues from baseline.	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			December 1, 2022
Year 3: Continue efforts from Years 1 and 2.			December 1, 2023

12/14/2021 – Reviewed / Updated – Year 1 timeline updated to reflect delay due to COVID-19

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.			

12/14/2021 – Reviewed / On Track

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

12/14/2021 – Reviewed / On Track

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/HC3 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

12/14/2021 – Reviewed / On Track

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	Output	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.	ROX, BOSS, and YAC programming for middle school and high school youth Too Good for Drugs	Beth Thomas/FCHD Ruth Peck, Recovery Services of NWO	May 1, 2022 May 1, 2022 May 1, 2023

12/14/2021 – Reviewed / On Track

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

12/14/2021 – Reviewed / On Track

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%	32%
Overweight	35%	35%	32%	36%	34%	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 (6th-12th)	Fulton County 2014 (6th-12th)	Fulton County 2016 (6th-12th)	Fulton County 2018 (6th-12th)	Fulton County 2018 (9th- 12th)	Ohio 2013 (9th-12th)	U.S. 2017 (9th-12th)
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.

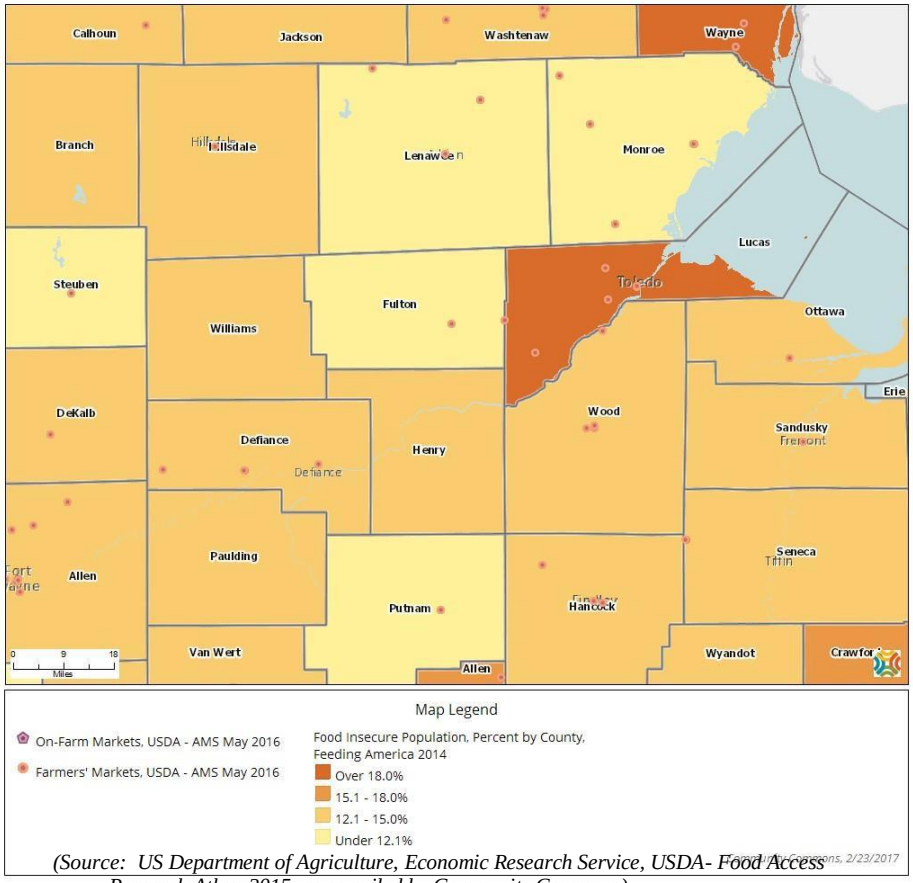
Fulton County adults with high blood cholesterol were more likely to have:
Been ages 65 years or older (57%)
Rated their overall health as fair or poor (49%)
Incomes less than $25,000 (37%)

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

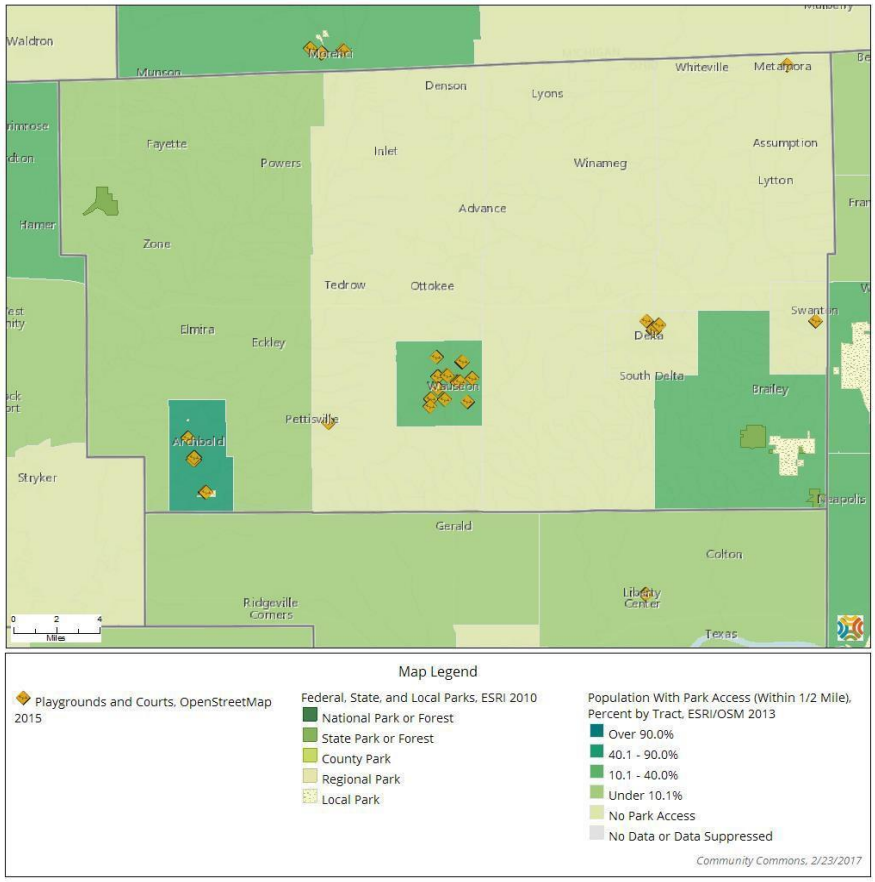
Priority #2 I Chronic Disease

Food Insecure Population, Percent by County, Feeding America 2014



(Source: US Department of Agriculture, Economic Research Service, USDA- Food Access Research Atlas: 2015, as compiled by Community Commons)

Population with Park Access (Within ½ Mile). Total by Tract, ESRI/OSM 2013



(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 I 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 6th-12th, 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 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**
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 Identify school districts/organizations who are willing to partner to increase access to non-sugary beverages at sport concession stands through price/promotion	Decrease sugar-sweetened beverages at schools	Rachel Kinsman, FCHD	December 31, 2022
Year 2: Partner with at least 2 identified school districts/organizations to work together to decrease/increase access. Devise plan to track beverage sales			December 31, 2022
Year 3: Evaluate data and modify strategies as informed by the data.			May 31, 2023

12/14/2021 – Reviewed / Updated – Timeline updated due to decreased access to schools due to COVID

2. Priority Topic: Chronic Disease (Heart 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

12/14/2021 – Reviewed / On track

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 6th – 12th 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. Increased fruit consumption Increased vegetable consumption	Rachel Kinsman, FCHD Fulton County Schools Elementary Physical Education Program	May 30, 2021
Year 2: Select and implement strategies.			September 30, 2022
Year 3: Evaluate data and modify strategies as informed by the data.			May 30, 2023

12/9/2021 – Reviewed / On Track - - Rachel checking with Gina re: Crunch Out Obesity status

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**
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. Update existing Walking Guides and push them out through social media outlets on a quarterly basis.	Increase youth and adult physical activity	Rachel Kinsman, FCHD	May 31, 2021 September 30, 2022
Year 2: Implement strategies and evaluate effectiveness.			
Year 3: Determined by Years 1 and 2.			May 31, 2023

12/9/2021 – Reviewed / On Track

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. Increased fruit consumption Increased vegetable consumption	Britney Ward Fulton County Health Center	May 30, 2021
Year 2: Implement point of purchase prompts in Fulton County Health Center cafeteria.			September 30, 2022
Year 3: Expand point of purchase prompts to other large employer cafeterias in the county.			May 30, 2023

12/9/2021 – Reviewed / On Track

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 Increased fruit consumption Increased vegetable	Britney Ward Fulton County Health Center	May 30, 2021
Year 2: Implement pricing changes in Fulton County Health Center cafeteria.			September 30, 2022
Year 3: Expand pricing changes for healthy foods to other large employer cafeterias in the county.			May 30, 2023

12/9/2021 – Reviewed / On Track

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 Increased fruit and vegetable consumption	Britney Ward Fulton County Health Center	May 30, 2021
Year 2: Implement Farm-to-Institution program at Fulton County Health Center			September 30, 2022
Year 3: Expand Farm-to-Institution program to other large employers in the county.			May 30, 2023

12/9/2021 – Reviewed / On Track

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.	Increased number of classes offered Increased number of locations offered	Britney Ward Fulton County Health Center	May 30, 2021
Year 2: Expand Community Fitness Programs to at least 3 communities in the county.			September 30, 2022
Year 3: Expand Community Fitness Programs to at least 4 communities in the county.			May 30, 2023

12/9/2021 – Reviewed / On Track – output corrected

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 Increased physical activity	Britney Ward Fulton County Health Center	May 30, 2021
Year 2: Expand programs above to offsite locations.			September 30, 2022
Year 3: Continue efforts from Years 1 and 2.			May 30, 2023

12/9/2021 – Reviewed / On Track

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

12/9/2021 – Reviewed / On Track

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**

Appendix B

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** **<u>Results</u> of Activities**	**Shorter-Term Outcomes** **(3 years)**	**Longer –Term Outcomes** **(5 years)**
Too many Fulton County residents under the age of 30 are experiencing mental health issues <u>Data to Support Problem Statement</u>: Adult: • 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 FC Health Status Report, 2019	***Perceived mental health stigma prevents individuals from seeking referral/treatment.*** Adult: • 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 FC Health Status Report, 2019 Youth (grades 6th -12th) • 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	**ADAMh's Board-Health Dept. Driven Media Campaign** **Provide Information:** • will help residents understand value of referral/treatment **Build Skills:** • help residents recognize signs/symptoms of mental health issues **Youth & Adult Mental Health First Aid Training** **Build Skills:** • Provide opportunity for professional and community adults working with youth and adults to recognize mental health wellness and signs/symptoms of mental health issues. **School based Signs of Suicide Program** **Build Skills:** • Provide opportunity for county MS/HS • students to recognize mental health wellness and signs/symptoms of mental health issues in their peers. **Enhance Access/Reduce Barriers**: • Provide opportunity for MS students to self-refer for assessment/treatment • Provide opportunity for HS students to be screened for mental health wellness.	**Provide Information:** Mental Health Wellness Media Campaign **Build Skills:** Professionals and community adults trained in Youth and Adult Mental Health First Aid HS and MS students trained in Signs of Suicide. **Enhance Access/Reduce Barriers** MS students self-refer for mental health issues HS students screened for suicide intention	***Perceived mental health stigma prevents individuals from seeking referral/treatment.*** 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. 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.	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. 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.

Youth: (grades 6th –12th) • 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** ** 2018 Fulton County Health Status Report *** 2016 Fulton County Health Status Report	***Lack of promotion of Mental Health Wellness*** **Adults:** rated their mental health as not good on four or more days in the previous month • 21 % (2016, HSR) • 17% (2014 HSR) Average days that mental health not good in past month • 3.2 (2016 HSR) • 2.6 days (2012 HSR) **Youth (grades 6th – 12th)** Youth who felt sad or hopeless almost every day for 2 or more weeks in a row • 29% 2018 HSR • 22% 2016 HSR • 18% 2014 HSR • 17% 2012 HSR • 14% 2010 HSR **Child:** 2 or more Adverse Childhood Experiences • 6% 2016 HSR	**Develop community screening program** **Modify Policy** • 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 **Expand School-based Mental Health Wellness Programs** **Build Skills** • Utilize ROX and Incredible Years programs to increase youth mental wellness.	Establish baseline for current screenings numbers of adults and youth for mental health issues. Increase in number community members routinely being screened for mental health issues. Establish indicated data baselines and plans for gathering, compiling, analyzing, and tracking data Annual collaborative report of mental health wellness skills/indicators present in youth involved in school based program. Increase in number of youth receiving school based programming through either ROX	Increase by 10% the number of adults/youth being screened for mental health issues by May 2023 as reported behavioral health agency conducting screenings	

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**	**Outputs** **Results of Activities**	**Shorter-Term Outcomes** **(2 year)**	**Longer –Term Outcomes** **(5 years)**
Too many Fulton County residents are obese. **Data to Support Problem Statement:** **Adult**: • 36% are Obese (HSR, 2019) Decrease from 43% reported in 2016 • 36% are Overweight (HSR, 2019) **Youth:** • 19% are Obese (HSR, 2018) • 13% are Overweight (HSR, 2018 • **Child (Ages 0-11 years):** • 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)	**Sedentary Life Style**. Adult: • 18% of Adults did not participate in physical activity in the past week, including those who are unable to exercise. (HSR, 2019) Youth: • 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) **Food Choice**. Adult: • 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***) **Adult Barriers - why they choose foods they eat:**** • Taste – 65% • Enjoyment – 65% • Cost – 45% • Ease of preparation – 46% • Healthiness of food – 55% • Foods they are used to – 47% • Availability – 30%	Provide social supports to increase physical activity	**Enhance access/reduce barriers:** Community promotion of available opportunities to engage in physical activity individually as well as in families **Enhance access/reduce barriers:** Decrease access to surgery beverages at local sport concession stands **Increase incentive/decrease disincentive** Increase cost of sugary beverages while decreasing cost of non-sugary beverages	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. 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.	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**.**

	• 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) **Barriers to consuming Fruits and Vegetables:** • 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) **Youth:** • 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.** **Child (Ages 0-11 years):** • 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)	Continue school-based programming in FC elementary schools: My Plate- 3rd graders across county Crunch out Obesity-4th graders across county			

Too many Fulton County residents are experiencing cardiovascular disease Heart disease and stroke accounted for 32% of all Fulton County adult deaths in the 2018 Coroners' Report. **Hypertension** • (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) **Hypercholesterolemia** • (30%) of Fulton County adults had • been diagnosed with high blood cholesterol (FC HSR, 2019) **Coronary Artery Disease** • 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)	**Root Causes** Cardiovascular Health **Obesity / lack of exercise / poor diet** • 36% of FC adults are Obese (HSR, 2019) • 36% of FC adults are Overweight (HSR, • 2019) **Stress** • 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) **Smoking** • 11% of adult males are current smokers • 13% of adult females are current smokers • (FC HSR, 2019) **Local Conditions** Obesity • Access to unhealthy foods • 2 parents working (lack of time/time management) • Family value/activity or lack of • Technology (increase use recreational/work) • Stress • Job • 2 parent working • Technology • Weather • Kids in a lot of activities • Smoking • Cultural / farm community • Work environment • Stress • Coping • Peer pressure	Develop system to track the amount of people who are in an unhealthy range for blood pressure and cholesterol during health screenings. **Enhance access/reduce barriers** Community Health screenings for blood pressure and cholesterol. Workplace health screenings for blood pressure and cholesterol. Health screenings for freshman and senior high school students for cholesterol. 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.		**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. Increase by 10% the number of Fulton County adults who are screened for blood pressure and cholesterol levels.	**Long Term Goals** 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.