Fulton County
PARTNERS
FOR HEALTH
Building a Healthy Community






2025 FULTON COUNTY ADULT COMMUNITY HEALTH NEEDS ASSESSMENT

PUBLISHED NOVEMBER 2025

Moxley
PUBLIC HEALTH

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A NOTE FROM FULTON COUNTY PARTNERS FOR HEALTH

Fulton County Partners for Health strives to bring together people and organizations to improve community wellness. The Community Heath Needs Assessment (CHNA) process is one way we can live out our mission. In order to fulfill this mission, we must be intentional about understanding the health issues that impact residents and work together to create a healthy community.

A primary component of creating a healthy community is assessing the needs and prioritizing those needs for impact. In 2025, the Fulton County Partners for Health collaborated to conduct a comprehensive CHNA to identify primary health issues, current health status, and other health needs. The results from the assessment provide critical information to those in a position to make a positive impact on the health of the service area's residents. The results also enable the community to measure impact and strategically establish priorities in order to develop interventions and align resources.

The Fulton County Partners for Health and their many community partners conduct CHNAs for measuring and addressing the health status of the Fulton County community. We have chosen to assess Fulton County as our community because this is where we, and those we serve, live and work. We collect both quantitative and qualitative data in order to make decisions on how to better meet the health needs of our community. We want to provide the best possible care for our residents, and we can use this report to guide us in our strategic planning and decision-making concerning future programs and health resources.

The 2025 Fulton County CHNA would not have been possible without the help of numerous community organizations, acknowledged on the following pages. It is vital that assessments such as this continue so that we know where to direct our resources and use them in the most advantageous ways.

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

Conducting the CHNA and publishing this report relies on the participation of many individuals in our community who committed to participating in interviews and focus groups and completing our community member survey. We are grateful for those individuals who are committed to promoting the health of the community, just as we are, and take the time to share their health concerns and ideas for improvement.

Sincerely,

Kimberly A. Cupp, RS, MPH
Health Commissioner
Fulton County Health Department

Patricia A. Finn, MBA
CEO
Fulton County Health Center

ACKNOWLEDGMENTS

This CHNA was made possible thanks to the collaborative efforts of the Fulton County Partners for Health, community partners, local stakeholders, non-profit partners, and community residents. Their contributions, expertise, time, and resources played a critical part in the completion of this assessment.

FULTON COUNTY PARTNERS FOR HEALTH WOULD LIKE TO RECOGNIZE THE FOLLOWING ORGANIZATIONS* FOR THEIR CONTRIBUTIONS TO THIS COMMUNITY HEALTH NEEDS ASSESSMENT REPORT:

Archbold Area Schools

Archbold Police Department

Christian Union Church

Community Education for Development

Continental Plaza

Crossroads Church

Delta Police Department

Educational Service Center of NWO

Evergreen Local Schools

Fairlawn Retirement Community

Fayette Community Development Corporation

Fayette Local Schools

Fayette Police Department

Four County ADAMhs Board

Four County Career Center

Fulton County Board of Developmental Disabilities

Fulton County Commissioners

Fulton County Drug Court

Fulton County Economic Development

Fulton County Family & Children First Council

Fulton County Free Clinic

Fulton County Health Center

Fulton County Health Department

Fulton County Job and Family Services

Fulton County Juvenile/Probate Court

Fulton County Senior Center

Fulton County Sheriff's Office

Fulton County Workforce Development

Fulton County Youth (Survey & Listening Sessions participants)

Health Partners of Western Ohio

Healthy Choices Caring Communities

Maumee Valley Guidance Center

Maumee Valley Planning Organization

New Horizon Academy

Northern Ohio Breast and Cervical Cancer Project

Northwestern Ohio Community Action Commission

Ohio Guidestone

OSU Extension

Pettisville Local Schools

Pike Delta York Local Schools

Recovery Services of Northwest Ohio

Sauder Woodworking

Shepherd Circle

Swanton Local Schools

The Center for Child & Family Advocacy

The Ridge Project

Triangular Processing

Trinity Lutheran Church Delta

United Way of Fulton County

Village of Archbold

Village of Fayette

Village of Swanton

Wauseon Exempted Village Schools

Wauseon Fire Department

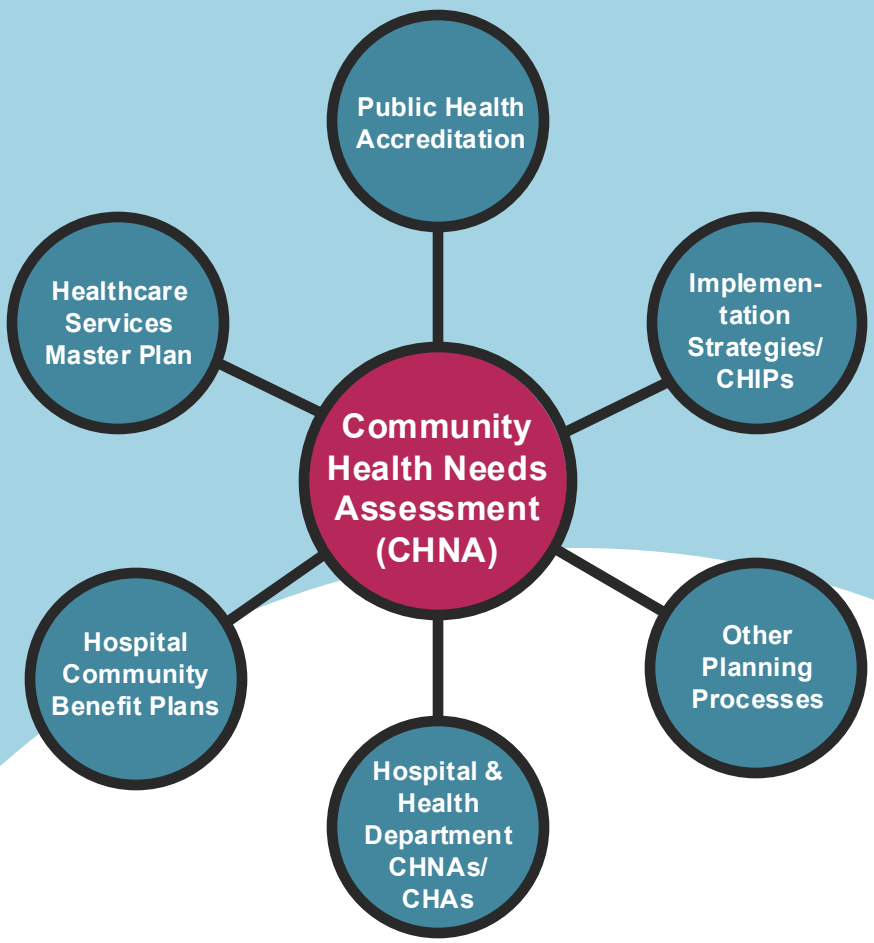
Wauseon Police Department

Worthington Industries

Note that the organizations that are **bolded either participated in or helped to coordinate key informant interviews and focus groups.*

INTRODUCTION

WHAT IS A COMMUNITY HEALTH NEEDS ASSESSMENT?



A **Community Health Needs Assessment (CHNA)** is a tool that is used to guide community benefit activities and for several other purposes. For hospitals, it is used to identify and address key health needs and supports the development of community benefit plans mandated by the Internal Revenue Service (IRS). For health departments, it is used to identify and address key health needs and supports the requirements for accreditation through the Public Health Accreditation Board (PHAB). The data from a CHNA is also used to inform community decision-making: the prioritization of health needs and the development, implementation, and evaluation of an Implementation Strategy (IS)/Improvement Plan (CHIP).

A CHNA is an important piece in the development of an IS/CHIP because it helps the community to understand the health-related issues that need to be addressed. To identify and address the critical health needs of the service area, the Fulton County Partners for Health utilized the most current and reliable information from existing sources, in addition to collecting new data through interviews, focus groups, and surveys with community residents and leaders.

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OVERVIEW OF THE PROCESS

In order to produce a comprehensive Community Health Needs Assessment (CHNA), the Fulton County Partners for Health followed a process that included the following steps:

STEP 1: Plan and prepare for the assessment.

STEP 2: Define the community.

STEP 3: Identify data that describes the health and needs of the community.

STEP 4: Understand and interpret the data.

STEP 5: Define and validate priorities.

STEP 6: Document and communicate results.

Affordable Care Act Requirements

Enacted on March 23, 2010, the Affordable Care Act (ACA) provided guidance at a national level for Community Health Needs Assessments (CHNAs) for the first time. Federal requirements included in the ACA stipulate that hospital organizations under 501(c)(3) status must adhere to new 501(r) regulations, one of which is conducting CHNA and Implementation Strategy (IS) every three years.

Accreditation Requirements

The Public Health Accreditation Board (PHAB) Standards & Measures serves as the official guidance for PHAB national public health department accreditation and includes requirements for the completion of CHAs and CHIPs for local health departments.

Ohio Department of Health Requirements

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

THE 2025 FULTON COUNTY CHNA MEETS ALL OHIO DEPARTMENT OF HEALTH AND FEDERAL REGULATIONS.

OVERVIEW OF THE PROCESS (CONTINUED)

ODH Requirements

The following image shows the framework from ODH that this report followed while also adhering to federal requirements and the community's needs.

The Fulton County Partners for Health desired to align with the priorities and indicators of Ohio's State Health Improvement Plan (SHIP). To do this, they used the following guidelines when prioritizing the health needs of their community.

First, the Fulton County Partners for Health used the same language as the state of Ohio when assessing the factors and health outcomes of their community in the 2025 Fulton County CHNA.

Figure 1: Ohio State Health Improvement Plan (SHIP) Framework

Equity — Health equity is achieved when all people in a community have the opportunity to reach their full health potential.

Priorities — The SHIP identifies three priority factors (community conditions/social determinants or drivers of health) and three priority health outcomes that affect the overall health and well-being of children, families, and adults of all ages.

What shapes our health and well-being?
Many factors, including these **3 SHIP priority factors***:

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

Health Behaviors
- Tobacco/nicotine use
- Nutrition
- Physical activity

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

How will we know if health is improving in Ohio?
The SHIP is designed to track and improve these **3 SHIP priority health outcomes**:

Mental Health & Addiction
- Depression
- Suicide
- Youth drug use
- Drug overdose deaths

Chronic Disease
- Heart disease
- Diabetes
- Childhood conditions (asthma, lead exposure)

Maternal, Infant & Child Health
- Preterm births
- Infant mortality
- Maternal morbidity

All Ohioans achieve their full health potential
- Improved health status
- Reduced premature death

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

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

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

ADULT TREND SUMMARY

ADULT TREND SUMMARY AND COMPARISONS

The following tables compare Fulton County rates of the identified health needs to previous years, Ohio state-level data and national data. Thesee tables are useful for monitoring and evaluation purposes in order to track the impact of our Implementation Strategy (IS)/Improvement Plan (CHIP) to address priority health needs.

ADULT TREND SUMMARY

This table summarizes results, trends, and comparisons for adults from the 2016, 2019, and 2025 Fulton County Community Health Needs Assessments (CHNAs).

ADULT TREND SUMMARY					
INDICATORS	**FULTON COUNTY 2016**	**FULTON COUNTY 2019**	**FULTON COUNTY 2025**	**OHIO***	**U.S.***
Health Care Coverage, Access, and Utilization					
Uninsured adults[1]	5%	7%	8%	9%	12%
Visited a doctor for a routine checkup in the past year[2]	54%	68%	83%	77%	74%
Preventive Medicine					
Ever had a pneumonia vaccination (age 65 and older)[3]	64%	71%	87%	73%	70%
Had a flu vaccine within the past year (age 65 and older)[4]	75%	77%	79%	51%	48%
Ever had a shingles or zoster vaccine[5]	14%	21%	36%	36%	35%
Had a sigmoidoscopy or colonoscopy within the past 5 years (age 50 and older, except for Fulton Co. 2025: age 45+)[6]	46%	56%	57%	68%	66%
Women's Health					
Had a mammogram in the past two years (age 40 and older, except for Fulton Co. 2025: age 35+)[6]	72%	68%	79%	76%	77%
Had a Pap smear in the past three years (ages 21-65, except for Fulton Co. 2025: ages 18-64)[6]	67%	77%	72%	74%	75%
Men's Health					
Had a PSA test in the past two years (age 40 and older, except for Fulton Co. 2025: age 35+)[7]	47%	54%	46%	32%	32%
Oral Health					
Adults who visited a dentist or dental clinic (in the past year)[6]	71%	77%	77%	64%	64%

N/A – Not Available

**Ohio and U.S. data are from multiple years and sources. Additional details can be found in Appendix H.*

ADULT TREND SUMMARY (CONT.)

ADULT TREND SUMMARY					
INDICATORS	**FULTON COUNTY 2016**	**FULTON COUNTY 2019**	**FULTON COUNTY 2025**	**OHIO***	**U.S.***
Health Status Perceptions					
Rated general health as fair or poor[4]	12%	10%	8%	18%	17%
Average days that physical health was not good (in the past month)[4]	3.2	2.8	4.4	4.3	3.9
Average days that mental health was not good (in the past month)[4]	3.2	3.6	6.2	6.1	5.1
Weight Status					
Adult obesity[4]	43%	36%	48%	38%	34%
Tobacco Use					
Current smoker[4]	13%	12%	3%	18%	13%
Former smoker (smoked 100 cigarettes in lifetime & now does not smoke)[8]	26%	24%	25%	25%	24%
Alcohol Consumption					
Current drinker (drank alcohol at least once in the past month)[9]	43%	55%	55%	52%	53%
Binge or heavy drinker (for men, consumed 5 or more alcoholic drinks on an occasion; for women, 4 or more drinks on an occasion)[4]	15%	18%	20%	21%	19%
Drug Use					
Adults who used recreational marijuana or hashish in the past 6 months (for Ohio & U.S.: used marijuana in the past 30 days)[6]	2%	3%	3%	13%	15%
Adults who misused prescription medication in the past 6 months	11%	5%	<1%	N/A	N/A

N/A – Not Available
**Ohio and U.S. data are from multiple years and sources. Additional details can be found in Appendix H.*

ADULT TREND SUMMARY (CONT.)

ADULT TREND SUMMARY					
INDICATORS	**FULTON COUNTY 2016**	**FULTON COUNTY 2019**	**FULTON COUNTY 2025**	**OHIO***	**U.S.***
Mental Health					
Considered attempting suicide in the past year[6]	3%	4%	3%	6%	N/A
Attempted suicide in the past year	2%	1%	<1%	N/A	N/A
Adult frequent mental distress (felt sad or hopeless for two or more weeks in a row)[4]	8%	10%	16%	19%	16%
Cardiovascular Health					
Ever diagnosed with angina or coronary heart disease[41, 42]	4%	4%	1%	6%	5%
Ever diagnosed with a heart attack or myocardial infarction[41, 42]	5%	3%	2%	5%	3%
Ever been told they had a stroke[6]	4%	2%	1%	4%	4%
Ever been told they had high blood pressure[2]	37%	33%	34%	36%	33%
Ever been told their blood cholesterol was high[2]	32%	30%	36%	36%	36%
Had their blood cholesterol checked within the last 5 years[10]	81%	84%	90%	87%	88%
Diabetes					
Ever been told they have diabetes (not pregnancy-related)[6]	11%	11%	12%	13%	12%
Ever been diagnosed with pregnancy-related diabetes	1%	1%	3%	N/A	N/A
Ever been diagnosed with pre-diabetes or borderline diabetes[6]	6%	4%	9%	12%	12%
Quality of Life					
Limited in some way because of physical, mental, or emotional problems	23%	18%	22%	N/A	N/A

N/A – Not Available
**Ohio and U.S. data are from multiple years and sources. Additional details can be found in Appendix H.*

STEP 1

PLAN AND PREPARE FOR THE ASSESSMENT

IN THIS STEP, FULTON COUNTY PARTNERS FOR HEALTH:

- ✓ DETERMINED WHO WOULD PARTICIPATE IN THE NEEDS ASSESSMENT PROCESS
- ✓ PLANNED FOR COMMUNITY ENGAGEMENT
- ✓ ENGAGED HEALTH DEPARTMENT AND HOSPITAL LEADERSHIP
- ✓ DETERMINED HOW THE COMMUNITY HEALTH NEEDS ASSESSMENT WOULD BE CONDUCTED
- ✓ DEVELOPED A PRELIMINARY TIMELINE

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PLAN AND PREPARE

Fulton County Partners for Health began planning for the current Fulton County CHNA in 2025. They involved the health department and hospital leadership, kept partnership members informed of the assessment activities, allocated funds to the process, and most importantly, engaged the community through various established relationships with leaders of organizations and community groups, in collaboration with Moxley Public Health.

The assessment team worked together to formulate the multistep process of planning and conducting a CHNA. They then formed a timeline for the process.

> ***A community health assessment and improvement planning process involves an ongoing collaborative, community-wide effort to identify, analyze, and address health problems.***
>
> - Public Health Accreditation Board (PHAB)

PREVIOUS COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) & COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP)

PREVIOUS CHNA (2022) AND CHIP

In 2022, Fulton County conducted its previous CHNA. Significant health needs were identified from issues supported by primary and secondary data sources gathered for the CHNA. The 2023-2026 Fulton County CHIP addressed chronic disease, access to care, and mental health and addiction.

The previous CHNA was made available to the public on the following websites:

https://fultoncountyhealthdept.com/data-resources/health-assessments

https://fultoncountyhealthcenter.org/wp-content/uploads/2024/06/2022-Fulton-County-Community-Health-Needs-Assessment-compressed.pdf

(Written comments on this report were solicited on the website where the report was posted.)

IMPACT/PROCESS EVALUATION OF 2023-2026 STRATEGIES

In collaboration with community partners, Fulton County developed and approved a CHIP report for 2023-2026 to address the significant health needs that were identified in the 2022 Fulton County CHNA (chronic disease, access to care, and mental health and addiction). **Appendix A** describes the evaluation of the strategies that were planned in the 2023-2026 CHIP.

STEP 2

DEFINE FULTON COUNTY'S SERVICE AREA

IN THIS STEP, FULTON COUNTY PARTNERS FOR HEALTH:

- ✓ DESCRIBED FULTON COUNTY'S SERVICE AREA
- ✓ DETERMINED THE PURPOSE OF THE NEEDS ASSESSMENT

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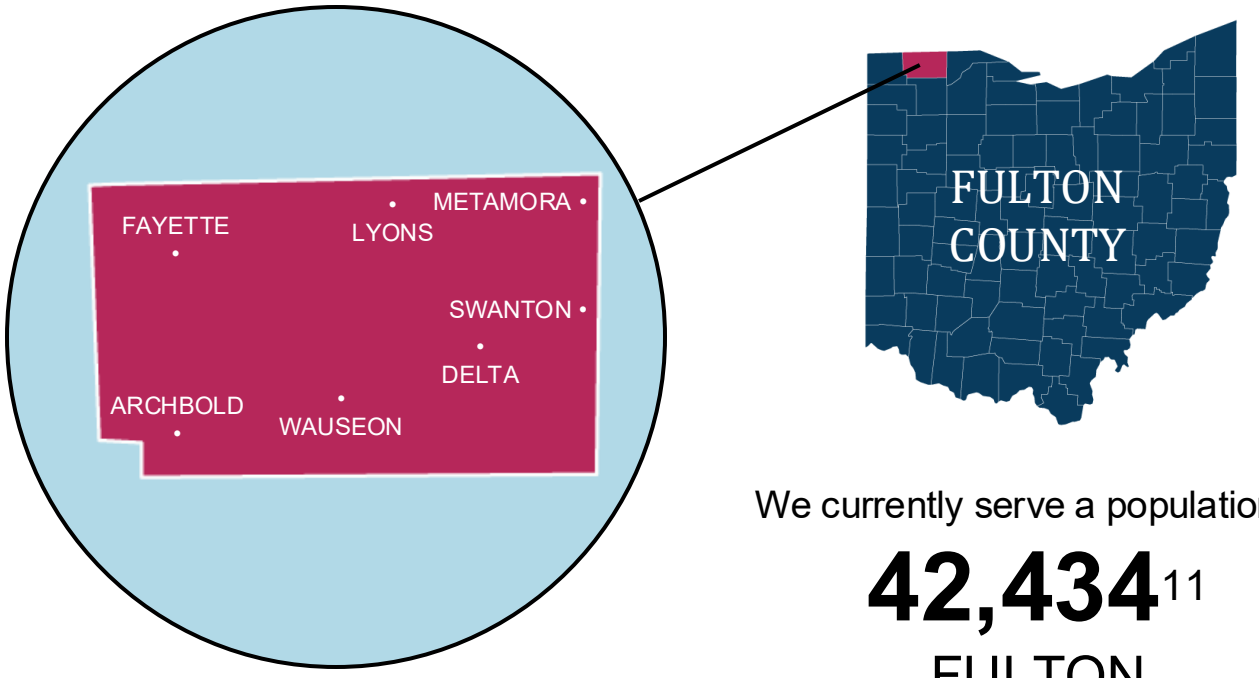
DEFINING THE FULTON COUNTY SERVICE AREA

For the purposes of this report, Fulton County defines their primary service area as being made up of Fulton County, Ohio.



We currently serve a population of

42,434[11]

FULTON COUNTY

FULTON COUNTY SERVICE AREA	
GEOGRAPHIC AREA	**ZIP CODE**
Archbold	43502
Delta	43515
Fayette	43521
Lyons	43533
Metamora	43540
Pettisville	43553
Swanton	43558
Wauseon	43567

FULTON COUNTY AT-A-GLANCE

1 in 242

Fulton County residents will **die prematurely**, which is lower than the Ohio state average (**1 in 212**).[4]

The life expectancy in Fulton County of **76.4 years is 1.2 years longer** than it is for the state of Ohio.[4]

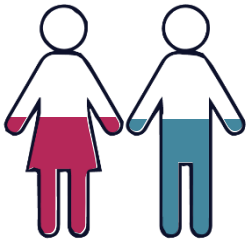
Youth ages 0-18 and seniors 65+ make up

42% of the population

(vs. **40%** for Ohio).

In the Fulton County service area, nearly **1 in 5 residents are ages 65+**.[11]

50% of Fulton County residents are **women** (vs. 51% for Ohio).[11]



50% 50%

7%

of Fulton County and Ohio residents are **veterans**.[12]

2% of Fulton County's population is **foreign-born** (vs. **5%** for Ohio), while **4%** of Fulton County residents **do not speak English as their first language** (vs. **8%** for Ohio).[12]

Other languages spoken in Fulton County include **Spanish** (3%), **other Indo-European** languages (0.8%), and **Asian and Pacific Islander** languages (0.3%).[12]

There is a **higher proportion of White residents and Hispanic/Latino residents** in Fulton County than in the state of Ohio.[11]

	FULTON COUNTY	OHIO
RACE		
White	90.3%	77.8%
Black/African American	0.4%	12.3%
American Indian/Alaska Native	0.4%	0.1%
Asian	0.4%	2.4%
Native Hawaiian/Pacific Islander	0%	0%
Some other race alone	3.3%	1.6%
Multiracial (two or more races)	5.1%	5.7%
ETHNICITY		
Hispanic/Latino (any race)	9.1%	4.6%

STEPS 3, 4 & 5

IDENTIFY, UNDERSTAND, AND INTERPRET THE DATA AND PRIORITIZE HEALTH NEEDS

IN THIS STEP, FULTON COUNTY PARTNERS FOR HEALTH:

- ✓ REVIEWED SECONDARY DATA FOR INITIAL PRIORITY HEALTH NEEDS
- ✓ COLLECTED PRIMARY DATA THROUGH INTERVIEWS, FOCUS GROUPS, AND A COMMUNITY MEMBER SURVEY
- ✓ COLLECTED COMMUNITY INPUT AND FEEDBACK
- ✓ REVIEWED PRIOR ASSESSMENTS AND REPORTS
- ✓ ANALYZED AND INTERPRETED THE DATA
- ✓ IDENTIFIED DISPARITIES AND CURRENT ASSETS
- ✓ IDENTIFIED BARRIERS OR SOCIAL DETERMINANTS OF HEALTH
- ✓ IDENTIFIED AND UNDERSTOOD CAUSAL FACTORS
- ✓ ESTABLISHED CRITERIA FOR SETTING PRIORITIES
- ✓ VALIDATED PRIORITIES
- ✓ IDENTIFIED AVAILABLE RESOURCES
- ✓ DETERMINED RESOURCE OPPORTUNITIES

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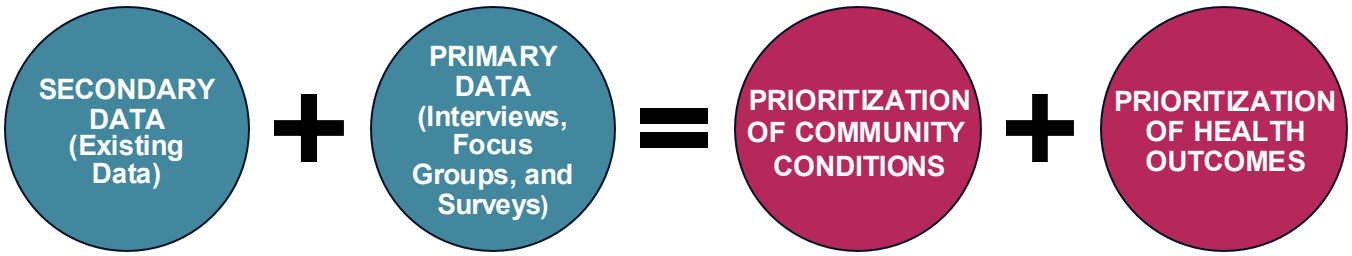
UNDERSTANDING PRIORITIZATION OF HEALTH NEEDS



COMMUNITY CONDITIONS (OR SOCIAL DETERMINANTS OF HEALTH OR BARRIERS TO HEALTH) are components of someone's environment, policies, behaviors, and healthcare that affect the health outcomes of residents of a community. Examples include housing, crime/violence, access to healthcare, transportation, access to childcare, nutrition and access to healthy foods, economic stability, etc.

HEALTH OUTCOMES are health results, diseases or changes in the human body. Examples include chronic diseases, mental health, suicide, injury, and maternal/infant health.

In order to align with the Ohio Department of Health's initiative to improve health, well-being, and economic vitality, Fulton County Partners for Health included the state's priority factors and health outcomes when assessing the community.

PRIMARY & SECONDARY DATA COLLECTION

ASSESSING HEALTH NEEDS THROUGH COMMUNITY DATA COLLECTION

Health needs were assessed through a review and analysis of the secondary (existing) health data, interviews with community leaders, focus groups with priority populations, and a community survey (primary data collection). Priority health needs were identified using the following criteria.

Criteria for Identification of Priority Health Needs:

1. The ranking of the problem using data from the community survey, focus groups, and interviews with residents.
2. The seriousness of the issue indicated by secondary data.
3. The identification of how the health need affects sub-populations within the community.

Furthermore, the health need indicators of the Fulton County service area identified in the secondary data were measured against benchmark data, specifically state rates, national rates and/or Healthy People (HP) 2030 objectives. HP 2030 benchmark data can be seen in **Appendix B**.

The health needs were assessed through the primary data collection – key informant interviews, focus groups, and a community member survey. The information and data from both the secondary and primary data collection informs this CHNA report and the decisions on health needs that Fulton County Partners for Health will address in its Implementation Strategy (IS)/Improvement Plan (CHIP).

The data collection process was designed to identify the priority issues in the community that affect health, solicit information on disparities among subpopulations, ascertain community assets to address needs, and uncover gaps in resources.

REVIEW OF PRIOR CHNA DATA

To build upon the work initiated previously, the 2022 CHNA was reviewed. When making final decisions for the 2026-2028 IS/CHIP, previous efforts will be assessed and analyzed.

This report will focus on presenting data at the county level where available. The geography for each indicator will be specified where county-level data is not available.

Secondary data was collected for the CHNA in Fall 2025. The most up-to-date data available at the time was collected and included in the CHNA report. Please refer to individual sources in the References section for more information on years and methodology.

2025 HEALTH NEEDS TO BE ASSESSED:

- Access to healthcare (primary, dental/oral, and mental)
- Chronic diseases (asthma, cancer, diabetes, heart disease, stroke, etc.)
- Community conditions (housing, education, income/poverty, internet access, transportation, adverse childhood experiences, crime and violence, access to childcare, food insecurity, etc.)
- Environmental conditions (air and water quality, vector-borne diseases, etc.)
- HIV/AIDS and Sexually Transmitted Infections (STIs)
- Injury
- Leading causes of death
- Maternal, infant, and child health (infant mortality, maternal morbidity and mortality, etc.)
- Mental health (depression and suicide, etc.)
- Nutrition and physical health (overweight and obesity population, etc.)
- Preventive care and practices (vaccines/immunizations, screenings, mammograms/pap smears, etc.)
- Substance use (alcohol and drugs, etc.)
- Tobacco and nicotine use

The secondary and primary data collection will ultimately inform the decisions on health needs that Fulton County Partners for Health will address in the IS/CHIP.

PRIMARY DATA COLLECTION
KEY INFORMANT INTERVIEWS

Key informant interviews were used to gather information and opinions from persons who represent the broad interests of the community. We spoke **with 20 experts** from various organizations serving the Fulton County community, including leaders and representatives of medically underserved, low-income, minority populations, and leaders from local health or other departments or agencies. A complete list of participants can be seen in **Appendix C**. The interview questions asked can be seen below.

KEY INFORMANT INTERVIEW QUESTIONS:
Broad questions asked at the beginning of the interview:
What are some of the major health issues affecting individuals in the community?
What are the most important socioeconomic, behavioral, or environment factors that impact health in the area?
Who are some of the populations in the area who are not regularly accessing healthcare and social services? Why?
Questions asked for each health need:
What are the issues/challenges/barriers faced for the health need?
Are there specific sub-populations and areas in the community that are most affected by this need?
Where do community residents go to receive help or obtain information for this health need? (resources, programs, and/or community efforts)

PRIMARY DATA COLLECTION
FOCUS GROUPS

Focus groups were used to gather information and opinions from specific sub-populations in the community who are most affected by health needs. We **conducted 3 focus groups** with a total of **32 people** in the Fulton County community. Focus groups included community members of medically underserved, low-income, and minority populations. A complete list of groups represented and focus group details can be seen in **Appendix D**. The focus group questions asked can be seen below.

FOCUS GROUP QUESTIONS:
What are your biggest health concerns/issues in our community?
How do these health concerns/issues impact our community?
What are some populations/groups in our community that face barriers to accessing health and social services?
What existing resources/services do you use in our community to address your health needs? How do you access information about health and health and social services? Does this information meet your needs?
What resources do you think are lacking in our community? What health information is lacking in our community? How could this information best reach you and our community?
Do you have any ideas for how to improve health/address health issues in our community?
Do you have any other feedback/thoughts to share with us?

THINGS PEOPLE LOVE ABOUT THE COMMUNITY FROM INTERVIEWS & FOCUS GROUPS

"It's a small community, but everyone we take care of each other. It's a very peaceful community. I say, very, very caring, loving people here."

Community Member Interview

"I think things around here tend to be for the most part pretty wholesome and traditional values."

Community Member Interview

"I love that people are so helpful, and willing to help others. Even when you don't know the needs of those people, we still can come together and be cooperative."

Community Member Interview

"The county is small, and I'm always running into friends or family. I enjoy raising a family here."

Community Member Interview

"Our community is very welcoming, secure, and safe."

Community Member Focus Group

"I enjoy how tight-knit the community is. If something happens, everyone just comes together."

Community Member Focus Group

"People are very hardworking here, and it makes a great community."

Community Member Interview

"We are a resourceful county and are able to keep our children and future generations here."

Community Member Interview

"We have really beautiful walking exercise paths... beautiful parks. They're amazing. We're blessed in this county to have several very nice walking areas parks."

Community Member Interview

TOP PRIORITY HEALTH NEEDS FROM INTERVIEWS & FOCUS GROUPS

FROM COMMUNITY INTERVIEWS:

Major health issues impacting community:
- Access to healthcare
- Nutrition and physical health
- Mental health

Top socioeconomic, behavioral, and/or environmental factors impacting community:
- Lack of transportation/walkability
- Mental health stigma
- Employment opportunities/job availability

FROM COMMUNITY FOCUS GROUPS:

Major health issues impacting community:
- Transportation barriers
- Mental health
- Access to healthcare

How health concerns are impacting community:
- Economic/financial strain
- Avoid/delay getting needed care
- Have to travel outside community for certain resources

"The need for transportation in general is difficult. Many people don't have their own vehicles, and they have to ask for rides from other people. And then that depends on whether or not they have availability to do it."

Community Member Interview

"We don't have grocery stores that are really within walking distance of a lot of our population."

Community Member Interview

"There is still a bit of a stigma with people, although not as much as there used to be, in seeking behavioral health care."

Community Member Interview

"Inflation has its trickle-down effect. People are having to make decisions about filling prescriptions, keeping medical appointments, and their ability to purchase healthy food, or enough food."

Community Member Interview

"It would be nice to see more doctors coming out to the area, because when you're elderly, you might not want to drive out far. Having local doctors is a good thing."

Community Member Focus Group

"Transportation [and the] ability to get to appointments is a big issue we see with our clients."

Community Member Focus Group

TOP PRIORITY GROUPS & RESOURCES FROM INTERVIEWS & FOCUS GROUPS

FROM COMMUNITY INTERVIEWS:

Sub-populations in the area that face barriers to accessing healthcare and social services:
- Low-income population
- Elderly/aging population
- Those with disabilities

FROM COMMUNITY FOCUS GROUPS:

Sub-populations in the area that face barriers to accessing healthcare and social services:
- Those without transportation
- Elderly/aging population
- Non-English speakers

Resources people use in the community to address their health needs:
- Fulton County Health Department
- Senior Center
- Churches

Top resources that are lacking in the community:
- Public transportation system
- Mental health services
- Communication of available resources

"I think overwhelmingly everyone's struggling with being able to just maintain basic needs."

Community Member Interview

"We live in a rural area, and we don't have great ride availability. If you don't drive by private vehicle, we don't have a ton of sidewalks, you know. So just from that aspect alone, we're definitely going to see some disparities there."

Community Member Interview

"There is some low-income housing available, but there's also a long waitlist which is an issue for someone in a dire situation with no place to stay."

Community Member Interview

"We have several communities that have a Dollar General as their grocery store. Transportation dictates this, and with the lack of health food it leads to health issues"

Community Member Interview

"There should be more exposure to resources available in Fulton County."

Community Member Focus Group

"Yes, there are [mental health] providers in our community, but affordability of that care is an issue."

Community Member Focus Group

"[People who] don't have cars or don't drive struggle to get to appointments or work."

Community Member Focus Group

TOP FINDINGS FROM FOCUS GROUPS

SENIORS:

Participants emphasized the senior center's role as Fulton County's most valued community hub and expressed urgent concerns about the need for additional local doctors, mental health services, and transportation options.

- **Top health issues** include hypertension, high cholesterol, diabetes, heart disease, pulmonary and kidney conditions, and mental health challenges such as depression and social isolation.
- **Access barriers** include lack of transportation, limited local specialists, high prescription costs, insurance acceptance issues, emergency room overcrowding, and communication gaps due to language and limited awareness of available resources.
- **Existing resources** include Fulton County Health Center, the senior center, local churches, community meals, limited transportation services, and VA programs for veterans.
- **Resource gaps** exist for public and non-medical transportation, senior-focused physical therapy and fall prevention, affordable healthcare and prescriptions, mental health counseling, assisted living/memory care, caregiver respite, and centralized community information.
- **Improvement suggestions** were recruiting more providers, expanding emergency room capacity, developing public and volunteer transportation, creating prescription assistance programs, building local assisted living facilities, enhancing caregiver support, expanding senior center programs, and improving promotion of community resources through centralized and regularly updated communication systems.

PARENTS:

This group prioritized youth and family mental health as their foremost concern while identifying critical gaps in accessible healthcare, childcare availability, and comprehensive support services.

- **Primary health concerns** include youth and family mental health issues (depression, self-harm, isolation), childhood obesity, insufficient prenatal and women's healthcare, shortage of specialized pediatric and neurology services, and inadequate support for children with special needs.
- **Barriers to care** encompass lack of public transportation, extensive travel requirements for specialized services, cost prohibitive services (particularly dental and mental health), language obstacles, and insurance coverage gaps among young adults working in trades or small businesses.
- **Current resources** include the Fulton County Health Department, the Board of Developmental Disabilities, the Crisis Pregnancy Center, Wauseon Recreation programs, and virtual appointment applications.
- **Service gaps** were identified in mental health urgent care, speech and occupational therapy, pediatric specialists, after-school childcare, transportation alternatives, housing and clothing assistance, translation services, and a centralized resource directory.
- **Recommended improvements** included expanding mental health education for parents, teachers, and coaches; educating students about social media impacts; developing a comprehensive, well-promoted county resource list; organizing regular health fairs; establishing mentor programs and adult education; and increasing school-based after-care options.

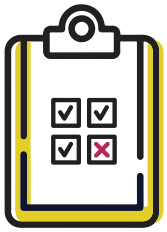
TOP FINDINGS FROM FOCUS GROUPS

HISPANIC/LATINO:

Participants described how the Hispanic/Latino community relies extensively on informal support networks—including family members, churches, and volunteers—for translation assistance, general support, and healthcare navigation, while facing substantial challenges related to language barriers, financial constraints, transportation limitations, and documentation concerns.

- **Most prevalent health issues** include cancer, hypertension, insufficient preventive care, dental health needs, and widespread limited access to pediatric and specialty medical services.
- **Obstacles to accessing care** include insufficient translation services, prohibitive healthcare expenses, lack of insurance coverage, transportation limitations, documentation-related challenges, and experiences of discrimination.
- **Available resources** include the health department, Fulton County Health Center, local churches, and volunteer/community-based translators.
- **Identified service gaps** encompass preventive health education, mental health services, Spanish-speaking healthcare providers, medical transportation, and coordinated community information sharing systems.
- **Proposed enhancements** included expanding interpreter and Spanish-language services, providing free or reduced-cost healthcare and transportation, establishing WhatsApp groups for health information dissemination, increasing preventive education and social support activities, and ensuring respectful, culturally competent care regardless of documentation status.

PRIMARY DATA COLLECTION
COMMUNITY MEMBER SURVEY



The health department, hospital, and community partners shared the online community survey link with clients, patients, and others who live and/or work in the community. Additionally, other methods were used to distribute the survey to the community such as each key informant interview participant was asked to complete it. The survey was available in English and Spanish. This resulted in **501 responses** to the community survey. The results of how the health needs were ranked in the survey for Fulton County are found in the tables below, separated by community conditions (including social determinants of health, health behaviors, and access to care) and health outcomes. In cases where health needs were ranked equally, we applied a secondary ranking criterion based on the frequency of mentions in key informant interview analysis, with higher-frequency needs becoming priority in the ranking. More details about the survey, questions, and demographics can be found in **Appendix E**.

COMMUNITY CONDITIONS RANKING FROM COMMUNITY MEMBER SURVEY	
#1 Access to healthcare	36%
#2 Nutrition & physical health/exercise	28%
#3 Substance use	27%
#4 Transportation	25%
#5 Access to childcare	24%
#6 Income/poverty	22%
#7 Adverse childhood experiences (ACEs)	22%
#8 Food insecurity	18%
#9 Employment/work	15%
#10 Community engagement	14%
#11 Housing and homelessness	12%
#12 Preventive care and practices	9%
#13 Tobacco and nicotine use/smoking/vaping	9%
#14 Crime and violence	7%
#15 Internet/WI-FI access	7%
#16 Environmental conditions	7%
#17 Education	5%
#18 Addiction to gambling, gaming, or sports betting	2%

HEALTH OUTCOMES RANKING FROM COMMUNITY MEMBER SURVEY	
#1 Mental health	89%
#2 Chronic diseases	80%
#3 Disabilities	39%
#4 Maternal, infant, and child health	20%
#5 Infectious diseases	20%
#6 Injuries	17%
#7 HIV/AIDS and Sexually Transmitted Infections (STIs)	2%

HEALTH NEEDS

COMMUNITY CONDITIONS

HEALTH NEEDS: COMMUNITY CONDITIONS

The following pages rank the community conditions category of health needs, which include the social determinants of health, health behaviors, and access to care. They are ranked and ordered according to the overall Fulton County ranking from the community member survey, as seen on page 29. Note that not every health need has its own section, and some health needs have been combined to form larger categories, such as mental health. Each health need section includes a combination of different data sources collected from our community: secondary (existing) data, and primary (new) data – from the community member survey, key informant interviews with community leaders, and focus groups with community members. Priority populations who are most affected by each health need and experience health disparities are also shown. Finally, where applicable, the Healthy People 2030 goals are highlighted, including the performance of Fulton County and the state compared to the benchmark goal.

Fulton County PARTNERS FOR HEALTH
Building a Healthy Community

#1 Health Need: ACCESS TO HEALTHCARE

83% of Fulton County survey respondents **had a routine checkup in the past year**, which is **higher** than the Ohio state average of 77%.[2]

77% of survey respondents **visited a dentist or dental clinic in the past year**, which is **more than** the Ohio average of 64%.[6]

IN OUR COMMUNITY

Fulton County has fewer primary and dental care providers relative to its population when comparing the ratios to Ohio.[4]

FULTON COUNTY	OHIO
**2,653:1[4]	**1,328:1[4]

***residents : primary care providers*

FULTON COUNTY	OHIO
***2,220:1[4]	***1,535:1[4]

****residents : dental care providers*

BARRIERS TO CARE

18% of survey respondents experienced **barriers** to getting needed **prescription medication** in the past year. The top reported barriers include:

- Too expensive (10%)
- I did not think I needed it (3%)
- Side effects (3%)

32% of survey respondents received care **outside** Fulton County **due to services not being available locally**. The top services respondents reported travelling for were:

- Specialty care (36%)
- Dental services (32%)
- Primary care (22%)

36%

of community survey respondents say access to healthcare is a **priority need**.

Over 1 in 5 (22%)

community survey respondents say that **specialist care** is lacking in the community. **17%** say dental care access is lacking, **13%** say primary healthcare access is lacking, **7%** say vision care access is lacking, and **7%** say hospital/acute/emergency care is lacking.

COMMUNITY FEEDBACK

"I think there is a lack of providers that take Medicaid, even dental care."

Community Member Interview

"Sometimes to see a specialist, we have to drive so far away, so it can impede access for some people."

Community Member Interview

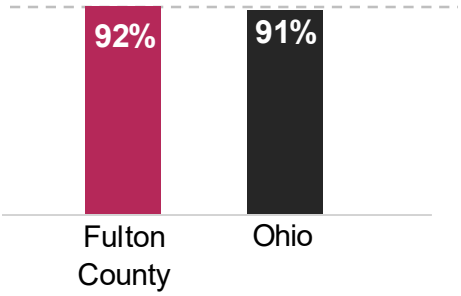
"We are very rural, so there are a lot of people who don't have a primary care physician. They rely on ERs and urgent cares."

Community Member Interview

#1 Health Need: ACCESS TO HEALTHCARE

HEALTHY PEOPLE (HP) 2030 NATIONAL TARGETS

ADULT HEALTH INSURANCE COVERAGE



HP 2030 TARGET: 92%

DESIRED DIRECTION: ↑

- ✓ Fulton County meets the target.[1]
- ✗ Ohio does not yet meet the target.[1]

COMMUNITY FEEDBACK

"People are struggling to access and mitigate their health issues because they wait until its an emergency, because they don't have the money."

Community Member Interview

INTERVIEW AND FOCUS GROUP FINDINGS

Top issues/barriers:
- Transportation barriers
- Healthcare/insurance cost
- Specialist access issues
- Healthcare provider shortage

Sub-populations most affected:
- Elderly/aging population
- Immigrants/international students
- Rural population
- Individuals with disabilities

Top resources, services, programs, and/or community efforts:
- Fulton County Health Department
- Fulton County Job and Family Services
- Fulton County Health Center

PRIORITY POPULATIONS

ACCESS TO HEALTHCARE

While **access to healthcare** is a potential concern for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

Community survey respondents from **Wauseon (43567)** and **Swanton (43558)** were more likely than those from other areas to have not visited a dentist within the past 5 years.

Survey respondents **ages 45-64** were more likely than other respondents to rate access to healthcare as a priority health need.

In the community survey, **women** were more likely than men to report traveling outside Fulton County to receive care.

Survey respondents with an **income of $20,000-$24,999** were more likely to report access to healthcare as a top concern.

Healthcare access barriers were highlighted in the **Seniors, Parents, and Hispanic/Latino** focus groups.

According to the 2025 Edelman Trust Barometer Special Report, **younger people (ages 18-34)** are more likely to take uncredentialed health advice.[13]

#2 Health Need: NUTRITION & PHYSICAL HEALTH

IN OUR COMMUNITY

28%

of community survey respondents ranked nutrition and physical health as a **priority health need.**

18% of survey respondents reported being **physically active** for at least 30 minutes on **3 days in the past week**. **12%** of respondents reported being active **every day**, while **13%** were active on **no days** in the past week.

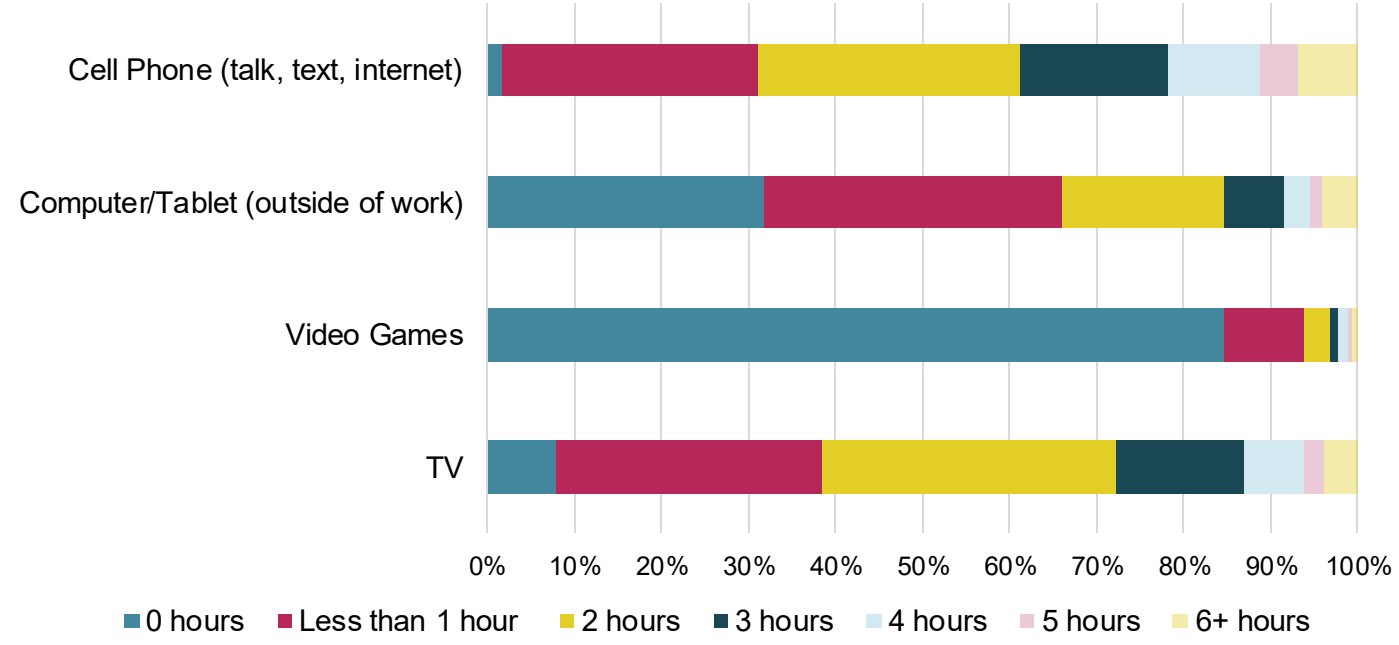
In the community member survey, respondents reported doing the following to **lose weight or keep from gaining weight**:

- Eat less food or fewer calories (57%)
- Drink more water (55%)
- Exercise (49%)
- Take medications prescribed by a health professional (16%)

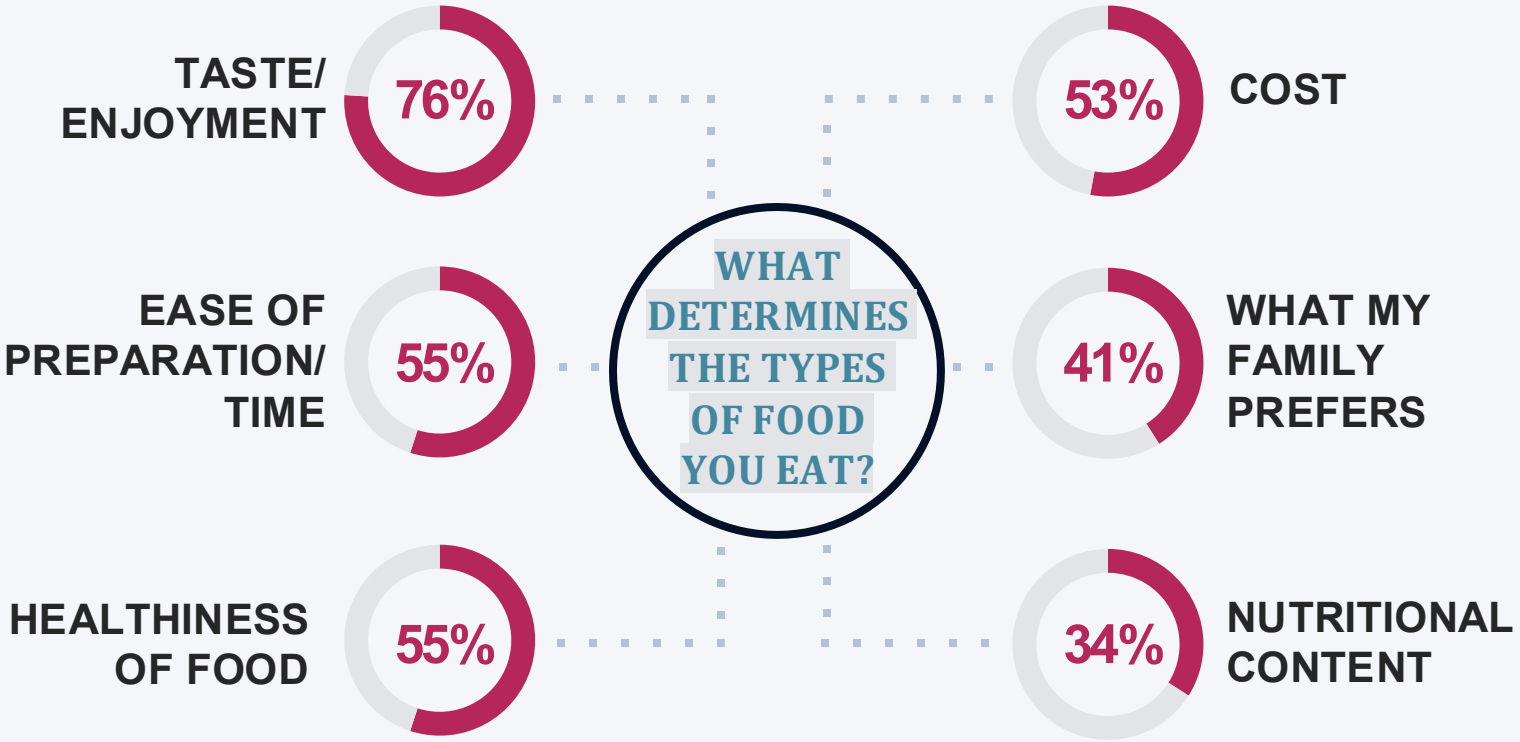
12% of community survey respondents **say that recreational spaces are lacking** in Fulton County.

The **majority** of survey respondents reported spending **2 hours or less** on the **non-active activities** shown below.

Cell phone use (39%) was the most reported activity that respondents spent 3 or more hours on, followed by watching TV (28%) and computer/tablet use (15%).



#2 Health Need: NUTRITION & PHYSICAL HEALTH



Reported in community member survey.

COMMUNITY FEEDBACK

"A lot of people talk about affordability of produce and a grocery store drought because we are so rural. In the wintertime, it's hard, and people have to make an effort to go to the store."

Community Member Interview

"Physical therapy for seniors would be helpful, like balance classes or yoga."

Community Member Focus Group

"There needs to be constant education to remind people how to spend their dollars to be nutritionally beneficial."

Community Member Interview

INTERVIEW AND FOCUS GROUP FINDINGS

Top issues/barriers:
- Healthy food access barriers
- Cost/affordability barriers
- Limited walkability/transportation

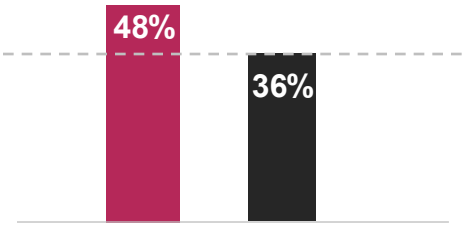
Sub-populations most affected:
- Rural population
- Elderly/aging population
- Children

Top resources, services, programs, and/or community efforts:
- Food pantries
- Farmers markets
- Local churches

#2 Health Need: NUTRITION & PHYSICAL HEALTH

HEALTHY PEOPLE (HP) 2030 NATIONAL TARGETS

ADULT OBESITY



HP 2030 TARGET: 36%

DESIRED DIRECTION: ↓

✗ Fulton County does not yet meet the target.

✓ Ohio meets the target.[43]

**As reported in the 2025 Fulton County community member survey.*

COMMUNITY FEEDBACK

"The group that accesses fast food because it is cheap is the economically deprived, and that's why you're going to gravitate towards that."

Community Member Interview

"So, we're fortunate that we still have a small grocery store in the community. We're fearful that we're going to lose that store in the near future if it's not doing well financially."

Community Member Interview

"There is such a financial barrier for people to afford healthy food, but I think we should keep educating because it doesn't have to be expensive."

Community Member Interview

PRIORITY POPULATIONS

NUTRITION & PHYSICAL HEALTH

While **nutrition and physical health** are potential concerns for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

Community survey respondents from **Delta (43515)** were more likely to report recreational spaces as a lacking resource in the community.

Female community survey respondents were slightly less likely than males to report their overall health as 'very good' or 'excellent'.

Community survey respondents with a **high school degree or equivalent** were significantly less likely than those with a post-graduate degree to say that the healthiness of food determines the type of food they eat.

On the community survey, respondents **ages 45-64** were more likely to report nutrition and physical health as a top health concern.

Community survey respondents with **lower household incomes** were more likely to report exercising on 0 days in the past week.

#3 Health Need: ADDICTION & SUBSTANCE USE

Trigger Warning: The following pages discuss problematic substance use and overdose, which may be disturbing for some people and trigger unpleasant memories or thoughts. You can call the 988 Suicide & Crisis Lifeline at 988 for 24-hour, confidential support.

IN OUR COMMUNITY

In the community survey, **27%** of Fulton County respondents reported **substance use** as a top concern, and **2%** ranked **addiction to gambling, gaming, or sports betting** as a top concern.

17% said that **substance use treatment/harm reduction services are lacking** in the community.

ACCORDING TO THE COMMUNITY MEMBER SURVEY, IN THE PAST 6 MONTHS:	
8%	of respondents reported that either they or a household member **drank more than they expected**.
6%	of respondents reported that either they or a household member **drove a vehicle/other equipment after having an alcoholic beverage**.
4%	of respondents reported that either they or a household member **generally spent a lot of time drinking**.

COMMUNITY FEEDBACK

"I feel that alcohol is an unrecognized problem. And just helping people to understand the long-term effects, whether it's impact on cancer or impact on mental health, [is needed]. I do feel like [we need] more education on the concerns of alcohol use, though it often falls on deaf ears. So that's a challenge."

Community Member Interview

4% of both Fulton County and Ohio **traffic crashes** in 2024 were **OVI* related**.[44]

**OVI: Operating a Vehicle Impaired (i.e., under the influence of alcohol or drugs).*

2% of community survey respondents said they have **used marijuana recreationally in the past 30 days.**

1% of community survey respondents reported that in the past 6 months, either they or someone in their household **misused prescription medication.**

INTERVIEW AND FOCUS GROUP FINDINGS

Top issues/barriers:
- Drug overdose
- Access to treatment

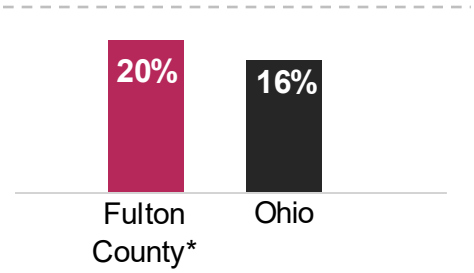
Sub-populations most affected:
- Youth/adolescents
- Disadvantaged population

Top resources, services, programs, and/or community efforts:
- ADAMHS Board
- Narcan
- Local AA meetings
- Catch My Breath Program

#3 Health Need: ADDICTION & SUBSTANCE USE

HEALTHY PEOPLE (HP) 2030 NATIONAL TARGETS

ADULT BINGE OR HEAVY DRINKING

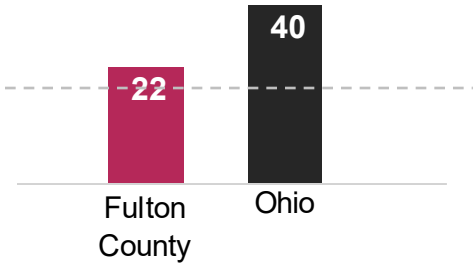


HP 2030 TARGET: 23%
DESIRED DIRECTION: ↓

✓ Fulton County and Ohio exceed the target.[43]

**As reported in the 2025 Fulton County community member survey.*

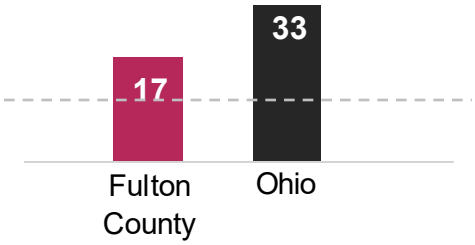
UNINTENTIONAL DRUG OVERDOSE DEATHS PER 100,000



HP 2030 TARGET: 20.7 per 100,000
DESIRED DIRECTION: ↓

✗ Fulton County and Ohio do not yet meet the target. Note that only crude rates were available.[14]

OPIOID OVERDOSE DEATHS PER 100,000



HP 2030 TARGET: 13.1 per 100,000
DESIRED DIRECTION: ↓

✗ Fulton County and Ohio do not yet meet the target. Note that only crude rates were available.[39]

PRIORITY POPULATIONS

ADDICTION & SUBSTANCE USE

While **addiction & substance use** are potential concerns for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

Survey respondents from **Delta (43515)** were more likely to rate substance use as a top concern.

In the community survey, **men (26%)** were more likely than women (19%) to report binge/heavy drinking at least 1 day in the past month.

Survey respondents with a household income of **$50,000-$149,999** were more likely to report having 'spent a lot of time drinking' in the past 6 months.

18-34-year-old survey respondents were more likely to say they used marijuana edibles in the past month.

At-risk or problem gambling is highest among Ohio **18–24-year-olds**.[15]

#4 Health Need: TRANSPORTATION

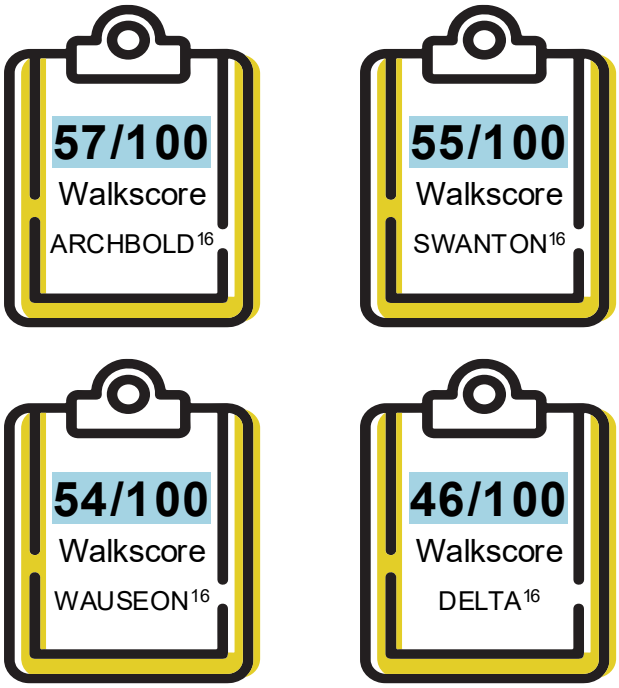
25% of community survey respondents reported **transportation** as a top health need in Fulton County.

IN OUR COMMUNITY

36% of community survey respondents say that **transportation is lacking** in Fulton County.

The **top transportation issues** reported in the community survey were **general car issues/expenses (4%), no public transportation available/accessible (4%), and not being able to afford gas (2%)**.

When analyzing the most populous places in **Fulton County,** according to Walkscore.com*, most areas were **'Somewhat Walkable',** with Delta being **'Car Dependent.'**[16]



**Scores are determined by analyzing walking routes to nearby amenities (e.g., groceries, dining, schools, parks). Points are awarded based on the distance to amenities and also factors in pedestrian friendliness by analyzing population density and road metrics.*

According to the **American Community Survey**:

89% of Fulton County residents **drive alone to work**, compared to 77% for Ohio.[1]

2% of Fulton County and Ohio residents **walk** to work, and **less than 1%** use **public transportation** (vs. 1% for Ohio).[1]

The average **daily commute time** for Fulton County workers **(23 minutes)** is the same as that for Ohio.[1]

COMMUNITY FEEDBACK

"We have really limited safe spaces to walk or ride a bike. In town it's pretty good, but there are challenges if you live only a mile or more outside of town."

Community Member Interview

#4 Health Need: TRANSPORTATION

COMMUNITY FEEDBACK

"Unless you have a private vehicle, there is no other options. We do not have Ubers, Lyfts, or taxi cabs. There is no county transportation either."

Community Member Interview

"Transportation is needed specifically for discharge from the hospital. Our biggest issue is once a persons been brought by the EMS, they have no other option to make it back home."

Community Member Interview

"Most senior transportation offered has to be for medical appointments. This doesn't even cover if you need to go pick up a prescription."

Community Member Focus Group

INTERVIEW AND FOCUS GROUP FINDINGS

Top issues/barriers:
- Limited public transportation
- Safety issues
- Lack of coverage in rural areas

Sub-populations most affected:
- Elderly/aging population
- Individuals with disabilities
- Low-income population

Top resources, services, programs, and/or community efforts:
- Senior Center
- Medicaid transportation
- Bike trails
- Board of Developmental Disabilities
- ADAMHS Board and Triangular Processing
- Church organizations
- Fulton County Veterans Office

PRIORITY POPULATIONS

TRANSPORTATION

While **transportation** is a potential concern for the entire community, some groups are more likely to be affected by this health need, based on data we collected from our community…

Community survey respondents with **lower household incomes** were more likely to say they experienced the transportation issues of not being able to afford gas or other car expenses.

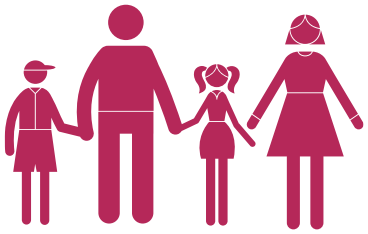
Survey respondents **ages 45-54 and 65+** were significantly more likely to rank transportation as a top concern in the community than those ages 35-44.

Survey respondents with a **college degree** were significantly more likely than those with a high school degree/equivalent or some college or technical school to report transportation as a priority need in the community.

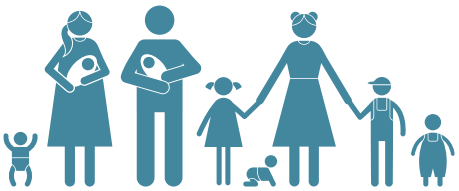
Community survey respondents from **Swanton (43558)** were more likely to report transportation as a resource that is lacking in the community than those from other areas.

#5 Health Need: ACCESS TO CHILDCARE

IN OUR COMMUNITY



The average two-child Fulton County household spends 24% of its income on childcare, compared to **32%** for Ohio.[4]

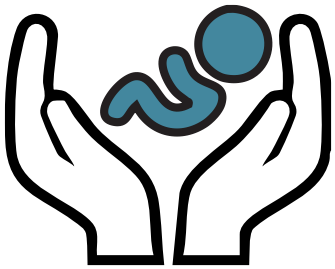


CHILDCARE AVAILABILITY

FULTON COUNTY 5

OHIO 6

Fulton County has **5 licensed child care centers per 1,000 children under 5 years old**, compared to **6** for Ohio.[53]



24% of Fulton County community survey respondents reported that **access to childcare** is a top community issue.

31% of community members surveyed reported that **access to childcare resources is lacking in the community**.

According to the 2024 Ohio Childcare Resource & Referral Association Annual Report, the average cost of childcare in Ohio ranges from **$8,631** per year (for school-aged children cared for outside of school hours) to **$13,859** per year (for infants under one year of age).[17]

73% of Ohioans surveyed say that quality childcare is expensive locally.[18]

According to the 2024 Groundwork Ohio statewide survey, **49% of working parents** stated that they have had to **cut back on working hours to care for their children.**[18]

#5 Health Need:
ACCESS TO CHILDCARE

COMMUNITY FEEDBACK

"I think the biggest issues are cost and availability for childcare. People are desperate for childcare."

Community Member Interview

"Local daycares are so expensive, so it keeps people from being able to go out and get a job."

Community Member Interview

"When multiple families live under one roof, a lot of times that care is falling onto our seniors and grandparents. They're not equipped to handle that at this point."

Community Member Interview

"I think schools should help provide after-care for children, especially those who get released earlier while their parents are still working."

Community Member Focus Group

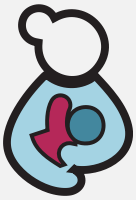
"I think child safety is also a concern. Families may not be making good choices on who they leave their children with."

Community Member Interview

PRIORITY POPULATIONS

ACCESS TO CHILDCARE

While **access to childcare** is a potential concern for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…



Community survey respondents from **Wauseon (43567) and Archbold (43502)** were more likely to report access to childcare as a priority need.

According to the community survey, Fulton County residents **ages 25-44** were more likely to rank childcare as a top health concern than residents of other ages. They were also more likely to report that access to childcare resources is lacking in the community.

Female survey respondents were significantly more likely than males to rank access to childcare as a priority concern.

INTERVIEW AND FOCUS GROUP FINDINGS

Top issues/barriers:
- Cost barriers
- Limited availability
- Schedule/hour constraints

Sub-populations most affected:
- Low-income families
- Hispanic population
- Parents who work rotating shifts
- Transient community

Top resources, services, programs, and/or community efforts:
- Job and Family Services (JFS)
- Head Start
- Child Protective Services

#6 Health Need: INCOME/POVERTY & EMPLOYMENT

Economic stability includes **income**, **employment**, **education,** and many of the most important social factors that impact the community's health.

8% of low-income Fulton County adults **utilize food stamps**, vs. **12%** for Ohio.[1]

5% of Fulton County and Ohio residents are **unemployed**.[45]

IN OUR COMMUNITY

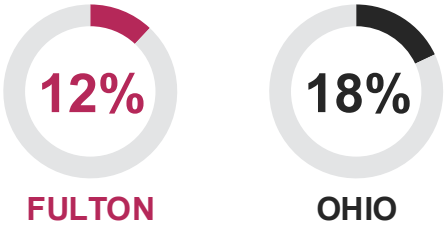
FULTON COUNTY: $72,866
OHIO: $67,873

Fulton County's median household income **($72,866)** is **higher** than the state average for Ohio **($67,873)**.[1]

POVERTY RATE

The **overall poverty rate** is **slightly lower** for Fulton County **(9%)**, compared to Ohio **(13%)**.[1]

CHILD POVERTY RATE



The child poverty rate for Fulton County **(12%)** is **slightly lower** than the rate for Ohio **(18%)**.[1]

22%

of community survey respondents reported **income and poverty** as a **top health need** in Fulton County, and **33%** reported that **quality, well-paying jobs are lacking** in the community.

COMMUNITY FEEDBACK

"If you don't have access to transportation, you're not getting to work or places to be trained to obtain a job."

Community Member Interview

#6 Health Need: INCOME/POVERTY & EMPLOYMENT

ALICE* data looks at households that earn more than the federal poverty level, but less than the basic cost of living for the county.

ACCORDING TO 2023 ALICE* DATA:[20]	
24%	of Fulton County are ALICE households, compared to **25%** for Ohio.
9%	of Fulton County households live in poverty, compared to **14%** for Ohio.

**ALICE: Asset Limited, Income Constrained, Employed.*

COMMUNITY FEEDBACK

"Many times, people won't go to the hospital because it costs too much for the service, and if they need it, they can't pay for it because they have a limited income."

Community Member Focus Group

"There is poverty in our northern regions because of the industry not being there, and employment is an issue."

Community Member Interview

INTERVIEW AND FOCUS GROUP FINDINGS

Top issues/barriers:
- Transportation barriers
- Financial/income challenges
- Childcare barriers
- Workforce issues (can't find people to work, work ethic)

Sub-populations most affected:
- Low-income population
- Immigrant Population
- Elderly/aging population

Top resources, services, programs, and/or community efforts:
- Job and Family Services
- Ohio Means Jobs
- Local churches

PRIORITY POPULATIONS

INCOME/POVERTY & EMPLOYMENT

While **income/poverty and employment** are potential concerns for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

Delta has a lower median income and experiences higher poverty levels than other areas in Fulton County.[1]

In the community survey, those with a **high school degree or equivalent** were more likely than those with higher educational levels to have a lower household income.

Female community survey respondents were less likely to report a household income of $100,000 or more than males. However, **males** were significantly more likely to rate employment/work as a top concern.

35–44-year-old community survey respondents were significantly more likely to rate income/poverty as a top concern than respondents ages 55+.

A family of four in Ohio with one infant and one preschool child in childcare **needs $79,224 a year** to afford health care and other basic essential needs. **A family of four in Fulton County would need $75,240.**[20]

#7 Health Need: ADVERSE CHILDHOOD EXPERIENCES

Trigger Warning: The following page discusses trauma and abuse, which may be disturbing for some people and trigger unpleasant memories or thoughts. You can call the 988 Suicide & Crisis Lifeline for 24-hour, confidential support.

Over half (55%) of Fulton County survey respondents report having experienced **at least one ACE,** compared to **67%** for Ohio adults.[6]

IN OUR COMMUNITY

22% of survey respondents said that **ACEs** are a top concern in the community.

FULTON COUNTY	1.8
OHIO	4.0

Fulton County (1.8) has a **lower** rate of substantiated child abuse reports per 1,000 children than the state of Ohio **(4.0)**.[12,19]

According to the community member survey, the most commonly reported ACEs among Fulton County respondents are:

- Household separation or divorce (24%)
- Household mental illness (22%)
- Emotional abuse (20%)
- Household alcohol abuse (20%)

COMMUNITY FEEDBACK

"A child raised in poverty is more likely to remain in poverty as an adult, as this is all they have known."

Community Member Interview

"A lot of these issues are linked to drug and sexual abuse."

Community Member Interview

PRIORITY POPULATIONS

ADVERSE CHILDHOOD EXPERIENCES

While **adverse childhood experiences** are a potential concern for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

Children with the following **risk factors** are more likely to be impacted by ACEs:[40]

- Lower income
- Precarious housing/homelessness
- Parents have mental health and/or substance use challenges
- Witnessing violence/incarceration
- Parents are divorced/separated
- Lack of connection to trusted adults

More survey respondents from **Archbold (43502)** ranked ACEs as a top concern in the area.

INTERVIEW AND FOCUS GROUP FINDINGS

Top issues/barriers:
- Barriers to mental/behavioral healthcare
- Abuse
- Limited available resources

Sub-populations most affected:
- Children who have experienced trauma
- Elderly/aging population

Top resources, services, programs, and/or community efforts:
- ADAMHS Board
- Adoption and Foster Care Programs
- Backpack Programs

#8 Health Need: FOOD INSECURITY

18% of survey respondents ranked **food insecurity** as a top health concern.

When asked what community resources were **lacking** in the community member survey, **23%** of respondents answered **affordable food.**

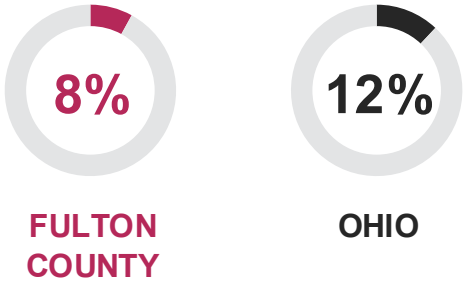
IN OUR COMMUNITY

According to Feeding America, **15% of Fulton County and Ohio residents experience food insecurity**.[21]

8% of community survey respondents reported experiencing **food access barriers**, including:

- Having to choose between paying bills and buying food (5%)
- Going hungry/eating less to provide more food for their family (4%)
- Worrying their food would run out (3%)

A **lower rate** of Fulton County than Ohio households access **Supplemental Nutrition Access Program (SNAP) benefits** (**8% vs. 12%**).[1]



FULTON COUNTY | OHIO

Fulton County's **food environment rating** (which includes access to healthy foods and food insecurity) out of 10 (0 being worst and 10 being best) is **8.1/10**, while Ohio's is **7.0/10**.[4]

8.1/10 FULTON COUNTY

7.0/10 OHIO

#8 Health Need: FOOD INSECURITY

COMMUNITY FEEDBACK

"There is the challenge of finances for those who are in between qualifying for food stamps."

Community Member Interview

"Overall junk food costs less than healthy foods. This can be a challenge."

Community Member Interview

"We don't have any grocery stores that are [within] walking distance of a large part of our population."

Community Member Interview

"We need education on understanding the importance of nutritional eating, the impact on mental health/brain processing, and warding off chronic diseases. Just knowing how important all of that is.

Community Member Interview

INTERVIEW AND FOCUS GROUP FINDINGS

Top issues/barriers:
- Limited grocery store access
- Cost barriers to healthy food
- Travel/transportation to get healthy food

Sub-populations most affected:
- Rural population
- Low-income population
- Elderly/aging population

Top resources, services, programs, and/or community efforts:
- Food pantries
- Farmers' market
- Community meals

PRIORITY POPULATIONS

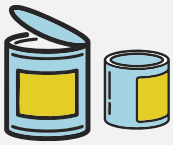
FOOD INSECURITY

While **food insecurity** is a potential concern for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

According to the Hunger in Ohio 2024 report, **minority populations** often experience higher rates of food insecurity due to disparities in employment, education, and access to resources.[22]

6% of Fulton County residents have limited access to healthy foods (**are low-income** and **do not live close to a grocery store**).[4]

Community survey respondents **25-34 years old** were more likely than other respondents to say they experienced food access issues, including going hungry/eating less to provide more for their family, having to choose between paying bills and buying food, and worrying that their food would run out.



29% of community survey respondents with a **household income of $35,000-$49,999** reported that affordable food is lacking in the community.

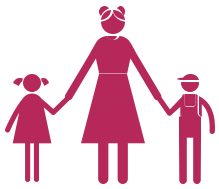
Community survey respondents from **Fayette (43521)** were more likely to report affordable food as a lacking resource in the community.

#9 Health Need: HOUSING & HOMELESSNESS

12% of community survey respondents ranked **housing and homelessness** as a priority health need, while **47%** of survey respondents reported **affordable housing** as a resource that is lacking in the community. **Affordable housing was the #1 reported resource needed in Fulton County in the community survey.**

IN OUR COMMUNITY

1% of Fulton County and Ohio households are considered **"crowded"** (more than one occupant per bedroom). Housing overcrowding is often a marker of poverty and social hardship.[23]



96% of community survey respondents reported that they have a **steady place to live**, while **3%** said that they are **worried about losing their housing** in the future.

Freddie Mac estimates that the **vacancy rate** should be **13%** in a well-functioning housing market. There was only a **5%** vacancy rate in Fulton County in 2023, while this was **8%** for Ohio.[23]

33% of Fulton County renters experience **severe housing cost burden** (spend 30% or more of their income on housing), vs. **45%** for Ohio.[23]

1% of both Fulton County and Ohio households experience **severe housing problems** (lack of kitchen facilities and/or lack of plumbing facilities).[23]

COMMUNITY FEEDBACK

"I believe there is some lower income housing, but there's also a wait list. So, if you have someone in a dire situation, they may not have a place to stay."

Community Member Interview

"Housing is obviously very expensive. There are many people who struggle with finding affordable housing, but who also have a health issue, causing them not to work. Then they don't have any income, making it even harder."

Community Member Interview

In 2025, the **homelessness** point-in-time count was reported as **3** in Fulton County.[24] Note that this count likely does not account for all who may be experiencing homelessness, as it is an observation from one day.

Data shows that **13%** of Fulton County and Ohio households are **seniors who live alone**. Seniors living alone may be isolated and lack adequate support systems.[12]

#9 Health Need: HOUSING & HOMELESSNESS

COMMUNITY FEEDBACK

"We definitely have an issue with affordable housing. Affordability is the greatest challenge especially those who are disabled or on Medicaid. There are some reduced-cost housing options, but the waitlists are too long."

Community Member Interview

"Many of our seniors will have to leave town for assisted living, so that's something I would like to see improved."

Community Member Focus Group

"Some of the homelessness stems from mental health issues not being treated."

Community Member Interview

"There is a high homeless rate in Fulton County, many of those people are veterans."

Community Member Focus Group

INTERVIEW AND FOCUS GROUP FINDINGS

Top issues/barriers:
- Limited/no affordable housing
- Homelessness
- Not enough housing in general

Sub-populations most affected:
- Low-income population
- Those struggling with mental health
- Elderly/aging population

Top resources, services, programs, and/or community efforts:
- Job and Family Services (JFS)
- Local homeless shelters
- Low-income housing

PRIORITY POPULATIONS

HOUSING & HOMELESSNESS

While **housing and homelessness** are potential concerns for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

Delta experiences higher rates of rental housing cost burden than Fulton County overall.[23]

25–44-year-old community survey respondents were more likely to say they are concerned about losing their housing than other age groups.

Women who responded to the community survey were more likely than men to report affordable housing as a resource that is lacking in the community.

Community survey respondents with a **high school degree/equivalent** were significantly more likely to report being worried about losing their housing than those with a post-graduate degree.

Community survey respondents with a **household income of $25,000-$34,999** were the most likely to report affordable housing as a lacking resource.

#10 Health Need: PREVENTIVE CARE & PRACTICES

IN OUR COMMUNITY

9%

of community survey respondents said that addressing **preventive care and practices** in Fulton County is a top concern.

ACCORDING TO THE FULTON COUNTY COMMUNITY MEMBER SURVEY:	
87%	of respondents age 65+ have had a **pneumonia vaccine** in their lifetime.
79%	of those age 65+ have had a **seasonal flu (influenza) vaccine** in the past year.
36%	have had a **zoster (Shingles) vaccine** in their lifetime.
22%	have had a **COVID vaccine** in the past year.

Over half (57%)

of Fulton County survey respondents age 45+ have **had a colonoscopy or sigmoidoscopy in the past 5 years,** while 26% have never had one.

79%

of female survey respondents age 35+ have **had a mammogram in the past 2 years,** while 10% have never had one.

72%

of female survey respondents age 18-64 have **had a pap smear within the past 3 years,** while 2% have never had one.

Nearly half (46%)

of male survey respondents age 35+ have **had a PSA (prostate-specific antigen) test in the past 2 years,** while 25% have never had one.

COMMUNITY FEEDBACK

"I think we need more education and communication about what can be done to prevent illness, and when to go to a doctor."

Community Member Focus Group

"There are barriers like transportation, lack of health insurance, and knowing what services are available [that] I see in Fulton County."

Community Member Interview

INTERVIEW AND FOCUS GROUP FINDINGS

Top issues/barriers:
- Lack of awareness/education
- Access barriers to services
- Transportation barriers

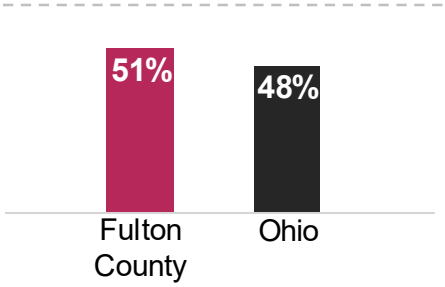
Sub-populations most affected:
- Children
- Elderly/aging population
- Individuals with disabilities

Top resources, services, programs, and/or community efforts:
- Fulton County Health Department
- Vaccine clinics
- Fulton County Health Center

#10 Health Need: PREVENTIVE CARE & PRACTICES

HEALTHY PEOPLE (HP) 2030 NATIONAL TARGETS

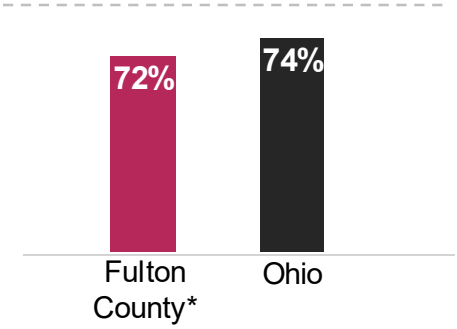
MEDICARE ENROLLEE ANNUAL FLU VACCINATION



HP 2030 TARGET: 70%
DESIRED DIRECTION: ↑

✗ Fulton County and Ohio do not yet meet the target.[46]

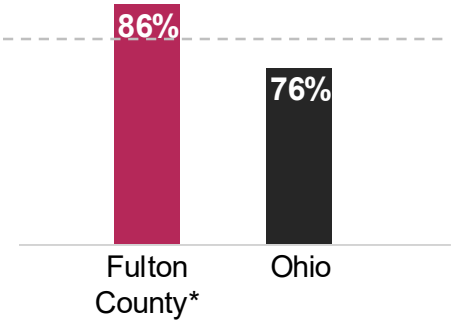
WOMEN 21-65 WITH PAP SMEAR IN PAST 3 YEARS



HP 2030 TARGET: 79%
DESIRED DIRECTION: ↑

✗ Fulton County and Ohio do not yet meet the target.[6]

WOMEN 50-74 WITH MAMMOGRAM IN PAST 2 YEARS

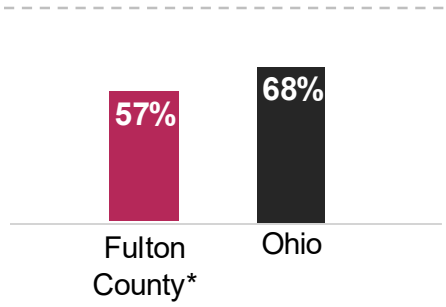


HP 2030 TARGET: 80%
DESIRED DIRECTION: ↑

✓ Fulton County exceeds the target.

✗ Ohio does not yet meet the target.[6]

ADULTS 45-75 WHO MEET COLORECTAL SCREENING GUIDELINES



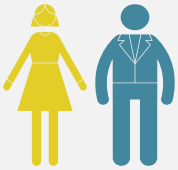
HP 2030 TARGET: 73%
DESIRED DIRECTION: ↑

✗ Fulton County and Ohio do not yet meet the target.[6]

PRIORITY POPULATIONS

PREVENTIVE CARE & PRACTICES

While **preventive care and practices** are potential concerns for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…



Community survey respondents **ages 25-34** were significantly more likely to get their health information from the internet than those age 65+.

Community survey respondents from **Wauseon (43567)** and **Archbold (43502)** were significantly less likely than those from Delta (43515) to have received an annual flu vaccine.

Data shows that Ohioans with **lower levels of education and income** are less likely to engage in preventive care.[6]

White/Caucasian survey respondents were more likely to rate preventive care and practices as a top community concern. No respondents of other races reported it as a top concern.

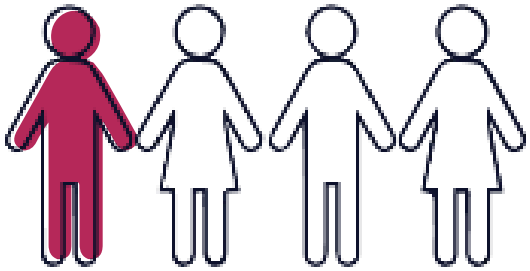
The **top sources** survey respondents prefer to get **information on their health or community concerns** are their **health care provider** (74%), the **internet** (39%), **family members/friends** (30%), and **social media** (29%).

**As reported in the 2025 Fulton County community member survey.*

#11 Health Need: TOBACCO & NICOTINE USE

9% of community survey respondents indicated that **tobacco and nicotine use** were top concerns in Fulton County.

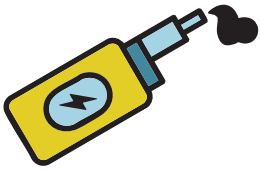
IN OUR COMMUNITY



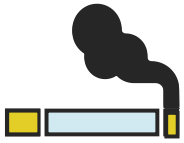
1 in 4 (25%)

Fulton County survey respondents are **former smokers** (have smoked at least 100 cigarettes in their life and now do not smoke).

4% of respondents have **stopped smoking for one day or longer because they were trying to quit**.



4% of respondents reported **using e-cigarettes in the past 30 days,** and an additional 3% have used them in the past year.

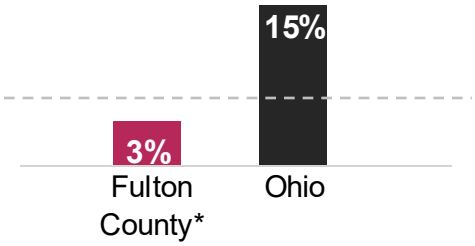


3% of respondents reported **smoking cigarettes in the past 30 days,** while an additional 3% have used them in the past year.

#11 Health Need: TOBACCO & NICOTINE USE

HEALTHY PEOPLE (HP) 2030 NATIONAL TARGETS

ADULT CIGARETTE SMOKING



HP 2030 TARGET: 6%
DESIRED DIRECTION: ↓

✓ Fulton County exceeds the target.

✗ Ohio does not yet meet the target.[43]

COMMUNITY FEEDBACK

"We certainly see the families who live in poverty use tobacco. Most of them are smokers because their parents were smokers, and their grandparents were too."

Community Member Interview

"Tobacco has changed. We see a lot of kids vaping, and now that marijuana is legal here, it has become a larger issue."

Community Member Interview

INTERVIEW AND FOCUS GROUP FINDINGS

Top issues/barriers:
- Vaping
- Too many vape shops
- Lack of education

Sub-populations most affected:
- Elderly/aging population
- Young adults/college students

Top resources, services, programs, and/or community efforts:
- Fulton County Health Department
- ADAMHS Board

PRIORITY POPULATIONS

TOBACCO & NICOTINE USE

While **tobacco and nicotine use** are potential concerns for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

Community survey respondents from **Wauseon (43567)** and **Swanton (43558)** were more likely to say that they vape or use e-cigarettes than those from other areas.

According to Ohio data, the smoking rate is highest in **those who are multi-racial, people ages 25-64, people with disabilities**, **those with lower-incomes,** and **people with lower education levels**.[6]

Community member survey respondents with a **high school degree/equivalent** were more likely to say they smoked or vaped in the past 30 days.

At the Ohio level, e-cigarette rates are highest in **people with disabilities**, **lower-income people,** and **those without a college degree**.[6]

Survey respondents with a **household income of $75,000-$99,999** were more likely to rate tobacco and nicotine use as a top community concern.

**As reported in the 2025 Fulton County community member survey.*

#12 Health Need: CRIME & VIOLENCE

Trigger Warning: The following page discusses violence, which may be disturbing for some people and trigger unpleasant memories or thoughts. You can call the 988 Suicide & Crisis Lifeline at 988 for 24-hour, confidential support.

7% of survey respondents said that **crime and violence** are top concerns in the community.

IN OUR COMMUNITY

Both property and violent crime rates are lower in Fulton County than Ohio overall.[26]

PROPERTY CRIME RATES PER 100,000[26]

VIOLENT CRIME RATES PER 100,000[26]

COMMUNITY FEEDBACK

"There's a lot of petty theft, break-ins, and domestic violence in the county."

Community Member Interview

"Our sheriff is a big advocate for mental health care, because he sees a lot of crime being connected to mental health issues."

Community Member Interview

"[Crime], to my knowledge, is fairly low. But I think people are less likely to turn to crime if they have a job."

Community Member Interview

PRIORITY POPULATIONS

CRIME & VIOLENCE

While **crime and violence** are potential concerns for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

Male community survey respondents were significantly more likely to rate crime and violence as a top concern than female respondents.

Community survey respondents from **Delta (43515)** were significantly more likely to rank crime and violence as a priority concern than those from Archbold (43502).

INTERVIEW AND FOCUS GROUP FINDINGS

Top issues/barriers:
- Domestic violence
- Drug-related crime/violence

Sub-populations most affected:
- Those involved with the criminal justice system
- Victims of domestic violence
- Low-income population

Top resources, services, programs and/or community efforts:
- Local law enforcement
- Northwestern Ohio Community Action Commission (NOCAC)

#13 Health Need: INTERNET ACCESS

Ohio ranks 30th out of the 50 U.S. States in BroadbandNow's 2025 rankings of internet coverage, speed, and availability (with 1 being better coverage).[25] **7%** of community survey respondents rate internet access as a **priority health need**.

IN OUR COMMUNITY

FULTON COUNTY | OHIO

84% of Fulton County households **have a broadband internet connection**, vs. **91%** for Ohio.[25]

COMMUNITY FEEDBACK

"For a lot of families internet is not even possible, let alone affordable for them."

Community Member Interview

"We have very few effective providers and access in the rural areas of the county."

Community Member Interview

"I know a lot of other people who have spotty Internet where they were able to get it. It's not fantastic, but it's not a consistent issue [either], it just depends on where you're living."

Community Member Interview

PRIORITY POPULATIONS

INTERNET ACCESS

While **Internet/Wi-Fi access** is a potential concern for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

Wauseon has lower broadband coverage than Fulton County overall, at 81%.[25]

According to the community survey, residents **ages 25-34** were more likely to rank internet access as a top concern than other age groups.

INTERVIEW AND FOCUS GROUP FINDINGS

Top issues/barriers:
- Rural access issues
- Cost barriers
- Infrastructure limitations

Sub-populations most affected:
- Rural population
- Low-income population
- Elderly/aging population
- Students

Top resources, services, programs, and/or community efforts:
- Public libraries
- Local cafes/coffee shops
- Local schools

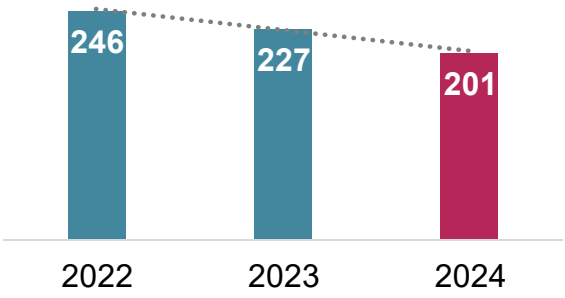
#14 Health Need: ENVIRONMENTAL CONDITIONS

7% of community survey respondents reported **environmental conditions** as a top health need for the community.

IN OUR COMMUNITY

In 2024, there were **2 drinking water violations** reported in Public Water Systems in Fulton County.[47]

WATER SAMPLE TESTS— PRIVATE WATER SYSTEMS[48]



The number of **water quality tests** for private water systems in Fulton County has **slightly decreased** since 2022.[48]

COMMUNITY FEEDBACK

"I am concerned about the safety and quality of our water; it can be a lot better."
Community Member Focus Group

"We do live very close to the turnpike, and there's also a railroad system that goes through our county. So we are very aware that there are hazardous materials traveling through our county."
Community Member Interview

"We are upstream from Lake Erie, so we contribute to the algal blooms that occur. A lot of that comes from our fertilizer and unsafe farm practices."
Community Member Interview

PRIORITY POPULATIONS

ENVIRONMENTAL CONDITIONS

While **environmental conditions** are a potential concern for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

Children, particularly young children, are more vulnerable to air pollution than adults, including long-term physical, cognitive, and behavioral health effects.[4]

Community survey respondents from **Lyons (43533)** were more likely to rate environmental conditions as a priority need than those from other areas.

Men who responded to the community survey were more likely than women to rate environmental conditions as a top community concern.

INTERVIEW AND FOCUS GROUP FINDINGS

Top issues/barriers:
- Water quality
- Housing challenges
- Air quality

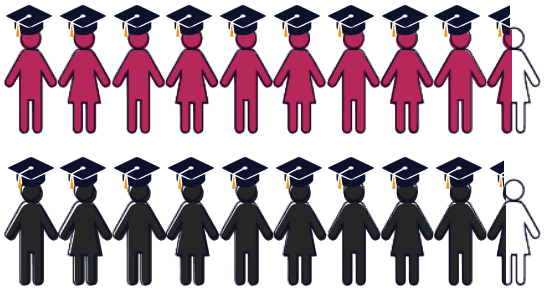
Sub-populations most affected:
- Elderly/aging population
- Rural population

Top resources, services, programs, and/or community efforts:
- Fulton County Health Department

#15 Health Need: EDUCATION

5% of community survey respondents reported education as a top health need in Fulton County.

IN OUR COMMUNITY



FULTON COUNTY (95%)

OHIO (92%)

According to the American Community Survey, Fulton County (95%) has **more** residents, aged 25 and older, with a **high school degree or equivalent** than Ohio (92%).[12]

Fewer residents, aged 25 and older, in Fulton County (31%) have **some college education** (includes those with associate's, bachelor's, or graduate/ professional degrees) than in the state of Ohio (40%).[12]

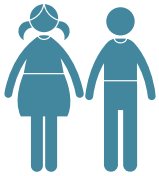
FULTON COUNTY (31%)

OHIO (40%)

PRESCHOOL ENROLLMENT[27]

FULTON COUNTY

OHIO



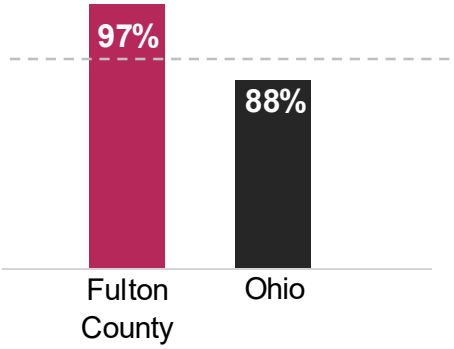
31% of 3- and 4-year-olds in Fulton County were enrolled in preschool in 2023. This is **lower** than the overall Ohio rate of **43%**.[27]

Preschool enrollment can improve short- and long-term socioeconomic and health outcomes, particularly for disadvantaged children.[28]

#15 Health Need: EDUCATION

HEALTHY PEOPLE (HP) 2030 NATIONAL TARGETS

HIGH SCHOOL GRADUATION RATE*



HP 2030 TARGET: 91%
DESIRED DIRECTION: ↑

- ✓ Fulton County exceeds the target.[49]
- ✗ Ohio does not yet meet the target.[49]

**Percent of cohort who graduates high school in 4 years.*

COMMUNITY FEEDBACK

"There aren't many full-day preschools, and the others have weird times. This is hard for those people who have to work and need help ."

Community Member Interview

"There is a group of people who miss the income cut-off that can really use it for Head Start."

Community Member Interview

"One of my biggest concerns in schools is the lack of special education. Students struggle year by year, unless they have a person who is going to maintain and advocate for them."

Community Member Interview

PRIORITY POPULATIONS

EDUCATION

While **education** is a potential concern for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

Community survey respondents from **Swanton (43558)** and **Lyons (43533)** were more likely to report their highest level of education is a high school degree/equivalent than those from other areas.

11% of community survey respondents with a **household income of $50,000-$74,999** ranked education as a priority community health need.

The community survey found that respondents **age 65+** were significantly less likely to have a college degree than other age groups.

INTERVIEW AND FOCUS GROUP FINDINGS

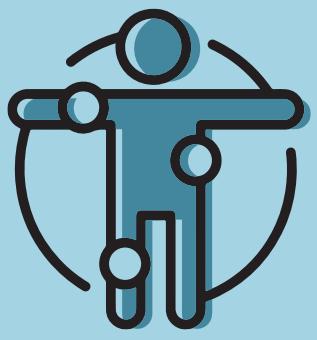
Top issues/barriers:
- Preschool/childcare accessibility
- Internet/Technology accessibility
- Adult education
- Special education

Sub-populations most affected:
- Non-English speaking population
- Adults who didn't learn in traditional settings
- Children affected by poverty

Top resources, services, programs, and/or community efforts:
- Fulton County Job and Family Services
- Local schools
- Northwest State Community College

HEALTH NEEDS

HEALTH OUTCOMES



HEALTH NEEDS: HEALTH OUTCOMES

The following pages rank the health outcomes category of health needs. They are ranked and ordered according to the Fulton County ranking from the community member survey as seen on page 29. Note that not every health need has its own section, and some health needs have been combined to form larger categories, such as mental health. Each health need section includes a combination of different data sources collected from our community: secondary (existing) data, and primary (new) data – from the community member survey, key informant interviews with community leaders, and focus groups with community members. Priority populations who are most affected by each health need and experience health disparities are also shown. Finally, where applicable, the Healthy People 2030 Goals are highlighted, including the performance of Fulton County and the state compared to the benchmark goal.

Fulton County PARTNERS FOR HEALTH
Building a Healthy Community

#1 Health Need: MENTAL HEALTH

Mental health was the **#1 ranked health outcome** in the community member survey **(89%)**.

40% of survey respondents said that **mental healthcare access is lacking** in the community.

11% of community survey respondents have **traveled outside** of Fulton County to **receive mental health care.**

IN OUR COMMUNITY

in Fulton County have been diagnosed with **depression**, compared to 25% of Ohio adults.[6, 50]

in Fulton County* experienced **poor mental health** on 14 or more days in the past month, compared to 17% of Ohio adults.[43]

**As reported in the 2025 Fulton County community member survey.*

FULTON COUNTY	OHIO
636:1	286:1

The 2025 County Health Rankings found that **Fulton County has fewer mental health providers relative to its population when comparing the ratio to Ohio** (ratio of residents : mental health providers).[4]

Fulton County adults experience an average of **6.2 mentally unhealthy days per month**, vs. **6.1 days** for Ohio adults.[4]

3% of community member survey respondents seriously **considered attempting suicide** in the past 12 months.

22% of community survey respondents said they are in some way **limited in activities because of physical, mental, or emotional problems**.

The top reported sources from respondents for **needed social and emotional support** were **family** (72%), **friends** (64%), **God/prayer** (43%), **church** (30%), and **a professional** (9%).

Top reported causes of anxiety, stress, or depression among survey respondents:

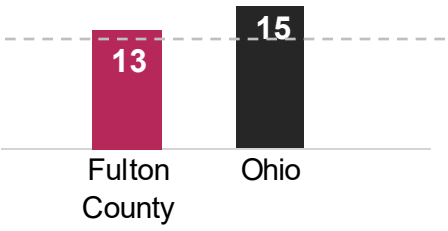
- Job stress (42%)
- Financial stress (34%)
- Death of close family member/friend (27%)
- Raising/caring for children (26%)
- Current news/political environment (26%)

The **top reasons** why survey respondents or their loved ones with emotional problems **are not using a program/service for help** are that **they have not thought of it** (14%), **they cannot afford to go** (9%), and **the co-pay/deductible is too high** (8%).

#1 Health Need: MENTAL HEALTH

HEALTHY PEOPLE (HP) 2030 NATIONAL TARGETS

SUICIDE RATE

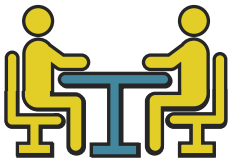


HP 2030 TARGET:
12.8 PER 100,000
DESIRED DIRECTION: ⬇

✕ Fulton County and Ohio do not yet meet the target.[14]

Survey respondents reported that they would do the following if they knew someone who was suicidal:

- Talk to them (72%)
- Call crisis line (44%)
- Take them to the ER (41%)
- Call 911 (38%)
- Call/text 988 (20%)



COMMUNITY FEEDBACK

"I think there is a big stigma around asking for help and people getting the help they need. From an employment perspective, some people cannot afford to take time off to address their issues."

Community Member Interview

"I feel like there is an increase in loneliness and isolation, leading to mental health issues, big and small."

Community Member Focus Group

"I know that it's a problem everywhere. There's not enough resources, not enough beds, not enough support as far as mental health goes."

Community Member Interview

PRIORITY POPULATIONS

MENTAL HEALTH

While **mental health** is a potential concern for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

Community survey respondents from **Wauseon (43567)** and **Archbold (43502)** were more likely to rate mental health as a top health concern.

Community survey respondents **ages 18-64** were more likely to rate mental health as a priority health need than those ages 65+. **35–44-year-olds** were the most likely to report mental healthcare access as lacking in the community.

On the community survey, **women** were more likely than men to rate mental health as a top community concern and mental healthcare access as lacking.

INTERVIEW AND FOCUS GROUP FINDINGS

Top issues/barriers:

- Lack of access to services
- Stigma
- Mental health provider shortage

Sub-populations most affected:

- Youth/adolescents
- Young adults/college students
- Elderly/aging population
- Military personnel/veterans

Top resources, services, programs and/or community efforts:

- Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board
- Fulton County Health Center

#2 Health Need: CHRONIC DISEASES

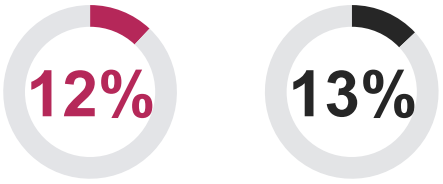
IN OUR COMMUNITY

About half (51%) of Fulton County survey respondents **rated their health as very good or excellent**. **8%** reported their health as **fair or poor**, compared to **20%** for Ohio adults.[43]

HEART DISEASE

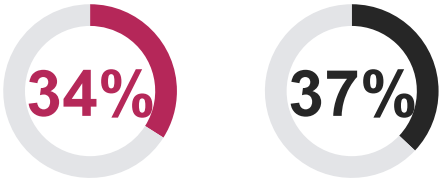
4% of Fulton County* adults report having been told they have **heart disease**, compared to **7%** of Ohio adults (includes heart attack, angina, coronary heart disease, and congestive heart failure).[43]

DIABETES



12% of Fulton County* adults report having been told they have **diabetes**, compared to **13%** of Ohio adults.[43]

HIGH BLOOD PRESSURE



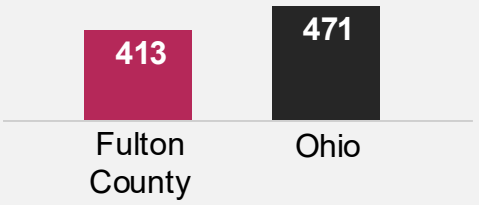
34% of Fulton County* adults report having been told they have high blood pressure, compared to **37%** of Ohio adults.[43]

15% of Fulton County adults identify as having a **disability**, vs. 14% for Ohio.[12]

80% of community survey respondents chose **chronic diseases** as a top community health need.

50% of community survey respondents said they have **at least one chronic health condition or disability**.

17% of community survey respondents **have not had a routine checkup within the past year**.



From 2020-2022, Fulton County had an average of **413** (age-adjusted) premature deaths per 100,000 residents under age 75, vs. **471** for Ohio.[4]

**As reported in the 2025 Fulton County community member survey.*

#2 Health Need: CHRONIC DISEASES

COMMUNITY FEEDBACK

"One thing that sticks out to me is cancer. I believe our community is a cancer cluster, because I know/see so many people dealing with cancer issues."

Community Member Interview

"To improve heart disease, we need to encourage people to eat healthy and exercise, as well as get screened."

Community Member Interview

"Diabetes is huge with the cost of medications and all the equipment needed to manage. A lot of people stop taking their insulin because they cannot afford to purchase more."

Community Member Interview

"We need to educate individuals to be more attentive to their health, and to see a doctor on a regular basis and get exams."

Community Member Interview

INTERVIEW AND FOCUS GROUP FINDINGS

Top issues/barriers:
- Diabetes
- Heart disease
- Limited healthy food/nutrition access
- Cancer
- Accessibility challenges

Sub-populations most affected:
- Low-income population
- Elderly/aging population
- Those with disabilities

Top resources, services, programs and/or community efforts:
- Fulton County Job and Family Services
- Fulton County Health Department
- Fulton County Health Center

PRIORITY POPULATIONS

CHRONIC DISEASES

While **chronic diseases** are potential concerns for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

Fayette (43521)—57% survey respondents were significantly more likely to report being told they have high blood cholesterol, compared to those from Wauseon (43567)—33%.

Residents **ages 55-64** who responded to the community survey were significantly more likely to rank chronic diseases among their top health concerns than those ages 25-34 and 65+.

Chronic conditions are more common in **older adults.**[6]

Male survey respondents were significantly more likely to report being told they have high blood pressure than female respondents.

Lower-income people are at a higher risk of developing many chronic conditions.[6]

Other groups who are more likely to be affected by chronic disease in the U.S.:
- People with **high exposure to air pollution.**[29]
- People who **smoke.**[30]
- People with **challenges with physical activity and nutrition.**[31]

#2 Health Need: CHRONIC DISEASES

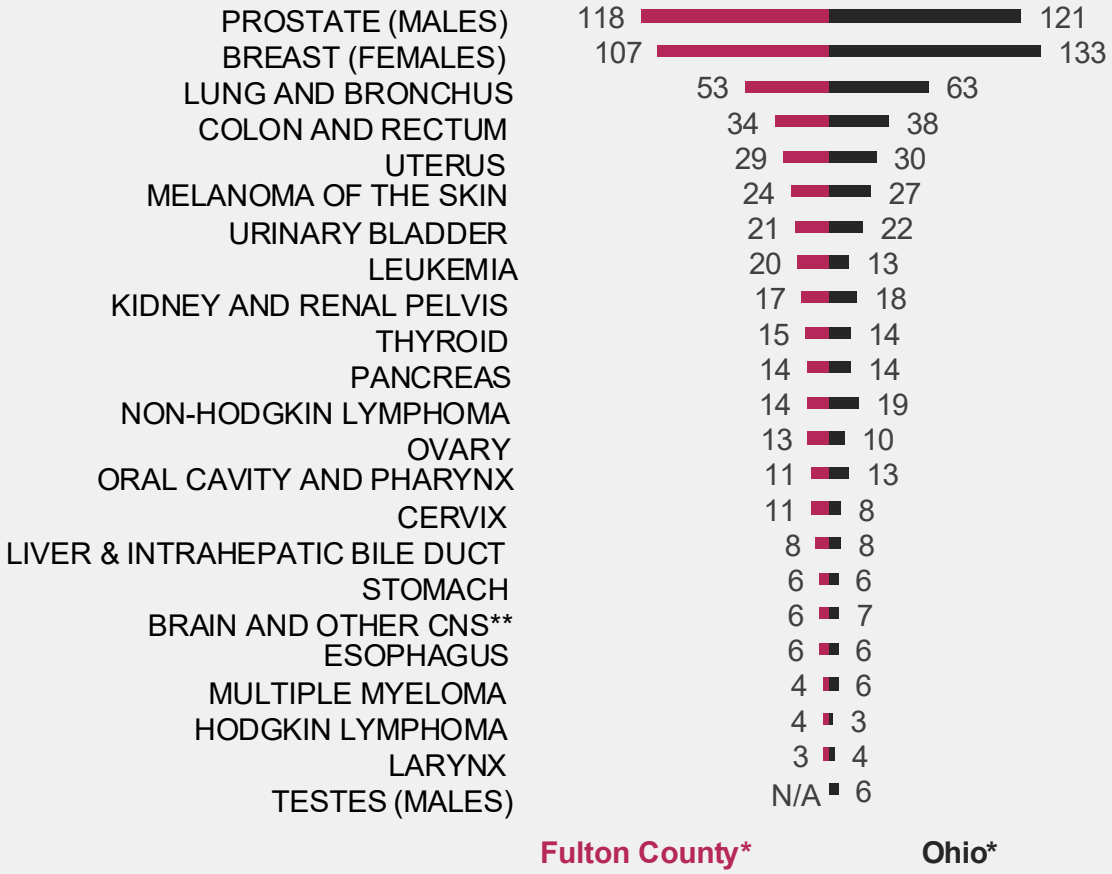
According to data from the Centers for Disease Control and Prevention, cancer is the **second leading cause of death** in Fulton County. Fulton County has a **slightly lower overall cancer incidence rate** per 100,000 than Ohio.[14, 32]

437
FULTON COUNTY[32]

471
OHIO[32]

CANCER INCIDENCE

Cervix, Hodgkin Lymphoma, Leukemia, Ovary, and Thyroid cancers had higher incidence rates in Fulton County than Ohio.[32]



**Age-adjusted rates per 100,000, 2018-2022 average*
***Central Nervous System*

HEALTHY PEOPLE (HP) 2030 NATIONAL TARGETS

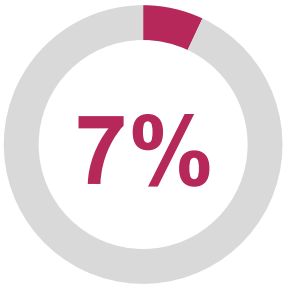
Fulton County does not yet meet the Healthy People 2030 target for colon and rectal, lung, and overall cancer mortality rates.[14] The specific targets can be found in **Appendix B**.

#3 Health Need: MATERNAL, INFANT, & CHILD HEALTH

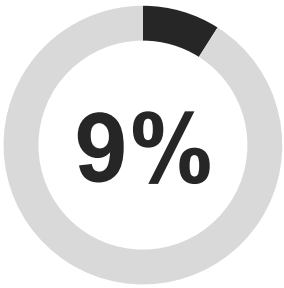
20% of community survey respondents say that addressing **maternal, infant, and child health** in the community is a top concern.

9% of survey respondents say that maternal, infant, and child healthcare **resources are lacking** in the community.

IN OUR COMMUNITY



FULTON COUNTY[33]



OHIO[33]

Fulton County has a **low-birth-weight rate** of **7%**, vs. **9%** for Ohio (less than 5 pounds and 8 ounces).[33]

Approximately 4% of all births in both Fulton County and Ohio are to **female teenagers** (ages 15-19).[33]

COMMUNITY FEEDBACK

"There is an OBGYN desert in small rural communities like ours. I think this could lead to more morbidity and mortality for both moms and babies because of traveling further to be able to access care."

Community Member Interview

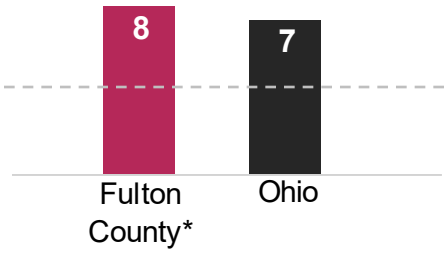
"We need to continue educating and encouraging early prenatal care, because it is so important."

Community Member Interview

#3 Health Need: MATERNAL, INFANT, & CHILD HEALTH

HEALTHY PEOPLE (HP) 2030 NATIONAL TARGETS

INFANT MORTALITY RATE PER 1,000

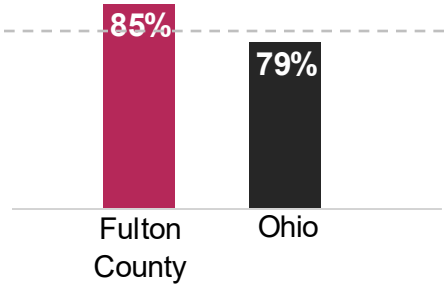


HP 2030 TARGET: 5 PER 1,000

DESIRED DIRECTION: ↓

✗ Fulton County and Ohio do not yet meet the target.[51]

EARLY AND ADEQUATE PRENATAL CARE



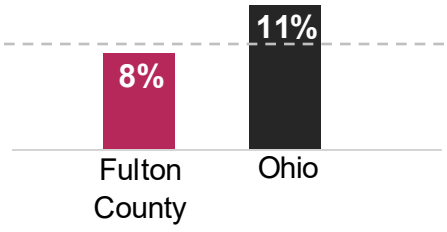
HP 2030 TARGET: 81%

DESIRED DIRECTION: ↑

✓ Fulton County exceeds the target.[52]

✗ Ohio does not yet meet the target.[52]

PRETERM BIRTH RATE



HP 2030 TARGET: 9%

DESIRED DIRECTION: ↓

✓ Fulton County exceeds the target.[33]

✗ Ohio does not yet meet the target.[33]

COMMUNITY FEEDBACK

"A lot of people utilize metropolitan areas near Fulton County. But some people aren't able to due to transportation, so they aren't receiving the care they need."

Community Member Interview

"I worry about non-English speaking pregnant moms who are afraid to seek help."

Community Member Interview

PRIORITY POPULATIONS

MATERNAL, INFANT, & CHILD HEALTH

While **maternal, infant, and child health** are potential concerns for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

Survey respondents from **Delta (43515)** were much more likely to rank maternal, infant, and child health resources as lacking than those from Swanton (43558).

Survey respondents with a **college degree** were significantly more likely to rate maternal, infant, and child health as a top concern than respondents of other education levels.

In Ohio, as in the nation, rates of severe maternal morbidity are much higher among **non-Hispanic Black women** compared to White women.[34]

INTERVIEW AND FOCUS GROUP FINDINGS

Top issues/barriers:
- Lack of prenatal/postnatal care
- Cost barriers

Sub-populations most affected:
- Immigrant population
- Low-income population
- Rural population

Resources, services, programs, and/or community efforts:
- Fulton County Health Department
- Reproductive health and wellness prenatal clinic

*Rates based on fewer than 20 infant deaths should be interpreted with caution.

#4 Health Need: INJURIES

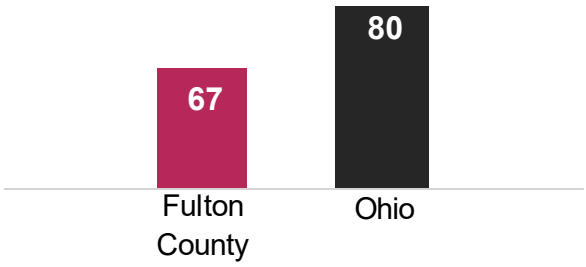
17% of community survey respondents chose **injuries** as a top community health need.

49% of survey respondents reported **eating while driving**, **23%** reported **texting**, and **16%** reported **driving without a seatbelt**.

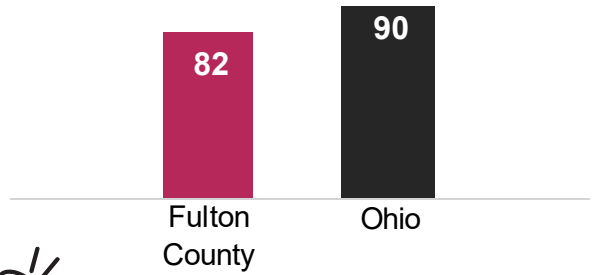
IN OUR COMMUNITY

Both Fulton County's **unintentional injury death rate** and **unintentional fall death rate among adults 65+** are **lower** than those of Ohio.[14, 35]

Unintentional Injury Death Rate per 100,000[14]



Unintentional Fall Deaths Among Adults 65+ per 100,000[35]



COMMUNITY FEEDBACK

"We definitely see our fair share of car accidents and local fender benders."

Community Member Interview

"We see a lot of falls in the elderly; our local EMS gets a lot of welfare checks."

Community Member Interview

"There is a lot of agricultural and blue-collar work, so we see accidents more frequently from them. Farming accidents are also more likely to occur."

Community Member Interview

PRIORITY POPULATIONS

INJURIES

While **injuries** are a potential concern for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

Survey respondents from **Archbold (43502)** were more likely to report injuries as a top health concern.

Individuals who work in jobs such as **manufacturing, construction, agriculture, transportation, trades,** and **frontline workers,** have a higher risk of occupational injuries.[36]

The rate of unintentional fall deaths in Ohio is higher among **males** and **adults 85+**.[35]

INTERVIEW AND FOCUS GROUP FINDINGS

Top issues/barriers:
- Workplace injuries
- Car accidents/traffic safety
- Falls

Sub-populations most affected:
- Elderly/aging population

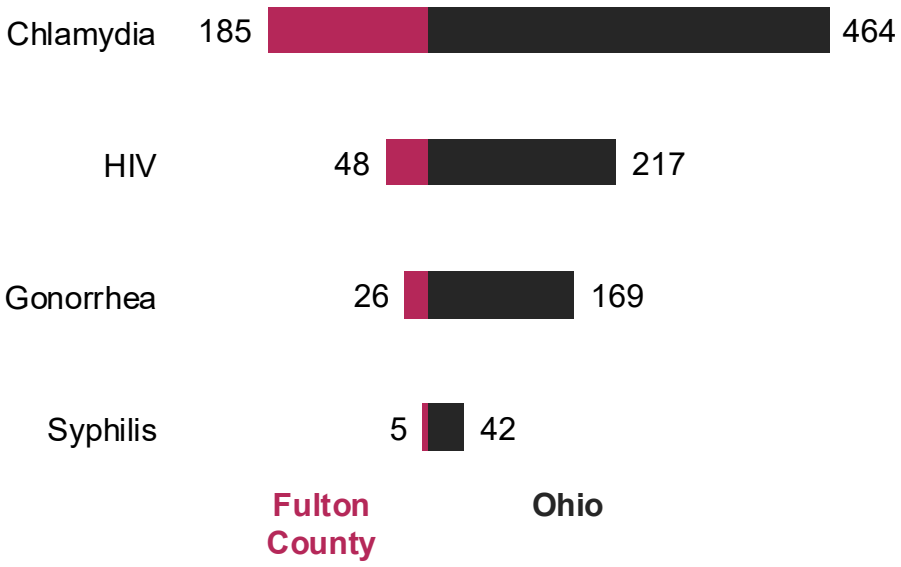
Top resources, services, programs, and/or community efforts:
- Local EMS

#5 Health Need: HIV/AIDS & STIs

IN OUR COMMUNITY

2% of community survey respondents in Fulton County feel that addressing **HIV/AIDS and Sexually Transmitted Infections (STIs)** in the community is a **top concern.**

STI/HIV rates per 100,000 people[37, 38]



Fulton County has **lower rates of HIV and STIs** than Ohio overall.[37, 38]

COMMUNITY FEEDBACK

"Some people don't access the services and things that are available, because they aren't aware of them."

Community Member Interview

"We need more education around STIs and HIV/AIDs."

Community Member Interview

PRIORITY POPULATIONS

HIV/AIDS & STIs

While **HIV/AIDS and STIs** are potential concerns for the entire community, these groups of people are more likely to be affected by this health need, based on data we collected from our community…

Community survey respondents from **Swanton(43558)** were more likely to report HIV/AIDS and STIs as a top health concern.

Chlamydia rates in Ohio are higher among **women** and **those ages 20-24**.[37]

State syphilis rates are higher among **men** and **those ages 30-34**.[37]

STI rates in Ohio are higher among **Black/African American** residents.[37]

In the community survey, those with **some college or technical school education** were more likely to rank HIV/AIDS and STIs as a priority health need.

INTERVIEW AND FOCUS GROUP FINDINGS

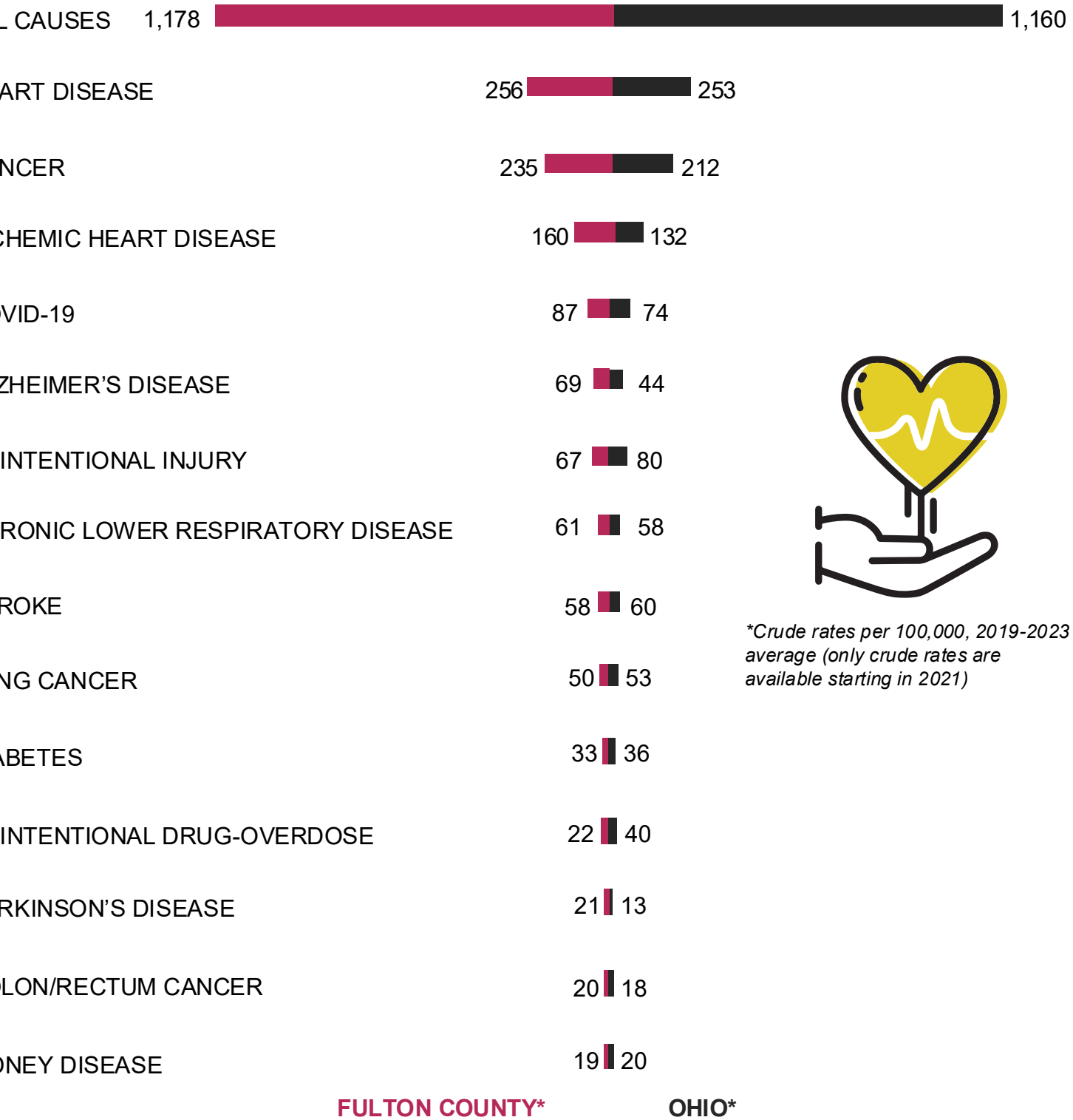
Top issues/barriers:
- Lack of education/awareness of resources

Sub-populations most affected:
- Youth/teenagers

Top resources, services, programs and/or community efforts:
- Fulton County Health Department

LEADING CAUSES OF DEATH

The top two leading causes of death in Fulton County are heart disease and cancer. Fulton County has a slightly higher all-cause (meaning the overall death rate from all causes) crude mortality rate per 100,000 than Ohio.[14]



**Crude rates per 100,000, 2019-2023 average (only crude rates are available starting in 2021)*

IDEAS FOR CHANGE FROM OUR COMMUNITY

These are ***ideas*** that we heard from community leaders and community members for potential suggestions to support community health.

ACCESS TO CHILDCARE

- Create more affordable childcare options for working families.
- Establish employer-sponsored childcare programs.
- Develop emergency childcare services.
- Create childcare subsidies for families just above poverty line.
- Establish childcare transportation services.
- Develop family childcare provider training and support programs.
- Create extended-hour childcare options for shift workers.
- Establish respite care services for caregivers.

ACCESS TO HEALTHCARE

- Recruit more doctors and specialists who accept local insurance plans.
- Establish more local healthcare offices to reduce travel distances.
- Train medical staff on protocols for special needs individuals.
- Improve scheduling and reduce emergency room wait times.
- Offer income-based healthcare discounts for seniors and undocumented residents.
- Provide human translation services instead of machine translators.
- Establish culturally specific healthcare services for Latino populations.
- Better communicate payment plans and financial assistance options.
- Establish emergency medical support groups.
- Create longer appointment availability and reduce wait times for new patients.
- Expand specialty services including orthopedics, neurology, and cardiology.
- Develop telemedicine programs to increase access to specialists.
- Create mobile health clinics for rural areas.
- Establish emergency psychiatric services locally instead of sending patients to Toledo or Columbus.

ACCESS TO HEALTHCARE (CONT.)

- Improve healthcare facility accessibility for individuals with disabilities.
- Create outreach programs to educate residents about preventive healthcare.

ACCESS TO HEALTHY FOOD

- Subsidize fruit and vegetable costs to make healthy food more affordable.
- Establish grocery stores in underserved areas like Fayette.
- Create smaller-sized, affordable, healthy food packages.
- Expand farmers' market programs with voucher systems.
- Develop nutrition education programs focused on budget-friendly healthy eating.
- Create community gardens or co-op purchasing programs.
- Establish food delivery services for homebound individuals.
- Expand food assistance programs for families just above poverty line.

ADDICTION AND SUBSTANCE USE

- Establish local residential treatment centers.
- Create immediate access crisis intervention programs.
- Develop transportation services for treatment programs.
- Establish prevention and education programs.
- Create employment support programs for individuals in recovery.
- Develop family support services for addiction issues.

EDUCATION

- Provide mental health training for adults who work with youth.
- Educate parents and schools about social media's impact on mental health.
- Bring mental health speakers to schools.

IDEAS FOR CHANGE FROM OUR COMMUNITY (CONTINUED)

These are ***ideas*** that we heard from community leaders and community members for potential suggestions to support community health.

EDUCATION

- Improve community awareness of available health resources through multiple communication methods.
- Focus health education on prevention rather than treatment.
- Create social media groups to share health information.
- Hold regular community meetings to increase service awareness.
- Establish more full-day preschool facilities in the county.
- Create affordable preschool options for working families who don't qualify for Head Start.
- Develop adult education programs, particularly English as a Second Language classes.
- Expand GED preparation programs.
- Create early childhood education programs that work with entire families.
- Establish community partnerships to support educational programming.
- Develop transportation services for preschool programs.
- Create financial assistance programs for preschool enrollment.

ENVIRONMENTAL CONDITIONS

- Improve affordable housing stock and housing quality standards.
- Address mold and housing safety issues.
- Continue water quality monitoring and improvement programs.
- Develop community clean-up initiatives.
- Create environmental health education programs.

FOOD INSECURITY

- Expand and better promote community meal programs.

HOUSING & HOMELESSNESS

- Address homelessness, particularly among veterans.
- Expand housing assistance programs for families.
- Increase caregiver support for homebound individuals.
- Provide economic support for vulnerable single-income families.
- Develop more affordable housing options throughout the county.
- Create emergency housing assistance programs.
- Establish rent control or stabilization programs.
- Build apartment complexes and multi-family housing units.
- Develop housing education programs to help residents understand available resources.
- Create transitional housing programs for families in crisis.
- Establish homeless services coordination programs.
- Develop housing quality improvement programs.
- Establish local assisted living facilities.
- Create adult day care centers for dementia patients.

INTERNET/WI-FI ACCESS

- Expand broadband infrastructure to rural areas throughout the county.
- Create affordable internet programs for low-income families.
- Develop public Wi-Fi access points in communities.
- Establish internet subsidies for individuals needing remote support services.
- Create digital literacy programs.
- Partner with internet providers to expand coverage areas.
- Develop mobile internet services for remote areas.

IDEAS FOR CHANGE FROM OUR COMMUNITY (CONTINUED)

These are ***ideas*** that we heard from community leaders and community members for potential suggestions to support community health.

MATERNAL/INFANT/CHILD HEALTH

- Recruit specialized pediatric doctors and expand pediatric health services.
- Expand breastfeeding support programs.
- Improve local prenatal and women's health services including mammograms.
- Expand childcare and after-school programs.
- Advocate for FQHC eligibility in the county.

MENTAL HEALTH

- Establish local mental health urgent care services.
- Increase affordable mental health care options.
- Offer physical therapy and wellness programs for seniors.
- Create youth mentor programs with background checks.
- Reduce mental health stigma through community education.
- Establish peer support groups for mental health discussions.
- Integrate mental health support into faith-based communities.
- Address immigrant-specific mental health stressors.
- Establish local inpatient mental health services.
- Create pediatric mental health specialists in the county.
- Develop crisis intervention services.
- Establish mental health transportation services.
- Create stigma reduction campaigns about mental health.
- Develop workplace mental health support programs.
- Create specialized services for individuals with developmental disabilities.

NUTRITION/PHYSICAL HEALTH

- Develop senior exercise and physical therapy programs.
- Improve water quality standards.
- Organize community clean-up initiatives and fitness programs.
- Prioritize road repairs throughout the community.
- Promote healthy eating and hydration education.
- Focus on chronic disease prevention programs.

TRANSPORTATION/WALKABILITY

- Create free medical transportation programs.
- Develop comprehensive public transportation system.
- Create ride services for medical appointments and essential needs.
- Expand and maintain sidewalk systems throughout communities.
- Establish safe bike trails and walking paths.
- Improve road safety through better signage and traffic control.
- Create transportation services specifically for individuals with disabilities.
- Develop community shuttle services.
- Establish emergency transportation programs.
- Establish public transportation services to address transportation barriers.
- Enforce handicap parking regulations.

OTHER OPPORTUNITES

- Create comprehensive community resource directories.
- Install and maintain community bulletin boards.
- Improve advertising of existing resources through multiple channels.
- Organize regular health fairs.
- Provide translation services and English classes to systematically address language barriers.
- Expand youth recreational and learning activities.
- Strengthen community support networks to reduce isolation.
- Advocate for policy changes to increase federal funding eligibility.

CURRENT RESOURCES ADDRESSING PRIORITY HEALTH NEEDS

FULTON COUNTY

Information was gathered on assets and resources that currently exist in the community. This was done using feedback from the community and an overall assessment of the service area. While this list strives to be comprehensive, it may not be complete.

Access to Healthcare

- Ability Center
- American Cancer Society
- American Heart Association
- American Lung Association
- Bryan Community Health Center
- Community Health Services
- Epilepsy Center of NW Ohio
- Fulton County Health Center
- Fulton County Health Department
- Free Clinic of Fulton County
- Health Partners of Western OH
- Kidney Foundation of Northwest Ohio
- Lions Club
- Northern Ohio Breast & Cervical Cancer Project
- Ohio's Best Rx

Community & Social Services

- Area Office on Aging of Northwestern Ohio, Inc
- Community Pregnancy Center
- Fulton County Child Support Enforcement Agency

Community & Social Services Cont.

- Fulton County Job & Family Services
- Fulton County Probate Court
- Fulton County Senior Center
- Hands of Grace
- Lutheran Social Services
- Shalom Ministries
- Social Security Office
- United Way of Fulton County
- Veterans Affairs

Education

- English for Speakers of Other Languages at Four County Career Center
- Fulton County Head Start Program
- Help Me Grow Central Intake
- Ohio State University Extension

Employment

- Bureau of Vocational Rehabilitation
- Ohio Means Jobs
- Quadco Rehabilitation Center

Food Insecurity

- Alano Club
- Christ United Methodist Church
- FISH
- Helping Hands Food Pantry
- Meals on Wheels
- Open Door of Delta
- Salvation Army
- St Vincent DePaul
- Trinity Assistance Fund
- WIC

Housing & Homelessness

- Inner Peace Homes
- New Home Development
- Northwest Ohio Community Action Commission
- Open Door of Delta
- P.A.T.H. Center
- St Vincent DePaul
- U.S.D.A. Rural Development

CURRENT RESOURCES ADDRESSING PRIORITY HEALTH NEEDS (CONTINUED)

FULTON COUNTY

Information was gathered on assets and resources that currently exist in the community. This was done using feedback from the community and an overall assessment of the service area. While this list strives to be comprehensive, it may not be complete.

Mental Health & Addiction

- Arrowhead Behavioral Health
- Center for Child & Family Advocacy Fulton County
- Alano Club
- Healthy Choices Caring Communities
- Maumee Valley Guidance Center
- Ohio Guidestone
- Recovery Services of Northwest Ohio
- 911
- 988

Nutrition & Physical Health

- Alzheimer's Association NW Ohio Chapter
- American Lung Association
- Fulton County Special Olympics
- Girl Scouts of America
- Live Vape Free
- Multiple Sclerosis Society, Northwestern Ohio Chapter
- Ohio Tobacco Quit Line

Transportation

- Fulton County Job & Family Services
- Fulton County Senior Center
- FISH
- Hands of Grace
- St Vincent DePaul

STEP 6

DOCUMENT, ADOPT/POST, AND COMMUNICATE RESULTS

IN THIS STEP, FULTON COUNTY PARTNERS FOR HEALTH:

- WROTE AN EASILY UNDERSTANDABLE COMMUNITY HEALTH NEEDS ASSESSMENT (CHNA) REPORT
- ADOPTED AND APPROVED CHNA REPORT
- DISSEMINATED THE RESULTS SO THAT IT WAS WIDELY AVAILABLE TO THE PUBLIC

Fulton County PARTNERS FOR HEALTH
Building a Healthy Community

DOCUMENT, ADOPT/POST, AND COMMUNICATE RESULTS

Fulton County Partners for Health worked with Moxley Public Health to pool expertise and resources to conduct the 2025 CHNA. By gathering secondary (existing) data and conducting new primary research as a team (through interviews with community leaders, focus groups with subpopulations and priority groups, and a community member survey), the stakeholders will be able to understand the community's perception of health needs. Additionally, the Fulton County Partners for Health will be able to prioritize health needs with an understanding of how each need compares against benchmarks and is ranked in importance by service area residents.

The 2025 Fulton County CHNA, which builds upon the prior assessment completed in 2022, meets all Internal Revenue Service (IRS), Public Health Accreditation Board (PHAB), and Ohio state requirements.

REPORT ADOPTION, AVAILABILITY AND COMMENTS

This CHNA report was adopted by Fulton County Health Department and Fulton County Health Center leadership and made widely available on their websites in December 2025.

Fulton County Health Department: https://fultoncountyhealthdept.com/data-resources/health-assessments

Fulton County Health Center: https://fultoncountyhealthcenter.org

Written comments on this report are welcomed and can be made by emailing: FCHD@fultoncountyoh.com.

CONCLUSION & NEXT STEPS

THE NEXT STEPS WILL BE:

- DEVELOP IMPLEMENTATION STRATEGY (IS)/ IMPROVEMENT PLAN (CHIP) FOR 2026-2028
- SELECT PRIORITY HEALTH NEEDS
- CHOOSE INDICATORS TO VIEW FOR IMPACT CHANGE FOR 2026-2028 PRIORITY HEALTH NEEDS
- DEVELOP SMART OBJECTIVES FOR IS/CHIP
- SELECT EVIDENCE-BASED AND PROMISING STRATEGIES TO ADDRESS PRIORITY HEALTH NEEDS

Fulton County PARTNERS FOR HEALTH
Building a Healthy Community

CONCLUSION & NEXT STEPS FOR FULTON COUNTY PARTNERS FOR HEALTH

- Monitor community comments on the CHNA report (ongoing) to the provided Fulton County Partners for Health contact.

- Select a final list of priority health needs to address using a set of criteria that is recommended by Moxley Public Health, MAPP 2.0, and PHAB (Public Health Accreditation Board) and approved by Fulton County Partners for Health. The identification process to decide the priority health needs that are going to be addressed will be transparent to the public. The information on why certain needs were identified as priorities and why other needs will not be addressed will also be public knowledge.

- Community partners (including the hospital, health department, and many other organizations throughout the service area) will select strategies to address priority health needs and priority populations. We will use, but not be limited by, information from community members and stakeholders and evidence-based strategies recommended by the Ohio Department of Health.

- The 2026-2028 Implementation Strategy (IS)/Improvement Plan (CHIP) (that includes indicators and SMART objectives to successfully monitor and evaluate the improvement plan) will be reviewed by the public prior to final approval by Fulton County Partners for Health. Once approved, the final draft will be publicly posted and made widely available to the community.

APPENDIX A

IMPACT AND PROCESS EVALUATION

IMPACT AND PROCESS EVALUATION

The following pages indicate the priority health needs selected from the 2022 Fulton County CHNA and the impact of the 2023-2026 CHIP on the previous priority health needs (based on the most recent available data from 2025). The pages that follow are not exhaustive of these activities but highlight what has been achieved in the service area since the previous CHNA. The impact data (indicators of each priority health need to show if it is getting better or worse) and process data (to show whether or not the strategies are happening) will be reported and measured in an evaluation plan. That data will be reported annually and in the next CHNA.

Fulton County PARTNERS FOR HEALTH
Building a Healthy Community

APPENDIX A:
IMPACT AND PROCESS EVALUATION OF PREVIOUS COMMUNITY HEALTH IMPROVEMENT PLAN (2023-2026)

PRIORITY #1: ACCESS TO CARE				
Goal 1: Increase local access and preventive services				
Objective 1: Decrease percentage of adults who are uninsured				
SPECIFICS ON EACH STRATEGY(S)	**LEAD PARTNER(S)**	**2023-2024 ACTIVITIES (action steps)**	**2024-2025 ACTIVITIES (action steps)**	**2025-2026 ACTIVITIES (action steps)**
1. Expand insurance enrollment assistance/use of navigators.	1. Merissa Kessler-JFS 2. Katarina-Lucas Co. CareNet	1. Determine how to access the navigator-phone, internet, in person 2. Meet with Julie Grasson from Toledo-Lucas County CareNet to discuss availability, process, location, and contact information	1. Educate to reduce stigma 2. Advertise to increase awareness 3. Use social media 4. Promote at community events	1. Assess need for further assistance, possibly seek funding for Community Health Worker
Progress Notes Fulton County no longer has a patient navigator for insurance assistance. JFS and ADAMHS Board are planning a Medicaid 101 training to help navigate the new changes.				
2. Improve marketing, communication & education of resources.	1. Andrea Schwiebert-FCHD 2. Barb Zimmerman-Business Community	1. Centralize efforts "one stop shop" for resource guides 2. Extend or strengthen ESC's resource guide 3. Include representative from Mental Health info & referral system, Medical (dental, vision)-keep accurate and updated 4. Tracking –data 5. Standardize-branding, logo, QR code	1. Centralize efforts –"one stop shop" for resource guide-extend or strengthen ESC's resource guide 2. Include representative from Mental Health info & referral system, Medical (dental, vision) 3. Keep accurate and updated 4. Track data 5. Standardize branding, logo, QR code	1. Training- train the trainer approach for all front line staff, providers offices 2. Include Chamber of Commerce, Lion's Club, Rotary Clubs, Churches, Economic Development 3. Develop tracking plan to collect data
Progress Notes Workgroup decided FCHD would be the centralized web page to keep resources in a one stop location and link them to each agency to update services and information as needed. Includes both the NOCAC and ESC resource guides' as a link as well. QR code was created to navigate to the resource guide page. Working on improving logistics and format on this page of FCHD website. Notify the public that this is the place to go and informing them on how it can be useful.				

APPENDIX A:
IMPACT AND PROCESS EVALUATION OF PREVIOUS COMMUNITY HEALTH IMPROVEMENT PLAN (2023-2026)

PRIORITY #1: ACCESS TO CARE				
Goal 1: Increase local access and preventive services				
Objective 2: Increase number of adults who have a routine check-up each year				
SPECIFICS ON EACH STRATEGY(S)	**LEAD PARTNER(S)**	**2023-2024 ACTIVITIES (action steps)**	**2024-2025 ACTIVITIES (action steps)**	**2025-2026 ACTIVITIES (action steps)**
3. Increase use of telehealth in provider and specialty offices.	1. Becky Taylor/Patti Finn-FCHC 2. Toni Long-ADAMHS Board	1. Look at current literature about the use of telehealth(then, now, and future) 2. Survey who may already provide these services and what their processes are(Parkview along with independent provider 3. Determine willingness to learn 4. Reach out to Mental Health providers that already do this for training on what works-check with other communities to see how they address this 5. Explore reimbursement and legal concerns, signing waiver	~~1.Accessibility-places other than libraries -expand number of sites, different community can utilize. -technology(wifi), affordability~~ ON HOLD- Continue to assess and promote what is currently working and available	~~1.Marketing~~
Progress Notes ON HOLD- Continue to assess and promote what is currently working and available.				

APPENDIX A:
IMPACT AND PROCESS EVALUATION OF PREVIOUS COMMUNITY HEALTH IMPROVEMENT PLAN (2023-2026)

PRIORITY #1: ACCESS TO CARE				
Goal 1: Increase local access and preventive services				
Objective 3: Decrease the number of adults who travel out of Fulton County to receive care				
SPECIFICS ON EACH STRATEGY(S)	**LEAD PARTNER(S)**	**2023-2024 ACTIVITIES (action steps)**	**2024-2025 ACTIVITIES (action steps)**	**2025-2026 ACTIVITIES (action steps)**
4. Increase dental services for Medicaid population.	1. Jen Ruetz-FCFC 2. Robin Shepherd-Board DD 3. Kim Rex-FQHC	Due to goals not being met, work in progress, moved these goals into 24-25 and the 24-25 goals into 25-26 year.	1. Survey Dental offices in Fulton Co. 2. Accept Medicaid? Serve poverty population? Why not? Where they refer for further needs 3. Awareness of what exists-where pts with Medicaid can currently go (even if its not in Fulton Co.). Such as Western Health Partner Dental locations 4. Free events @schools, low-income housing, community events-promotion of Western Health Partners dental mobile outreach	1. Continue to gather data
Progress Notes Dental list created and posted on FCHD website resource page.				

APPENDIX A:
IMPACT AND PROCESS EVALUATION OF PREVIOUS COMMUNITY HEALTH IMPROVEMENT PLAN (2023-2026)

PRIORITY #1: ACCESS TO CARE				
Goal 1: Increase local access and preventive services				
Objective 3: Decrease the number of adults who travel out of Fulton County to receive care				
SPECIFICS ON EACH STRATEGY(S)	**LEAD PARTNER(S)**	**2023-2024 ACTIVITIES (action steps)**	**2024-2025 ACTIVITIES (action steps)**	**2025-2026 ACTIVITIES (action steps)**
5. Create a transportation network.	1. Britney/Tiffany-FCHC 2. Sally Kovar-ESC 3. Kathy Shaw-Triangular Processing 4. Sierra Nathans-MVPO	1. Moved to 2024-2025 year	1. Gather data on what specific transportation is needed 2. Determine options: 3. FCHC needs to have a way to get pts home from the hospital(ED to home) 4. Uber Health Account? HC Transportation(but need to be able to transport to & from appointment, not just one way) 5. Seek drivers 6. Reimbursement options-find coverage policies for non-Medicaid providers, can it be billed-call top 3 commercial coverages and see if transportation is covered 7. Monitor ADAMHS Board pilot program "brokerage model" for possible expansion	1. Promotion-senior Centers/Hands of Grace/Meals on Wheels/churches

Progress Notes:

Continue to stay updated with the Five County Transportation Coordination & Mobility Coalition progress.

Workgroup members to assist in creating survey to help collect necessary data.

APPENDIX A:
IMPACT AND PROCESS EVALUATION OF PREVIOUS COMMUNITY HEALTH IMPROVEMENT PLAN (2023-2026)

PRIORITY #2: YOUTH ADDICTION				
STRATEGY 1: Strengthen Community Second Hand Smoke policies				
SPECIFICS ON EACH STRATEGY(S)	**LEAD PARTNER(S)**	**2023-2024 ACTIVITIES (action steps)**	**2024-2025 ACTIVITIES (action steps)**	**2025-2026 ACTIVITIES (action steps)**
1. Implement second-hand smoke (SHS) policies in community organizations	1. Beth Thomas 2. HC3 3. Fayette CDC	1. Identify potential policy targets – focus on behavioral health organizations and schools 2. Select 2 organizations to focus efforts 3. Identify model policy 4. Work with selected organizations to consider policy change 5. Support Fayette CDC to strengthen Fayette Community Parks' SHS policy	1. Work with Fayette CDC to identify 2 potential policy targets in Fayette community and 1 school to meet new Ohio Department of Health's tobacco policy requirements 2. Select 2 organizations to focus efforts 3. Identify model policy 4. Work with selected organizations to consider policy change	1. Identify a second school to meet new ODH tobacco policy requirements 2. Bring the policy recommendations to decision making body and create support for change.

Progress Notes

2025:
Fayette CDC worked with "The Gym" and the "Helping Hands Food Bank", both Fayette organizations to support and encourage them to adopt and/or strengthen a second-hand smoke policy for their organization. They were able to successfully support "The Gym" to adopt a policy in May 2025.
FCHD staff worked with local district, PDY Schools to adopt an "alternative to suspension" policy to provide student first offenders to receive assessment/referral to provide support vs. an automatic suspension.

2024:
Tobacco related policy – Fayette CDC has been working with local officials to consider passing an ordinance to prohibit tobacco/nicotine use in the park. The council appeared supportive initially but voted it down. They did agree to placing signage (without enforcement) encouraging people not to smoke, vape or use marijuana in the park. CDC paid for the signs and the village staff will install them.

2023:
Identified and worked with behavioral health organizations but were unable to convince identified organizations to bring policy considerations to decision making body.

APPENDIX A:
IMPACT AND PROCESS EVALUATION OF PREVIOUS COMMUNITY HEALTH IMPROVEMENT PLAN (2023-2026)

PRIORITY #2: YOUTH ADDICTION				
STRATEGY 2: Increase youth access to screening and referral				
SPECIFICS ON EACH STRATEGY(S)	**LEAD PARTNER(S)**	**2023-2024 ACTIVITIES (action steps)**	**2024-2025 ACTIVITIES (action steps)**	**2025-2026 ACTIVITIES (action steps)**
2. Increase the number of youth screened for tobacco and referred to cessation support.	1. Robin Willson 2. Britney Ward	1. Continue to support FCHC and their provider offices with training for cessation support 2. Continue to provide FCHC provider offices with cessation support materials 3. Collect, track, and monitor data to ensure screenings are continuing	1. Continue to identify opportunities within the community to provide tobacco screening to youth 2. Continue to identify adult allies for training on motivational interviewing and cessation referral process	
Progress Notes: **2025:** FCHC, WIC, and Community Health Services continue to screen; we have been able to resolve the tracking data issue. **2024:** FCHC, WIC, Community Health Services continue to screen clients for tobacco/nicotine use; we have faced some challenges on collection of data so Robin will be working to determine a process to make this more effective. **2023:** Number of youth screened for tobacco use and referred for cessation as appropriate.				
3. Increase the number of youth receiving education on the health and safety concerns of electronic nicotine delivery system (ENDS) use	1. Rachel Kinsman 2. Beth Thomas	1. Continue to provide educational opportunities to youth and their adult allies on the health and safety concerns of ENDS use	1. Continue to identify additional opportunities for education of both youth and their adult allies on the health and safety concerns of ENDS use	
Progress Notes: **2023-2025:** We continue to provide educational opportunities to youth, parents and community adults as requested by community organizations.				

APPENDIX A:
IMPACT AND PROCESS EVALUATION OF PREVIOUS COMMUNITY HEALTH IMPROVEMENT PLAN (2023-2026)

PRIORITY #3: MENTAL HEALTH				
STRATEGY 1: Reduce adult and youth depression and anxiety				
SPECIFICS ON EACH STRATEGY(S)	**LEAD PARTNER(S)**	**2023-2024 ACTIVITIES (action steps)**	**2024-2025 ACTIVITIES (action steps)**	**2025-2026 ACTIVITIES (action steps)**
1. Increase awareness of available MH services	1. Businesses / Employer Worthington Indus. Sauder Woodworking 2. ADAMH's Board 3. FCHC (Hospital) 4. MH Provider Recovery Services of NW OH, Center for Child & Family Advocacy, Ohio Guidestone, MV Guidance Center 5. Schools: Swanton, Wauseon 6. JFS 7. Fulton County Sheriff's Office 8. Archbold Police Dept. and Mayor 9. FC Health Dept. 10. FC Board of DD 11. Crossroads Church	1. Develop standard MH Info. handout/ poster/rack card	1. Produce videos of local organizations talking about what MH services they provide 2. Develop and promote Social Media Site (Credible Mind) 3. QR Code 4. Recognizable Icon 5. Placement of QR Code/Icon on business, school and agency websites. 6. Promote Mental Health Agencies (videos), training (MH First Aid), etc. 7. Complete X Physician Office Visits to inform of MH resources 8. FCHC Assure distribution of resource guides (MH, comprehensive and standard MH information) to all PCP's and FCHS Depts.	1. Develop Sustainability of yr. 1 & 2 Accomplishments 2. Assure X presentations/yr. to staff to inform of MH resources 3. FCHC Complete X Human Resource Dept./staff Visits to inform of MH resources 4. Host lunch n learn at hosp. with employees – highlight those depts. That we don't know as much about (incl. Behavioral Health)

Progress Notes

2025:

MH rack cards and resource guide information was distributed at FCHC (Hospital) February Dept. Head and Office Manager mtgs. BJ Horner spoke at May Quarterly FCHC staff Lunch & Learn

Four County Health Departments (Defiance, Fulton, Henry and Williams) redirected annual ADAMH's Board Funding to initiate provision of Credible Mind Web-based Platform. Campaign to inform public of the availability of Credible Mind web-based platform.

2024:

BJ Horner, ADAMHs Board developed two versions of the MH Info. rack card with input from the MH Coalition. Distribution of rack cards in 2024 and 2025.

BJ Horner requested recorded videos promoting providers and services to post on social media. Continued to collect and share in 2025.

MH Coalition viewed a demonstration of Credible Mind web-based resource for self- assessment and self-help options as well as ability to house MH provider contact information and services.

APPENDIX A:
IMPACT AND PROCESS EVALUATION OF PREVIOUS COMMUNITY HEALTH IMPROVEMENT PLAN (2023-2026)

PRIORITY #3: MENTAL HEALTH				
STRATEGY 1: Reduce adult and youth depression and anxiety				
SPECIFICS ON EACH STRATEGY(S)	**LEAD PARTNER(S)**	**2023-2024 ACTIVITIES (action steps)**	**2024-2025 ACTIVITIES (action steps)**	**2025-2026 ACTIVITIES (action steps)**
2. Increase accessibility of information and services to individuals with wages at or below $25,000/yr. and those whose primary language is not English.	1. Businesses / Employer Worthington Indus. Sauder Woodworking 2. ADAMH's Board 3. FCHC (Hospital) 4. MH Provider Recovery Services of NW OH, Center for Child & Family Advocacy, Ohio Guidestone, MV Guidance Center 5. Schools: Swanton, Wauseon 6. JFS 7. Fulton County Sheriff's Office 8. Archbold Police Dept. and Mayor 9. FC Health Dept. 10. FC Board of DD 11. Crossroads Church	1. Invite a representative of the Spanish-speaking community to join FC MH Coalition 2. Translate the standard MH info into Spanish and/or common dialects, other languages 3. Develop the standard MH info at 6-8th grade reading level 4. Use pictures and videos in addition or instead of translated word as appropriate	1. Distribute translated standard MH info to churches with Spanish services 2. Develop connection with food-bank/assistance programs 3. Distribute Standard MH Info. to food banks, churches, assistance programs	

Progress Notes:

2025: Listening Session held with representatives of Hispanic/Latino community. MH questions were included in the discussion.

2024: The rack cards provide information in both English and Spanish. One version is designed with more pictures and lower reading level to appeal to 6-8th gr. readers or below.
Mark Sanchez, MVGC, joined the MH Coalition in Jan. 2025.

APPENDIX A:
IMPACT AND PROCESS EVALUATION OF PREVIOUS COMMUNITY HEALTH IMPROVEMENT PLAN (2023-2026)

PRIORITY #3: MENTAL HEALTH				
STRATEGY 1: Reduce adult and youth depression and anxiety				
SPECIFICS ON EACH STRATEGY(S)	**LEAD PARTNER(S)**	**2023-2024 ACTIVITIES (action steps)**	**2024-2025 ACTIVITIES (action steps)**	**2025-2026 ACTIVITIES (action steps)**
3. Increase parent engagement	1. Businesses / Employer Worthington Indus. Sauder Woodworking 2. ADAMH's Board 3. FCHC (Hospital) 4. MH Provider Recovery Services of NW OH, Center for Child & Family Advocacy, Ohio Guidestone, MV Guidance Center 5. Schools: Swanton, Wauseon 6. JFS 7. Fulton County Sheriff's Office 8. Archbold Police Dept. and Mayor 9. FC Health Dept. 10. FC Board of DD 11. Crossroads Church	1. Conduct survey with parents to gain an understanding of why parents are not engaging. 2. Gain understanding of what parents need/want in way of MH info. 3. Using input from parents, identify/develop materials.	1. Develop a plan for distribution of MH Information to target audience, parents. 2. Coalition members attend at least one event at each of the seven public schools in Fulton County 3. Distribute Rack Cards 4. Provide opportunities to discuss MH with parents, reduce stigma 5. Provide incentives promoting MH coalition members' agencies & invite interaction 6. Distribute MH messaging developed for parents via social media in May, Mental Health Awareness Month 7. Re-survey parents to identify change from 2024 survey.	1. Develop Sustainability of yr. 1 & 2 Accomplishments

Progress Notes:

2025: Five of seven schools provided MH Resource table at sporting events. Rack cards distributed at several community events and County Fair.

2024: In consultation with BJ Horner, ADAMHs Board and Superintendents, Troy Armstrong and Chris Lake, FCHD Intern, Brooke Schuette developed a survey tool. The schools distributed the survey in spring 2024.

2024: Using parent survey results, MH information for distribution via social media was compiled/developed.

APPENDIX A:
IMPACT AND PROCESS EVALUATION OF PREVIOUS COMMUNITY HEALTH IMPROVEMENT PLAN (2023-2026)

PRIORITY #4: CHRONIC DISEASE				
STRATEGY 1: Improve Adult & Youth Nutrition				
SPECIFICS ON EACH STRATEGY(S)	**LEAD PARTNER(S)**	**2023-2024 ACTIVITIES (action steps)**	**2024-2025 ACTIVITIES (action steps)**	**2025-2026 ACTIVITIES (action steps)**
1. Improve Nutrition/ Increase Fruit & Vegetable Consumption	1. FCHC/FCHD	1. Increase Point-of-Purchase Prompts 2. Implement Competitive Pricing for Healthy Foods 3. Offer a Medical Weight Management Program (MWM) at FCHC 4. Implement My Plate in all 3rd Grades 5. Implement Community Gardens	1. Expand Point-of-Purchase Prompts 2. Expand Competitive Pricing for Healthy Foods 3. Expand MWM Program at FCHC 4. Continue Implementation My Plate in all 3rd Grades 5. Create Toolbox for Community Garden Implementation	1. Continue Current Point of Purchase Prompts 2. Expand Competitive Pricing for Healthy Foods 3. Expand MWM Program to reach more patients per month 4. Continue Implementation My Plate in all 3rd Grades 5. Create Toolbox for Community Garden Implementation 6. Implement FCHC Farm stand for employees

PROGRESS NOTES

2024-2025

1. FCHC Cafeteria swapped out snacks for fruit near registers
2. The salad bar is the first thing you see when entering the cafeteria. It is priced so that it is typically cheaper than buying a less healthy meal
3. In Dec 2025 a second MWM provider was added.
4. Archbold, Delta, Evergreen, Fayette, Pettisville, Swanton & Wauseon have completed 4 sessions of My plate.
5. Determining potential partners. Gathering information from current community gardens to create a toolbox for other communities to utilize.

2023-2024

1. Met with FCHC Exec Wellness Committee and Dietary Staff
2. Met with FCHC Exec Wellness Committee and Dietary Staff to discuss pricing
3. In Nov 2023 FCHC opened its MWM program.
4. All 7 Fulton Co Schools Completed 4 MyPlate Sessions serving 495 students, in 26 classrooms. 51.1% average increase in knowledge gain from pre to post test. 74. 9% of 3rd graders tried a new fruit or vegetable during the taste test.
5. Community garden, determining plan of action & who to partner with

APPENDIX A:
IMPACT AND PROCESS EVALUATION OF PREVIOUS COMMUNITY HEALTH IMPROVEMENT PLAN (2023-2026)

PRIORITY #4: CHRONIC DISEASE				
STRATEGY 2: Improve Adult & Youth Physical Activity				
SPECIFICS ON EACH STRATEGY(S)	**LEAD PARTNER(S)**	**2023-2024 ACTIVITIES (action steps)**	**2024-2025 ACTIVITIES (action steps)**	**2025-2026 ACTIVITIES (action steps)**
2. Improve Physical Activity	1. FCHD/FCHC	1. Expand Community Fitness Programs 2. Implement Workplace Physical Activity Programs & Policies 3. Encourage Reading Trails with all 2nd Grades and Younger 4. Implement Crunch Out Obesity in all 4th Grades	1. Expand Community Fitness Programs 2. Continue Implementation of Workplace Physical Activity Programs & Policies 3. Encourage Reading Trails with all 2nd Grades and Younger 4. Determine if Crunch Out Obesity in all 4th Grades is feasible	1. Expand Community Fitness Programs 2. Continue Implementation of Workplace Physical Activity Programs & Policies 3. Encourage Reading Trails with all 2nd Grades and Younger 4. Determine if Crunch Out Obesity in all 4th Grades is feasible

Progress notes

2024-2025

1. Expanded Silver Sneakers program to new Senior Center
2. FCHC meet with other large Fulton Co employees to replicate physical activity programs
3. Reading trails – plan to communicate with Fulton Co Libraries to determine interest in hosting Reading Trails in their communities. Archbold hosts a Reading Trail in Ruihley Park.
4. Crunch Out Obesity – determining funding opportunities and if program is feasible or if an alternative option is available through the schools or for the schools

2023-2024

1. Met with FCHC Administration and FCHC Fitness Manager. Expanded Silver Sneakers to Swanton
2. FCHC piloted programs with FCHC employers, Worthington
3. Reading trails – Archbold is the only current Reading Trail available as weather permits. Contacted Wauseon Library – they are interested in a Reading Trail possibly on the Cannonball Trail.
4. Crunch Out Obesity – no longer being conducted for Fulton Co 4th graders due to funding. Communications with Fulton Co United Way to determine feasibility and potential funding options

APPENDIX A:
IMPACT AND PROCESS EVALUATION OF PREVIOUS COMMUNITY HEALTH IMPROVEMENT PLAN (2023-2026)

PRIORITY #4: CHRONIC DISEASE				
STRATEGY 3: Increase Screenings and Awareness of Heart Disease and Diabetes				
SPECIFICS ON EACH STRATEGY(S)	**LEAD PARTNER(S)**	**2023-2024 ACTIVITIES (action steps)**	**2024-2025 ACTIVITIES (action steps)**	**2025-2026 ACTIVITIES (action steps)**
3. Reduce Heart Disease	1. FCHD/FCHC	1. Provide Screenings at Community Events and Health Fairs 2. Provide Employee Screenings at Worksites 3. Increase Awareness of Heart Disease	1. Provide Screenings at Community Events and Health Fairs 2. Provide Employee Screenings at Worksites 3. Increase Awareness of Heart Disease	1. Provide Screenings at Community Events and Health Fairs 2. Provide Employee Screenings at Worksites 3. Increase Awareness of Heart Disease

Progress Notes:

2024-2025

1. 527 adults were screened at 7 events
2. Provided screenings for FCHC, FC Employees, Worthington
Meeting with other large FC Employers
3. Heart Disease was the focus of FCHC's Aug 2024 fair booth. FCHC Foundation's 2025 focus is Heart Health education. Multiple events and social media posts have taken place.

2023-2024

1. 472 adults were screened at 6 events
2. Provided screenings at FCHC, FC Employees, Worthington
3. FCHC opened a new Heart and Vascular Center, with financial help from the FCHC Foundation. This was the main story in Health Centering that goes out to the entire county.

APPENDIX A:
IMPACT AND PROCESS EVALUATION OF PREVIOUS COMMUNITY HEALTH IMPROVEMENT PLAN (2023-2026)

PRIORITY #4: CHRONIC DISEASE				
STRATEGY 3: Increase Screenings and Awareness of Heart Disease and Diabetes				
SPECIFICS ON EACH STRATEGY(S)	**LEAD PARTNER(S)**	**2023-2024 ACTIVITIES (action steps)**	**2024-2025 ACTIVITIES (action steps)**	**2025-2026 ACTIVITIES (action steps)**
4. Reduce Diabetes	1. FCHD/FCHC	1. Provide Screenings at Community Events and Health Fairs 2. Provide Employee Screenings at Worksites 3. Offer the Diabetes Prevention Program (DPP) at FCHC 4. Provide Diabetes Education Support for Providers, Free Clinic, and Community	1. Provide Screenings at Community Events and Health Fairs 2. Provide Employee Screenings at Worksites 3. Continue Offering the Diabetes Prevention Program at FCHC 4. Provide Diabetes Education Support for Providers, Free Clinic, and Community	1. Provide Screenings at Community Events and Health Fairs 2. Provide Employee Screenings at Worksites 3. Continue Offering the Diabetes Prevention Program at FCHC 4. Provide Diabetes Education Support for Providers, Free Clinic, and Community

Progress Notes:

2024-2025

1. No update until June
2. Provided screenings for FCHC, FC Employees, Worthington
Meeting with other large FC Employers
3. DPP is now billing for Medicare patients, so the program is now self-sustainable. 3-4 cohorts per year.
4. FCHC brought rep into provider offices to educate them on how best to get continuous glucose monitors (CGMs) approved and free. Still attending Free Clinic.

2023-2024

1. 472 adults were screened at 6 events
2. Provided screenings for FCHC, FC Employees, Worthington
3. The DPP is up and running at FCHC. It is CDC-approved and FCHC applied to bill for Medicare patients. 3-4 cohorts per year.
4. Diabetes education information was given to all provider offices. Diabetes Ed staff attended Free Clinic and follow up with patients. Diabetes education and screenings provided at events and fairs.

APPENDIX B

BENCHMARK COMPARISONS

BENCHMARK COMPARISONS

The following table compares Fulton County rates of the identified health needs to national goals called **Healthy People 2030 Objectives**. These benchmarks show how the service area compares to national goals for the same health need. This appendix is useful for monitoring and evaluation purposes in order to track the impact of our IS/CHIP to address priority health needs.

Fulton County PARTNERS FOR HEALTH
Building a Healthy Community

APPENDIX B:
HEALTHY PEOPLE OBJECTIVES & BENCHMARK COMPARISONS

Where data were available, Fulton County health and social indicators were compared to the Healthy People 2030 objectives. The **black** indicators are Healthy People 2030 objectives that did not meet established benchmarks, and the **green** items met or exceeded the objectives. Certain indicators were not reported, marked as N/R. Healthy People Objectives are released by the U.S. Department of Health and Human Services every decade to identify science-based objectives with targets to monitor progress, motivate and focus action.

BENCHMARK COMPARISONS			
INDICATORS	**DESIRED DIRECTION**	**FULTON COUNTY**	**HEALTHY PEOPLE 2030 OBJECTIVES**
High school graduation rate (% who graduate in 4 years)[49]	↑	97.2%	90.7%
Child health insurance rate[1]	↑	95.5%	92.4%
Adult health insurance rate[1]	↑	92.0%	92.4%
Ischemic heart disease deaths[14]	↓	160.5*	71.1 per 100,000 persons
Cancer deaths[14]	↓	234.5*	122.7 per 100,000 persons
Colon/rectum cancer deaths[14]	↓	19.5*	8.9 per 100,000 persons
Lung cancer deaths[14]	↓	49.8*	25.1 per 100,000 persons
Female breast cancer deaths[14]	↓	13.3*	15.3 per 100,000 persons
Prostate cancer deaths[14]	↓	10.4*	16.9 per 100,000 persons
Stroke deaths[14]	↓	58.4*	33.4 per 100,000 persons
Unintentional injury deaths[14]	↓	67.4*	43.2 per 100,000 persons
Suicides[14]	↓	13.3*	12.8 per 100,000 persons
Liver disease (cirrhosis) deaths[14]	↓	11.4*	10.9 per 100,000 persons
Unintentional fall deaths, adults 65+[35]	↓	82.4	63.4 per 100,000 persons ages 65+
Unintentional drug-overdose deaths[14]	↓	22.3*	20.7 per 100,000 persons
Overdose deaths involving opioids[39]	↓	17.3*	13.1 per 100,000 persons
Early and adequate prenatal care[52]	↑	85.0%	80.5%
Preterm births, babies born before 37 weeks of gestation[33]	↓	8.4%	9.4%
Infant death rate[51]	↓	7.6**	5.0 per 1,000 live births
Adults, ages 18+, obese+	↓	47.7%	36.0%, adults ages 20+
Adults engaging in binge drinking+	↓	19.6%	22.7%
Cigarette smoking by adults+	↓	3.4%	6.1%
Pap smears, ages 18-64, screened in the past 3 years+	↑	72.4%	79.2%, ages 21-65
Mammograms, ages 45+, screened in the past 2 years+	↑	86.1%	80.3%, ages 50-74
Colorectal cancer screenings, ages 45+, per guidelines+	↑	57.3%	72.8%, ages 45-75
Medicare enrollee annual influenza vaccinations[46]	↑	51.0%	70.0%, all adults
Food insecure households[21]	↓	13.3%	6.0%

**Crude rates per 100,000, 2019-2023 average (only crude rates are available starting in 2021)*
***Rates based on fewer than 20 infant deaths should be interpreted with caution.*
+As reported in 2025 Fulton County community member survey.

APPENDIX C

KEY INFORMANT INTERVIEW PARTICIPANTS

KEY INFORMANT INTERVIEW PARTICIPANTS

Listed on the following page are the names of **20** leaders, representatives, and members of the community who were consulted for their expertise on the needs of the community. The following individuals were identified by the CHNA team as leaders based on their professional expertise and knowledge of various target groups throughout the service area.

Fulton County PARTNERS FOR HEALTH
Building a Healthy Community

APPENDIX C:
KEY INFORMANT INTERVIEW PARTICIPANTS

FULTON COUNTY

INTERVIEW PARTICIPANTS		
NAME(S)	**ROLE**	**ORGANIZATION**
1. Amanda Short	Interpreter	Fulton County Health Department
2. Amy Metz-Simon	FC JFS Director	Fulton County Job & Family Services
3. Amy White	Certified Physician's Assistant	FCHC—Urgent Care
4. Cara Leininger	Workforce Development Coordinator	Fulton County Workforce Development
5. Cecily Rohrs	Founder/Director	Shepherd Circle
6. Christine McVay	Director of Crisis Services	Ohio Guidestone
7. Chuck Whitmire	Pastor	Christian Union Church
8. Jessica Double	Human Resources	Worthington Steel
9. Jon Rupp	County Commissioner	Fulton County Board of County Commissioners
10. Kathy Shaw	Director	Triangular Processing
11. Kim Cupp	Health Commissioner	Fulton County Health Department
12. Mayor Brad Grime	Mayor	Village of Archbold
13. Patti Finn	CEO	Fulton County Health Center
14. Phil Kessler	Wauseon Fire Chief	Wauseon Fire Department
15. Rebecca Shirley	Nurse Practitioner	Fulton County Health Center

APPENDIX C:
KEY INFORMANT INTERVIEW PARTICIPANTS
FULTON COUNTY

INTERVIEW PARTICIPANTS		
NAME(S)	**ROLE**	**ORGANIZATION**
16. Robin Shepherd	Superintendent	Fulton County Board of Development Disabilities
17. Roy Miller	Sheriff	Fulton County Sheriff
18. Sabrina Lind	Emergency Room Director	Fulton County Health Center
19. Sheri Rychener	Director	Fulton County Senior Center
20. Tonie Long	CEO	Four County ADAMHS Board

APPENDIX D

FOCUS GROUP PARTICIPANTS

FOCUS GROUP PARTICIPANTS

Listed on the following page are the details of the **3 focus groups** conducted with a total of **32 community members**, including the number of participants, format, and group represented.

Fulton County PARTNERS FOR HEALTH
Building a Healthy Community

APPENDIX D:
FOCUS GROUP PARTICIPANTS

FOCUS GROUP PARTICIPANTS			
GROUP/TOPIC REPRESENTED	FORMAT	PARTICIPATING ORGANIZATION(S)	# OF PARTICIPANTS
Seniors	In-person	Fulton County Senior Center	15
Parents	Virtual	Fulton County Health Department	7
Hispanic/Latino	In-person	Fulton County Health Department	10

APPENDIX D:
FOCUS GROUP DEMOGRAPHICS

Note: 88% of focus group participants responded to some or all of the optional demographic questions. Focus groups were meant to hear specifically from priority populations in the community most affected by health disparities, not necessarily to represent the overall demographics of the community.

- The greatest proportion of participants came from **Wauseon (43567)** – 78%, with representation from Archbold (43502), Delta (43515), and Swanton (43558) as well.
- **65+ was the most represented age group (44%),** followed by 35-44 (15%), 45-54 (11%), and 55-64 (11%). With the exception of those under 18, all age groups had some representation.
- **79% of participants were women**.
- There was representation from **White/Caucasian** (70%) and **Hispanic/Latino** (30%) residents.
- **71% of participants primarily speak English at home**, and 29% primarily speak Spanish.
- **75% of participants had no children** in their home, while 25% had 1 or more children in their home.
- **Most participants' highest level of education was a high school degree or equivalent (36%)**, followed by some college but no degree (25%) and trade school or vocational certificate (21%).
- **43% of participants were employed either full or part-time,** while 43% were retired and 14% were not employed.
- **58% of participants had a household income of less than $50,000**, while 42% had a household income of $50,000 or higher. Each income category had representation.
- **15%** of participants **identified as having a disability**.
- **82%** of participants reported **having a steady place to live**.

APPENDIX E

COMMUNITY MEMBER SURVEY

COMMUNITY MEMBER SURVEY

On the following pages are the questions and demographics from the community member survey that was distributed to Fulton County residents to get their perspectives and experiences on the health assets and needs of the community they call home. **501 responses** were received.

Fulton County PARTNERS FOR HEALTH
Building a Healthy Community

APPENDIX E:
COMMUNITY MEMBER SURVEY

Welcome!

Fulton County is conducting a Community Health Needs Assessment (CHNA) to identify and assess the health needs of the community. We are asking community members (those who live and/or work in Fulton County) to complete this, 15-20 minute survey. This information will help guide us as we consider services, programs, and policies that will benefit the community.

Be assured that this process is completely anonymous - we cannot access your name or any other identifying information. Your individual responses will be kept strictly confidential and the information will only be presented in aggregate (as a group). Your participation in this survey is entirely voluntary and you are free to leave any of the questions unanswered/skip questions you prefer not to answer (so only answer the questions you want to answer!). Thank you for helping us to better serve our community!

Language

Please select your preferred language / Por favor seleccione su idioma preferido.
- English
- Español

Demographics

1. What is your zip code where you currently live? (choose one)
- 43567
- 43558
- 43515
- 43502
- 43521
- 43533
- 43540
- 43553
- Prefer not to answer
- Other (feel free to specify)

2. Which of the following best describes your age?
- Under 18
- 18-24
- 25-34
- 35-44
- 45-54
- 55-64
- 65+
- Prefer not to answer

3. What is your gender? (SELECT ALL THAT APPLY)
- Female
- Male
- Prefer not to answer
- Other (please specify)

4. What is your race and/or ethnicity? (SELECT ALL THAT APPLY)
- Asian
- Black or African American
- Hispanic/Latino/a
- White/Caucasian
- Multiracial/More than one race
- Native American/Alaska Native
- Native Hawaiian/Pacific Islander
- Prefer not to answer
- Not Listed (feel free to specify)

5. What is your current living situation? (SELECT ALL THAT APPLY)
- I have a steady place to live
- I have a place to live today, but I am worried about losing it in the future
- I do not have a steady place to live (I am temporarily staying with others)
- I am staying in a shelter
- I am living outside
- I am living in a car
- I am living elsewhere
- Prefer not to answer
- Other (feel free to specify)

6. What is the highest grade of school you completed?
- Never attended or only attended kindergarten
- Grades 1 through 8 (Elementary)
- Grades 9 through 11 (some high school)
- Grade 12 or GED (high school graduate)
- College 1 tear to 3 years (some college or technical school)
- College 4 years or more (college graduate)
- Post-graduate
- Prefer not to answer

7. What is your annual household income?
- Less than $10,000
- $10,000 to $14,999
- $15,000 to $19,999
- $20,000 to $24,999
- $30,000 to $34,999
- $35,000 to $49,999
- $50,000 to $74,999
- $75,000 to $99,999
- $100,000 to $149,999
- $150,000 or more
- Don’t know
- Prefer not to answer

8. How much do you weigh without your shoes on? (use pounds, ex: 120 pounds)

9. How tall are you without your shoes on? (use feet/inches, ex: 5’4”)

APPENDIX E: COMMUNITY MEMBER SURVEY

10. Do you have any of the following disabilities or chronic conditions? (SELECT ALL THAT APPLY)
- Attention deficit
- Autism
- Blind or visually impaired
- Cancer
- Chronic Liver Disease/Cirrhosis
- Chronic Obstructive Pulmonary Disease (COPD)
- Deaf or hard of hearing
- Dementia (e.g. Alzheimer's and other worsening confusion and cognitive decline)
- Diabetes
- Health-related disability
- Heart disease and/or stroke
- Hypertension
- Kidney disease
- Learning disability
- Mental health condition
- Mobility-related disability
- Parkinson's
- Speech-related
- Substance use disorder
- None
- Prefer not to answer
- Other/Not Listed (feel free to specify or tell us more)

Health Needs and Community Resources

11. While it can be hard to choose, please do your best to select what you feel are the TOP 5 COMMUNITY OR SOCIAL CONDITIONS of concern in your community. (please check your top 3)
- Access to childcare
- Access to healthcare (e.g. doctors, hospitals, specialists, mental healthcare, dental/oral care, vision care, medical appointments, health insurance coverage, health literacy, etc.)
- Addiction to gambling, gaming or sports betting
- Adverse childhood experiences (e.g. child abuse, mental health, family issues, trauma, etc.)
- Community engagement (not sure how to find resources or referrals)
- Crime and violence
- Education (e.g. early childhood education, elementary school, postsecondary education, etc.)
- Employment/work
- Environmental conditions (e.g. air and water quality)
- Food insecurity (e.g. not being able to access and/or afford healthy food)
- Housing and homelessness
- Income/poverty
- Internet/Wi-Fi access
- Nutrition and physical health/exercise (includes overweight and obesity)
- Preventive care and practices (e.g. screenings, mammograms, pap tests, vaccinations)
- Substance use (alcohol and drugs)
- Tobacco and nicotine use/smoking/vaping
- Transportation (e.g. public transit, cars, cycling, walking)
- Other/Not Listed (feel free to specify)

12. While it can be hard to choose, please do your best to select what you feel are the TOP 3 HEALTH ISSUES (e.g. impacts, diseases, conditions, etc.) of concern in your community. (please check your top 3)
- Chronic diseases (e.g. heart disease, diabetes, cancer, asthma, etc.) - Please specify which chronic disease(s) you feel is the biggest issue in the community in the 'Other' box below
- Disabilities
- HIV/AIDS and Sexually Transmitted Infections (STIs)
- Infectious diseases (flu, RSV, measles, E.coli, etc.)
- Injuries (workplace injuries, car accidents, falls, etc.)
- Maternal, infant and child health (e.g. pre-term births, infant mortality, maternal morbidity and mortality)
- Mental health (e.g. depression, anxiety, suicide, etc.)
- Other/Not Listed (feel free to specify)

13. What resources are lacking within your community? (SELECT ALL THAT APPLY)
- Affordable food
- Affordable housing
- Childcare
- Dental/oral healthcare access
- Hospital/acute and emergency healthcare
- Maternal, infant, and child healthcare (e.g. OB/GYN, midwives, doulas, pediatricians, etc.)
- Mental healthcare access
- Primary healthcare access (family physician, nurse practitioner, etc.)
- Quality, well-paying jobs
- Recreational spaces (e.g. parks, walking paths, community centers, gyms/workout facilities, etc.)
- Specialist healthcare (e.g. oncologist/cancer care, cardiologist/heart care, nephrologist/kidney care, physical therapy, dietitian, etc.)
- Substance use treatment/harm reduction
- Transportation
- Vision healthcare access
- There is no lack of resources in my community
- I don't know what resources are lacking in my community
- Other/Not Listed (feel free to specify)

Health Status

14. Would you say that in general your health is:
- Excellent
- Very Good
- Good
- Fair
- Poor

APPENDIX E: COMMUNITY MEMBER SURVEY

Health Care Access & Utilization

15. About how long has it been since you last visited a doctor/health care provider for a routine checkup? A routine checkup is a general physical exam, not an exam for specific injury, illness or condition.
- Within the past year (anytime less than 12 months ago)
- Within the past 2 years (1 year but less than 2 years ago)
- Within the past 5 years (2 years but less than 5 years ago)
- 5 or more years ago
- Don't know
- Never

16. In the past 12 months, have you chosen to go outside of Fulton County for the following healthcare services? (SELECT ALL THAT APPLY)
- I did not use any healthcare services outside of Fulton County
- Specialty care
- Primary care (family doctor)
- Dental services
- Cardiac care
- Orthopedic care
- Cancer care
- Mental health care/counseling services
- Hospice/palliative care
- Pediatric care
- Pediatric therapies (e.g. physical therapy, occupational therapy, speech therapy)
- Obstetrics/gynecology
- Addiction services
- Female health services
- Dermatological (skin care)
- Podiatry (foot/ankle) care
- Bariatric (obesity) care
- Ear, nose, throat care
- Skilled nursing rehabilitation
- Other (feel free to specify)

17. In the past 12 months, why have you gone outside of Fulton County for health care services? (SELECT ALL THAT APPLY)
- I did not go outside of Fulton County for health care services
- I did not like local services/providers
- Service was not available locally
- I had insurance restrictions
- I went there because I used to live there
- Confidentiality/anonymity
- I work there
- The wait list was too long in Fulton County
- There was a better quality of program
- Word of mouth
- Had a bad experience locally
- Hours not convenient
- Other (feel free to specify)

Health Care Coverage

18. During the past 12 months, why did you not get a prescription from your doctor filled? (SELECT ALL THAT APPLY)
- I had all prescriptions filled
- My doctor did not prescribe me any medications
- I have no insurance
- I am taking too many medications
- Too expensive
- There was no generis equivalent of what was prescribed
- I stretched my current prescription by taking less than what was prescribed
- Transportation
- Side effects
- Fear of addiction
- I did not think I needed it
- Other (feel free to specify)

Oral Health

19. How long has it been since you last visited a dentist or a dental clinic for any reasons? Include visits to dental specialists, such as orthodontists.
- Within the past year (anytime less than 12 months ago)
- Within the past 2 years (1 year but less than 2 years ago)
- Within the past 5 years (2 years but less than 5 years ago)
- 5 or more years ago
- Don't know
- Never

Preventive Medicine & Health Screenings

20. Have you ever been told by a doctor that you have diabetes?
- Yes
- Yes, but only during pregnancy
- No
- No, told I have pre-diabetes or borderline diabetes
- Don't know

21. Have you ever been told by a doctor, nurse, or other health professional that you have high blood pressure?
- Yes
- Yes, but only during pregnancy
- No
- No, told I had borderline high blood pressure or that I was pre-hypertensive
- Don't know

22. Have you ever been told by a doctor, nurse, or other health professional that your blood cholesterol is high?
- Yes
- No
- Don't know

APPENDIX E:
COMMUNITY MEMBER SURVEY

23. About how long has it been since you last had your blood cholesterol checked?
- Within the past year (anytime less than 12 months ago)
- Within the past 2 years (1 year but less than 2 years ago)
- Within the past 5 years (2 years but less than 5 years ago)
- 5 or more years ago
- Don’t know
- Never

24. Has a doctor, nurse, or other health professional ever told you that you have had any of the following? (SELECT ALL THAT APPLY)
- Heart attack or myocardial infarction
- Angina or coronary heart disease
- Had a stroke
- Congestive heart failure
- None of the above

25. A sigmoidoscopy or colonoscopy is when a tube is inserted in the rectum to view the bowel for signs of cancer and other health problems. When did you have your last sigmoidoscopy or colonoscopy?
- Within the past year (anytime less than 12 months ago)
- Within the past 2 years (1 year but less than 2 years ago)
- Within the past 3 years (2 years but less than 3 years ago)
- Within the past 5 years (3 years but less than 5 years ago)
- Within the past 10 years (5 years but less than 10 years ago)
- 10 or more years ago
- Never
- Don’t know

26. Have you had any of the following vaccines?

	Yes	No	Don't know
Annual seasonal flu (Influenza) vaccine in the past year	○	○	○
Pneumonia vaccine in your lifetime	○	○	○
Zoster (Shingles) vaccine in your lifetime	○	○	○
COVID vaccine in the past year	○	○	○

Alcohol Consumption

27. During the past 30 days, how many days per month did you have at least one drink of any alcoholic beverage such as beer, wine, a malt beverage, or liquor?
- No drinks in the past 30 days
- 1-5 days
- 6-10 days
- 11-25 days
- 26-29 days
- All 30 days
- Don't know
- Prefer not to answer

28. Considering all types of alcoholic beverages, how many times during the past 30 days did you have (for males) 5 or more drinks on an occasion, or (for females) 4 or more drinks on an occasion?
- 0 days
- 1-5 days
- 6-10 days
- 11-25 days
- 26-29 days
- All 30 days
- Don't know
- Prefer not to answer

29. During the past six months, have you, an immediate family member, or someone in your household experienced any of the following? (SELECT ALL THAT APPLY)
- Had to drink more to get same effect
- Drove vehicle or other equipment after having any alcoholic beverage
- Used prescription drugs while drinking
- Drank more than you expected
- Gave up other activities to drink
- Spent a lot of time drinking
- Tried to quit or cut down (but could not)
- Continued to drink despite problems caused by drinking
- Drank to ease withdrawal symptoms
- Failed to fulfill duties at work, home, or school
- Placed yourself or your family in harm
- Had legal problems
- None of the above
- Don’t know
- Prefer not to answer

Tobacco Use

30. Have you smoked at least 100 cigarettes in your entire life and now do not smoke?
- Yes
- No, I currently smoke
- Don't know
- I have never smoked
- Prefer not to answer

31. During the past 12 months, have you stopped smoking for one day or longer because you were trying to quit smoking?
- Yes
- No
- Did not smoke in the past 12 months
- Don't know
- Prefer not to answer

APPENDIX E:
COMMUNITY MEMBER SURVEY

32. When was the most recent time you used the forms of tobacco listed below? (SELECT ALL THAT APPLY)

	In the past 30 days	In the past 12 months	Not at all
Cigarettes	○	○	○
E-cigarettes or other electronic vaping products (e.g. vapes)	○	○	○
Hookah	○	○	○
Little cigars	○	○	○
Bidis	○	○	○
Chewing tobacco, snuff, snus	○	○	○
Dissolvable tobacco	○	○	○
Cigars (e.g. Black & Milds)	○	○	○
Pipes	○	○	○
Cigarillos (e.g. Swisher Sweets)	○	○	○
Tobacco pouch	○	○	○

Marijuana and Drug Use

33. During the past six months, have you, an immediate family member, or someone in your household used any of the following? (SELECT ALL THAT APPLY)

	You	Immediate family member or someone in my household	Not Applicable
Misused prescription medications	☐	☐	☐
Used recreational marijuana or hashish	☐	☐	☐

34. In the past 30 days, have you used any of the following? (SELECT ALL THAT APPLY)
- Recreational marijuana
- Medical marijuana
- Other products that have THC oil
- Marijuana that you, a family member, or a friend grew
- Vapes with THC
- Edibles
- None of the above
- Prefer not to answer

Women's Health
MEN-SKIP AND GO TO MEN'S SECTION ON NEXT PAGE

35. A mammogram is an x-ray of each breast to look for breast cancer. How long has it been since your last mammogram?
- Have never had a mammogram
- Within the past year
- Within the past 2 years (1 year but less than two years ago)
- Within the past 3 years (2 years but less than three years ago)
- Within the past 5 years (3 years but less than five years ago)
- 5 or more years ago
- Breasts were removed
- Don't know
- Not applicable

36. A Pap smear is a test for cancer of the cervix. How long has it been since you had your last pap smear?
- Have never had a Pap smear
- Within the past year
- Within the past 2 years (1 year but less than two years ago)
- Within the past 3 years (2 years but less than three years ago)
- Within the past 5 years (3 years but less than five years ago)
- 5 or more years ago
- Breasts were removed
- Don't know
- Not applicable

Men's Health
WOMEN-SKIP AND GO TO WEIGHT CONTROL SECTION ON NEXT PAGE

37. A Prostate-Specific Antigen test, also called a PSA test, is a blood test used to check men for prostate cancer. When was your last PSA test?
- Have never had a PSA test
- Within the past year
- Within the past 2 years (1 year but less than two years ago)
- Within the past 3 years (2 years but less than three years ago)
- Within the past 5 years (3 years but less than five years ago)
- 5 or more years ago
- Don't know
- Not applicable

Weight Control

38. On an average day, how many hours do you spend doing the following non-active activities?

	TV	Video Games	Computer/Tablet (outside of work)	Cell Phone (talk, text, internet)
0 hours	☐	☐	☐	☐
Less than 1 hour	☐	☐	☐	☐
2 hours	☐	☐	☐	☐
3 hours	☐	☐	☐	☐
4 hours	☐	☐	☐	☐
5 hours	☐	☐	☐	☐
6+ hours	☐	☐	☐	☐

APPENDIX E: COMMUNITY MEMBER SURVEY

39. During the past 30 days, did you do any of the following to lose weight or keep from gaining weight? (SELECT ALL THAT APPLY)
- I did not do anything to lose weight or keep from gaining weight
- Eat less food or fewer calories
- Follow a special diet (e.g. low carb, low fat, Keto, etc.)
- Drink more water
- Exercise
- Go without eating for 24 hours
- Take any diet pills, powders, or liquids without a doctor's advice
- Vomit after eating
- Take laxatives
- Smoke cigarettes
- Use e-cigarettes or other electronic vaping products
- Bariatric surgery (preparation or maintenance)
- Use a weight loss program such as Weight Watchers, Atkins Diet, etc.
- Participate in a dietary or fitness program prescribed by a health professional
- Take medications prescribed by a health professional
- Health coaching
- Use a medical weight management program
- Other (feel free to specify)

Exercise

40. During the past 7 days, how many days did you engage in some type of exercise or physical activity for at least 30 minutes?
- 0 days
- 1 day
- 2 days
- 3 days
- 4 days
- 5 days
- 6 days
- 7 days
- Not able to exercise

Diet and Nutrition

41. What determines the types of food you eat? (SELECT ALL THAT APPLY)
- Cost
- Healthiness of food
- If it is genetically modified
- (GMO)
- If it is organic
- Calorie content
- Nutritional content (reading label)
- Taste/enjoyment
- Gluten-free
- Lactose-free
- Other food sensitivities
- Artificial sweetener content
- Availability
- Ease of preparation/time
- Food that I am used to
- What my family prefers
- Limitations set by WIC
- Limitations due to dental issues
- Health care provider's advice
- Availability of food at the food pantry
- Don't know
- Other (feel free to specify)

Mental Health

42. During the past 12 months, did you ever feel so sad or hopeless almost every day for two weeks or more in a row that you stopped doing some usual activities?
- Yes
- No
- Prefer not to answer

43. During the past 12 months, did you ever seriously consider attempting suicide?
- Yes
- No
- Prefer not to answer

44. During the past 12 months, how many times did you actually attempt suicide?
- 0 times
- 1 time
- 2 or 3 times
- 4 or 5 times
- 6 or more times
- Prefer not to answer

45. What would you do if you knew someone who was suicidal? (SELECT ALL THAT APPLY)
- Call 9-1-1
- Call crisis line (1-800-468-4357)
- Call/text 988
- Text crisis line
- Take them to the ER
- Call a friend
- Talk to them
- Call your spiritual leader
- Nothing
- Prefer not to answer
- Other (feel free to specify)

46. What causes you anxiety, stress, or depression? (SELECT ALL THAT APPLY)
- Fighting in the home
- Unemployment
- Poverty/no money
- Marital/dating relationships
- Death of close family member or friend
- Divorce/separation
- Family member is sick
- Raising/caring for children
- Caring for a parent
- Family member with a mental illness
- Not having a place to live
- Not feeling safe at home
- Not having enough to eat
- Not feeling safe in the community
- Sexual orientation/gender identity
- Job stress
- Financial stress
- Social media
- Current news/political environment
- Other stress at home
- None of the above
- Prefer not to answer
- Other (feel free to specify)

APPENDIX E: COMMUNITY MEMBER SURVEY

47. Where do you get the social and emotional support you need? (SELECT ALL THAT APPLY)

- I do not get the social and emotional support I need
- I do not need support/can handle it myself
- Text crisis line
- Friends
- Family
- Neighbors
- Internet
- Church
- God/prayer
- Community
- A professional
- Self-help group
- Online support group
- Prefer not to answer
- Other (feel free to specify)

48. What are your reasons for not using a program or service to help with depression, anxiety, or other emotional problems for you or for a loved one? (SELECT ALL THAT APPLY)

- A program has been used
- Not needed/not necessary
- Transportation
- Fear
- Took too long to get in to see a doctor/health care provider
- Co-pay/deductible is too high
- Cannot afford to go
- Cannot get to the office or clinic
- Cannot find a mental health doctor or provider
- Don't know how to find a program
- Embarrassed to seek mental health services
- The clinic my insurance covers is too far away
- Cannot find a provider to address both mental health and disability
- Other priorities
- Have not thought of it
- Don't know
- Prefer not to answer
- Other (feel free to specify)

Quality of Life

49. Are you limited in any way in any activities because of physical, mental, or emotional problems?

- Yes
- No
- Don't know

50. Are you responsible for providing regular care or assistance to any of the following? (SELECT ALL THAT APPLY)

- Multiple children
- Children with discipline issues
- An adult child
- A friend, family member, or spouse who has a health problem
- A friend, family member, or spouse with a mental health issue
- Someone with special needs
- A friend, family member, or spouse with memory loss or dementia
- Elderly parent or loved one
- Grandchildren
- Foster children
- Children whose parent(s) use drugs and are unable to care for their children
- Children whose parent(s) lost custody due to other reasons
- None of the above
- Other (feel free to specify)

Social Determinants of Health

51. Trigger Warning: The following question about your childhood may be disturbing for some people and trigger unpleasant memories or thoughts. Please remember you can always skip any question you don't feel comfortable reading or answering.
Did any of the following happen to you as a child (under the age of 18) (SELECT ALL THAT APPLY)

- Lived with someone who was depressed, mentally ill or suicidal
- Lived with someone who was a problem drinker or alcoholic
- Lived with someone who used illegal street drugs, or who abused prescription medications
- Lived with someone who served time or was sentenced to serve time in a prison, jail, or other correctional facility
- Your parents became separated or were divorced
- Your parents were not married
- Your parents or adults in your home slapped, hit, kicked, punched, or beat each other up
- A parent or adult in your home hit, beat, kicked, or physically hurt you in any way (not including spanking)
- A parent or adult in your home swore at you, insulted you, or put you down
- Someone at least 5 years older than you or an adult touched you sexually
- Someone at least 5 years older than you or an adult tried to make you touch them sexually
- Someone at least 5 years older than you or an adult forced you to have sex
- Your family did not look out for each other, feel close to each other, or support each other
- You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you
- None of the above has happened to me
- Prefer not to answer
- Other (feel free to specify)

52. Have you experienced any of the following in the past 12 months? (SELECT ALL THAT APPLY)

- My food assistance was cut
- Loss of income led to food insecurity issues
- I had to choose between paying bills and buying food
- I went hungry/ate less to provide more food for my family
- I was hungry, but did not eat because I did not have money for food
- I was worried food would run out
- I did not experience any of these things in the past 12 months

53. What transportation issues do you have? (SELECT ALL THAT APPLY)

- I do not have any transportation issues
- No car
- No driver's license/suspended license
- No car insurance
- Other car issues/expenses
- Cannot afford gas
- Disabled
- Limited public transportation available or accessible
- No public transportation available or accessible
- Cost of public or private transportation
- Do not feel safe to drive

APPENDIX E: COMMUNITY MEMBER SURVEY

54. In the past 30 days, did you do any of the following while driving? (SELECT ALL THAT APPLY)
- Drive without a seatbelt
- Talk on hand-held cell phone
- Talk on hands-free cell phone
- Text
- Drive under the influence of alcohol
- Drive under the influence of recreational drugs
- Drive under the influence of prescription drugs
- Read
- Eat
- Use Internet on cell phone
- I do not drive
- None of the above
- Other (feel free to specify)

55. In the past 12 months, have you, an immediate family member, or someone in your household received assistance from a governmental or community agency for any of the following? (SELECT ALL THAT APPLY)

	Received assistance	Did not know where to look	Did not need assistance
Affordable child care	☐	☐	☐
Assistance in care for the disabled and/or elderly (either in-home or out-of-home)	☐	☐	☐
Cancer support group/counseling	☐	☐	☐
Clothing	☐	☐	☐
Credit counseling	☐	☐	☐
Dental care	☐	☐	☐
Diapers	☐	☐	☐
Drug or alcohol addiction	☐	☐	☐
Employment	☐	☐	☐
End-of-life care or Hospice care	☐	☐	☐
Family Planning	☐	☐	☐
Food	☐	☐	☐
Free tax preparation	☐	☐	☐
Gambling addiction	☐	☐	☐
Health care	☐	☐	☐
Home repair	☐	☐	☐
Legal aid services	☐	☐	☐
Marital or family problems	☐	☐	☐
Medicare/Medicaid	☐	☐	☐
Mental illness issues (including depression)	☐	☐	☐
Post incarceration transition issues	☐	☐	☐
Prescription assistance	☐	☐	☐
Rent/mortgage	☐	☐	☐
Septic/well repairs	☐	☐	☐
Tobacco cessation	☐	☐	☐
Transportation	☐	☐	☐
Unplanned pregnancy	☐	☐	☐
Utilities	☐	☐	☐
Weight problem	☐	☐	☐

Parenting

56. What did you discuss with your 12 to 17 year-old child in the past year? (SELECT ALL THAT APPLY)
- I do not have a child 12 to 17 years old
- Abstinence and how to refuse sex (age appropriate)
- Birth control/condoms/safer sex/STD prevention (age appropriate)
- Dating and relationships
- Volunteering
- Career plan/post-secondary education
- Body image
- Weight status (eating habits, physical activity, and screen time)
- Bullying (cyber, indirect, physical, verbal)
- Social media issues
- Energy drinks
- Depression, anxiety, suicide
- Refusal skills/peer pressure
- Negative effects of alcohol, tobacco, illegal drugs or misusing prescription drugs
- School/legal consequences using alcohol, tobacco or other drugs
- Limiting phone/screen time
- Gun safety
- Marijuana/cannabis/weed/THC vape
- Did not discuss any of the above

Miscellaneous Health

57. How do you prefer to get information about your health and/or community concerns? (SELECT ALL THAT APPLY)
- Family member or friend
- My doctor/health care provider
- Newspaper articles or radio/television news stories
- Faith-based community/church
- Internet
- Advertising or mailings
- Social media (Facebook, Twitter, Instagram)
- Billboards
- Texts on cell phone
- In-person education/classes
- Podcasts/webinars

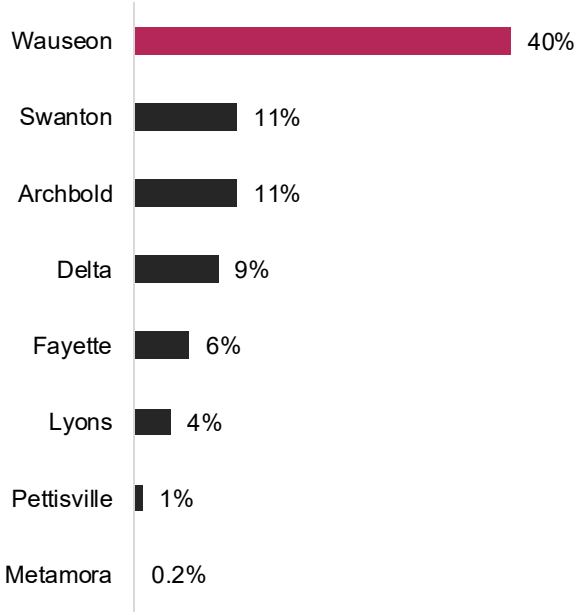
Final Comments

Thank you! Please send this survey to anyone you know who lives and/or works in Fulton County.

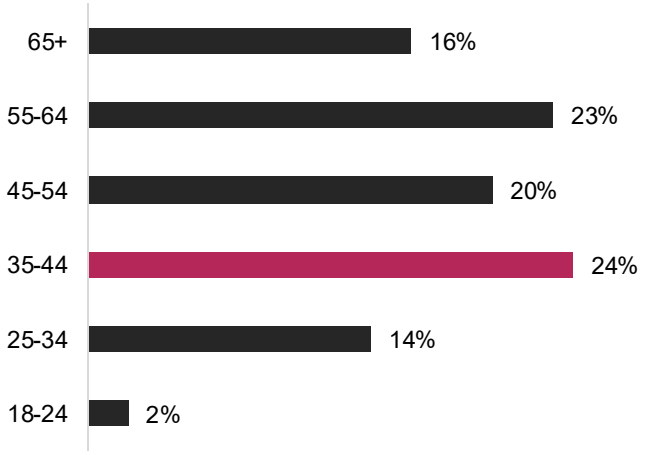
58. Do you have any other feedback or comments to share with us?

APPENDIX E:
COMMUNITY MEMBER SURVEY DEMOGRAPHICS

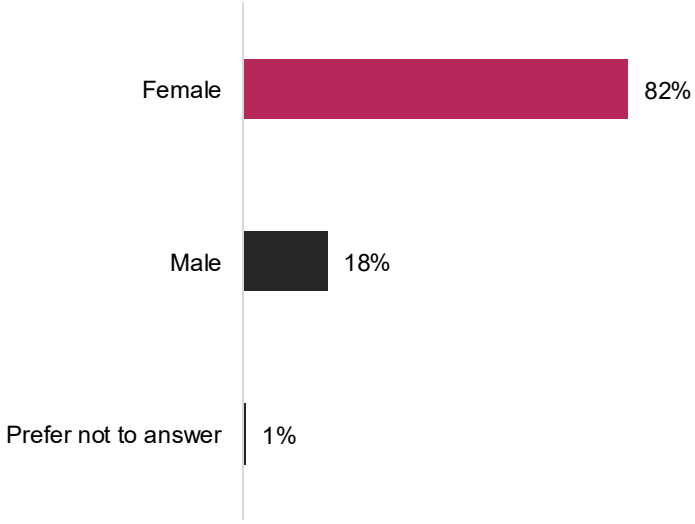
The majority of respondents live in **Wauseon (43567)**, while there was representation from Swanton (43558), Archbold (43502), and Delta (43515).



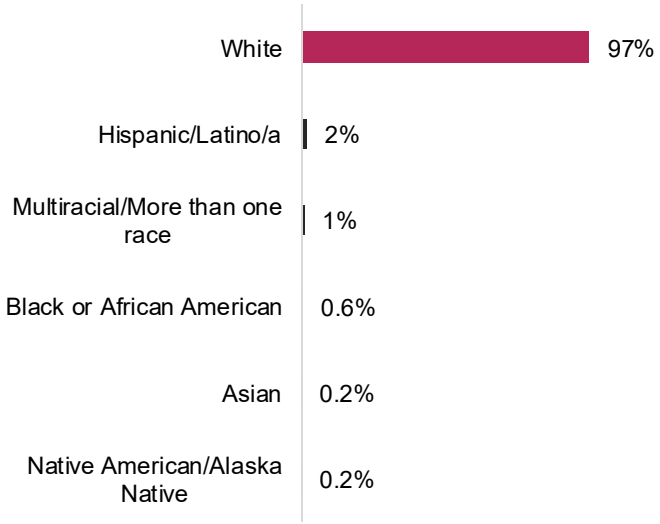
There was a greater proportion of survey responses from **middle-aged adults** rather than younger adults, particularly from the 35-44, 55-64, and 45-54 year-old age groups.



The majority of respondents were **female** (males were underrepresented).

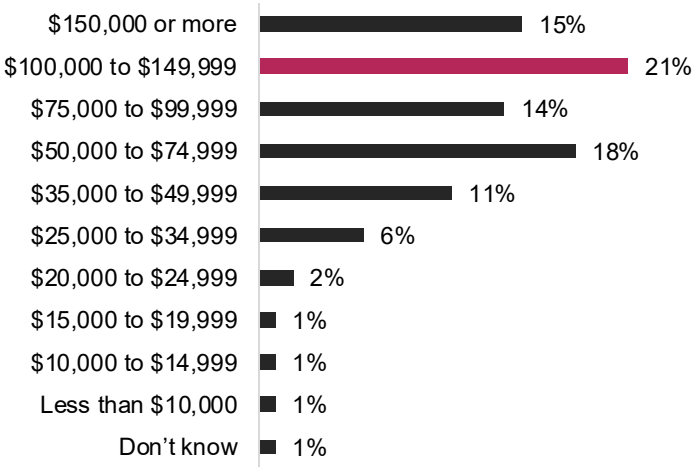


The majority of respondents were **White**, consistent with the composition of the service area. However, Hispanic/Latino and Multiracial residents were slightly underrepresented.



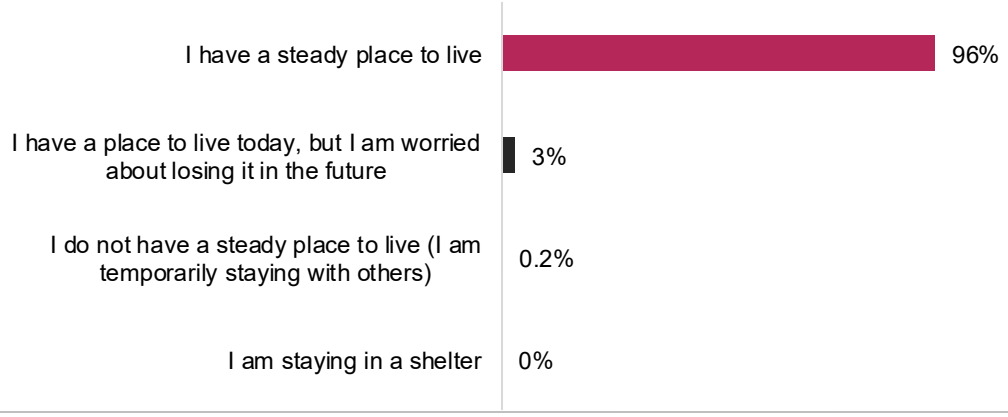
APPENDIX E:
COMMUNITY MEMBER SURVEY DEMOGRAPHICS

Respondents were generally **higher income**, with over half having an annual household income of $50,000-$150,000 or more. This representation is similar to the service area as a whole.

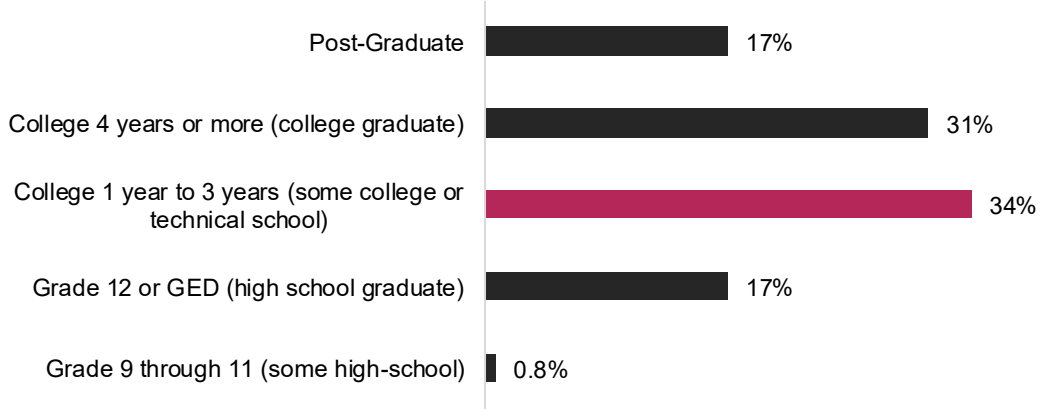


99% of respondents reported that their primary language spoken at home was **English.**

The majority of respondents have a **steady place to live**, while some are worried about losing it in the future.

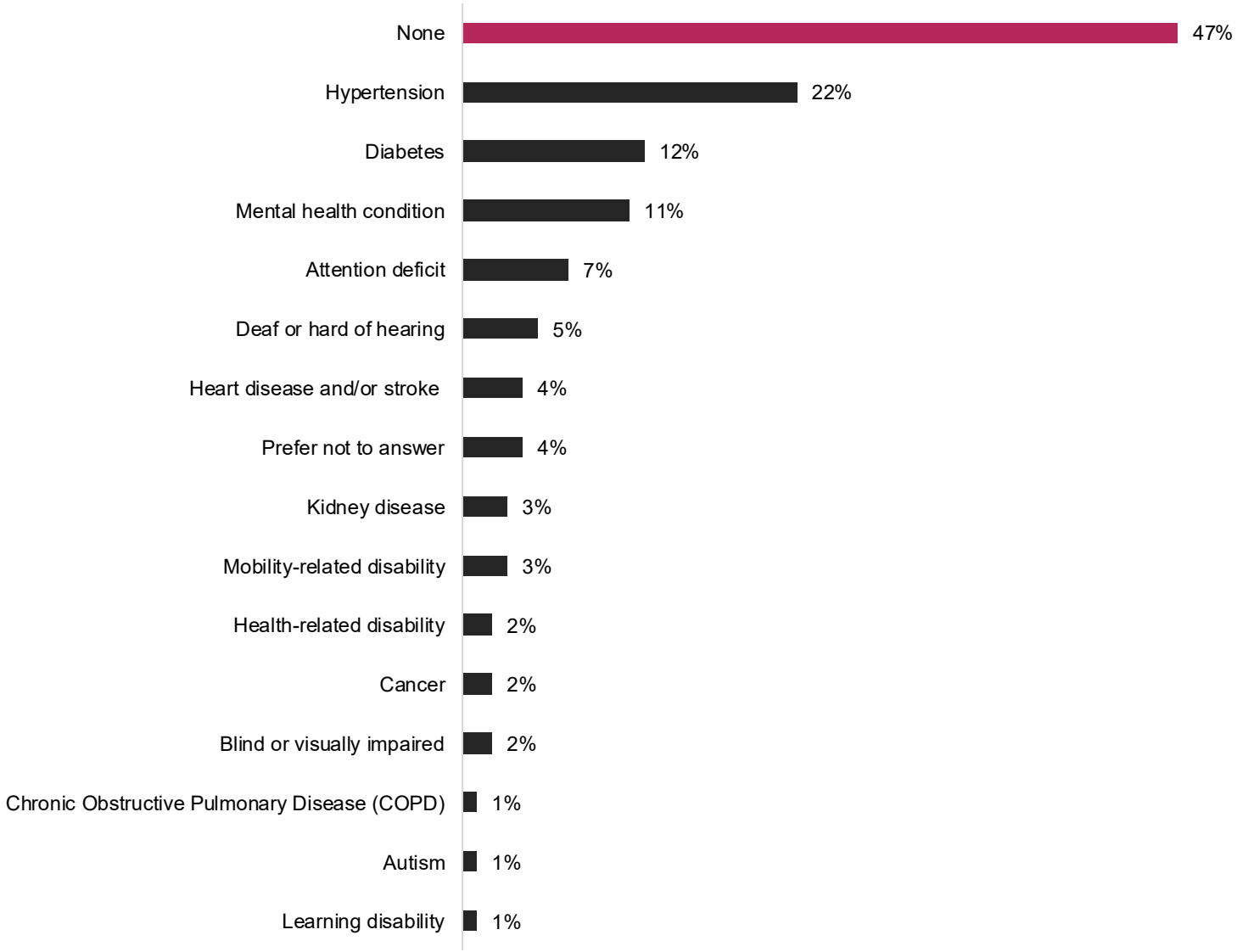


The majority of respondents have at least a **high school degree or equivalent, with a significant number having a Bachelor's or Graduate degree.**



APPENDIX E:
COMMUNITY MEMBER SURVEY DEMOGRAPHICS

More than half (53%) of respondents reported having at least one **disability and/or chronic health condition**, the most common being hypertension.



APPENDIX F

INTERNAL REVENUE SERVICE (IRS) CHECKLIST: COMMUNITY HEALTH NEEDS ASSESSMENT

MEETING THE IRS REQUIREMENTS FOR COMMUNITY HEALTH NEEDS ASSESSMENT

The IRS requirements for a CHNA serve as the official guidance for IRS compliance. The following pages demonstrate how this CHNA meets those IRS requirements.

APPENDIX F:
IRS CHNA REQUIREMENTS CHECKLIST

INTERNAL REVENUE SERVICE REQUIREMENTS FOR COMMUNITY HEALTH NEEDS ASSESSMENTS				
YES	**PAGE #**	**IRS REQUIREMENTS CHECKLIST**	**REGULATION SUBSECTION NUMBER**	**NOTES/ RECOMMENDATIONS**
✓	Appendix A (77-90)	**A. Activities Since Previous CHNA(s)** i. Describes the written comments received on the hospital's most recently conducted CHNA and most recently adopted implementation strategy. ii. Describes an evaluation of the impact of any actions that were taken, since the hospital facility finished conducting its immediately preceding CHNA, to address the significant health needs identified in the hospital facility's prior CHNA(s).	(b)(5)(C) (b)(6)(F)	
✓	3-7, 12-28	**B. Process and Methods**		
		Background Information		
		i. Identifies any parties with whom the facility collaborated in preparing the CHNA(s).	b)(6)(F)(ii)	
		ii. Identifies any third parties contracted to assist in conducting a CHNA.	(b)(6)(F)(ii)	
		ii. Defines the community it serves, which:		
		a. Must take into account all patients without regard to whether (or how much) they or their insurers pay for care or whether they are eligible for assistance.	(b)(i)	
		b. May take into account all relevant circumstances including the geographic area served by the hospital, target population(s), and principal functions.	(b)(3)	
		c. May not exclude medically underserved, low-income, or minority populations who live in the geographic areas from which the hospital draws its patients.	(b)(6)(i)(A)	
		iv. Describes how the community was determined.	(b)(6)(i)(A)	
		v. Describes demographics and other descriptors of the hospital service area.	(b)(6)(i)(A)	

APPENDIX F:
IRS CHNA REQUIREMENTS CHECKLIST

INTERNAL REVENUE SERVICE REQUIREMENTS FOR COMMUNITY HEALTH NEEDS ASSESSMENTS				
YES	**PAGE #**	**IRS REQUIREMENTS CHECKLIST**	**REGULATION SUBSECTION NUMBER**	**NOTES/ RECOMMENDATIONS**
✓	Methods: 3-7, 12-28 Appendix B, C, D, E Data: 9-11, 16-17, 24-72	*Health Needs Data Collection* i. Describes data and other information used in the assessment:	(b)(6)(ii)	Primary and secondary data is integrated together throughout the report
		a. Cites external source material (rather than describe the method of collecting the data).	(b)(6)(F)(ii)	
		b. Describes methods of collecting and analyzing the data and information.	(b)(6)(ii)	
		i. CHNA describes how it took into account input from persons who represent the broad interests of the community it serves in order to identify and prioritize health needs and identify resources potentially available to address those health needs.	(b)(1)(iii)	
		ii. Describes the medically underserved, low-income, or minority populations being represented by organizations or individuals that provide input.	(b)(5)(i)	
		a. At least one state, local, tribal, or regional governmental public health department (or equivalent department or agency) or a State Office of Rural Health. b. Members of the following populations, or individuals serving or representing the interests of populations listed below. (Report includes the names of any organizations - names or other identifiers not required.)	(b)(6)(F)(iii) (b)(6)(F)(iii)	
		1. Medically underserved populations 2. Low-income populations 3. Minority populations		
		c. Additional sources (optional) – (e.g. healthcare consumers, advocates, nonprofit and community-based organizations, elected officials, school districts, healthcare providers and community health centers).	(b)(5)(i)(A)	
		iii. Describes how such input was provided (e.g., through focus groups, interviews or surveys).	(b)(5)(i)(B)	
		iv. Describes over what time period such input was provided and between what approximate dates.	(b)(5)(ii)	
		v. Summarizes the nature and extent of the organizations' input.	(b)(6)(F)(iii)	

APPENDIX F:
IRS CHNA REQUIREMENTS CHECKLIST

INTERNAL REVENUE SERVICE REQUIREMENTS FOR COMMUNITY HEALTH NEEDS ASSESSMENTS				
YES	**PAGE #**	**IRS REQUIREMENTS CHECKLIST**	**REGULATION SUBSECTION NUMBER**	**NOTES/ RECOMMENDATIONS**
		C. CHNA Needs Description & Prioritization		Integrated throughout the report
✓	5-7, 12-28	i. Health needs of a community include requisites for the improvement or maintenance of health status both in the community at large and in particular parts of the community (such as particular neighborhoods or populations experiencing health disparities). ii. Prioritized description of significant health needs identified.	(b)(4) (b)(6)(i)(D)	Community member survey included a question that asked respondents to select their top community health needs and rate the importance of addressing each health need.
		iii. Description of process and criteria used to identify certain health needs as significant and prioritizing those significant health needs.	(b)(6)(i)(D)	
	71-72	iv. Description of the resources potentially available to address the significant health needs (such as organizations, facilities, and programs in the community, including those of the hospital facility.	(b)(4) (b)(6)(E)	
✓		**D. Finalizing the CHNA**		Integrated throughout the report. The CHNA was adopted by Fulton County Health Department and Fulton County Health Center leadership in November 2025 and made widely available by posting on their websites (report will be made available in other formats such as paper upon request): Fulton County Health Department: https://fultoncountyhealthdept.com/data-resources/health-assessments Fulton County Health Center: https://fultoncountyhealthcenter.org
		i. CHNA is conducted in such taxable year or in either of the two taxable years immediately preceding such taxable year.	(a)1	
		ii. CHNA is a written report that is adopted for the hospital facility by an authorized body of the hospital facility (authorized body defined in §1.501(r)-1(b)(4)).	(b)(iv)	
		iii. Final, complete, and current CHNA report has been made widely available to the public until the subsequent two CHNAs are made widely available to the public. "Widely available on a web site" is defined in §1.501(r)- 1(b)(29).	(b)(7)(i)(A)	
		a. May not be a copy marked "Draft."	(b)(7)(ii)	
		b. Posted conspicuously on website (either the hospital facility's website or a conspicuously located link to a website established by another entity).	(b)(7)(i)(A)	
		c. Instructions for accessing CHNA report are clear.	(b)(7)(i)(A)	
		d. Individuals with Internet access can access and print reports without special software, without payment of a fee, and without creating an account.	(b)(7)(i)(A)	
		e. Individuals requesting a copy of the report(s) are provided the URL.	(b)(7)(i)(A)	
		f. Makes a paper copy available for public inspection upon request and without charge at the hospital facility.	(b)(7)(i)(B)	

APPENDIX G

PUBLIC HEALTH ACCREDITATION BOARD (PHAB) CHECKLIST: COMMUNITY HEALTH ASSESSMENT

MEETING THE PHAB REQUIREMENTS FOR COMMUNITY HEALTH ASSESSMENT

The PHAB Standards & Measures serves as the official guidance for PHAB national public health department accreditation and includes requirements for the completion of CHAs/CHNAs for local health departments. The following page demonstrates how this CHNA meets the PHAB requirements.

Fulton County PARTNERS FOR HEALTH
Building a Healthy Community

APPENDIX G:
PHAB CHA/CHNA REQUIREMENTS CHECKLIST

PUBLIC HEALTH ACCREDITATION BOARD REQUIREMENTS FOR COMMUNITY HEALTH ASSESSMENTS			
YES	**PAGE #**	**PHAB REQUIREMENTS CHECKLIST**	**NOTES/ RECOMMENDATIONS**
✓	4	a. A list of participating partners involved in the CHA process. Participation must include: i. At least 2 organizations representing sectors other than governmental public health. ii. At least 2 community members or organizations that represent populations who are disproportionately affected by conditions that contribute to poorer health outcomes.	Integrated throughout the report Community member survey included a question that asked respondents to select their top community health needs and rate the importance of addressing each health need.
✓	5-7, 12-28	b. The process for how partners collaborated in developing the CHA.	
✓	9-11, 16-17, 24-72	c. Comprehensive, broad-based data. Data must include: i. Primary data. ii. Secondary data from two or more different sources.	Primary and secondary data is integrated together throughout the report
✓	16-17	d. A description of the demographics of the population served by the health department, which must, at minimum, include: i. The percent of the population by race and ethnicity. ii. Languages spoken within the jurisdiction. iii. Other demographic characteristics, as appropriate for the jurisdiction.	
✓	9-11, 16-17, 24-72	e. A description of health challenges experienced by the population served by the health department, based on data listed in required element (c) above, which must include an examination of disparities between subpopulations or sub-geographic areas in terms of each of the following: i. Health status ii. Health behaviors.	Integrated throughout the report. Health disparities and potential priority populations are listed clearly for EACH health need.
✓	9-11, 16-17, 24-72	f. A description of inequities in the factors that contribute to health challenges (required element e), which must, include social determinants of health or built environment.	Integrated throughout the report. Health disparities and potential priority populations are listed clearly for EACH health need.
✓	71-72	g. Community assets or resources beyond healthcare and the health department that can be mobilized to address health challenges. The CHNA (or CHA) must address the jurisdiction as described in the description of Standard 1.1.	

APPENDIX H

REFERENCES

Fulton County PARTNERS FOR HEALTH
Building a Healthy Community

APPENDIX H: REFERENCES

The following reference list provides the sources for the secondary data that was collected for the CHNA in Summer 2025. The most up-to-date data available at the time was collected and included in the CHNA report. Please refer to individual sources for more information on years and methodology.

[1]U.S. Census Bureau, American Community Survey, DP03, 2023 5-year estimate. http://data.census.gov

[2]Ohio Behavioral Risk Factor Surveillance System: 2021 Annual Report. Chronic Disease Epidemiology and Evaluation Section, Bureau of Health Improvement and Wellness, Ohio Department of Health, 2024.

[3]United Health Foundation, America's Health Rankings, 2025. Data from U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 2023.

[4]University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps 2025. www.countyhealthrankings.org.

[5]Terlizzi EP, Black LI. Shingles vaccination among adults aged 60 and over: United States, 2018. NCHS Data Brief, no 370. Hyattsville, MD: National Center for Health Statistics. 2020.

[6]Ohio Behavioral Risk Factor Surveillance System: 2022 Annual Report. Chronic Disease Epidemiology and Evaluation Section, Bureau of Health Improvement and Wellness, Ohio Department of Health, 2024.

[7]Prostate Cancer in Ohio 2023. Ohio Cancer Incidence Surveillance System, Ohio Department of Health, February 2023.

[8]NIH, National Cancer Institute. Former Smoking Prevalence (Age 18+), 2021-2023. https://sae.cancer.gov/nhis-brfss/estimates/former-smoking.html

[9]NIH, HD Pulse Data Portal. Health Determinants: Knowledge, Attitudes & Behaviors, 2023. https://hdpulse.nimhd.nih.gov/data-portal/quick-profile/39/knowledge

[10]KFF, Adults who report having a cholesterol check in the past 5 years, 2023. KFF analysis of the Centers for Disease Control and Prevention (CDC)'s 2023 Behavioral Risk Factor Surveillance System (BRFSS). https://www.kff.org/state-category/health-status/heart-disease/

[11]U.S. Census Bureau, American Community Survey, DP05, 2023 5-year estimate. http://data.census.gov

[12]U.S. Census Bureau, American Community Survey, DP02, 2023 5-year estimate. http://data.census.gov

[13]Edelman Trust Institute, 2025 Edelman Trust Barometer Special Report: Trust and Health.

[14]Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 2018-2023 on CDC WONDER Online Database, released in 2024. Data are from the Multiple Cause of Death Files, 2018-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10-expanded.html

[15]Ohio Department of Mental Health & Addiction Services, Ohio Gambling Survey 2022 Highlights.

[16]Walk Score, 2025. https://www.walkscore.com

[17]Ohio Childcare Resource & Referral Association, 2024 Annual Report. https://d2hfgw7vtnz2tl.cloudfront.net/wp-content/uploads/2025/06/OCCR-3085-Annual-Report-D5_no-bleed.pdf

[18]Groundwork Ohio, 2024 Poll Data. https://www.groundworkohio.org/poll

[19]Ohio Department of Jobs & Family Services, Child Abuse and Neglect Referrals and Outcomes Dashboard. (2024). Https://Data.Jfs.Ohio.Gov/Dashboards/Foster-Care-And-Adult-Protective-Services/Child-Abuse-And-Neglect-Referrals-And-Outcomes

[20]United for ALICE, The State of ALICE in Ohio (2023). https://www.unitedforalice.org/county-reports/ohio#17/41.75860/-84.37493

[21]Feeding America, Map The Meal Gap, 2023. https://map.feedingamerica.org

[22]Ohio Association of Foodbanks, Hunger in Ohio 2024. https://ohiofoodbanks.org/site/assets/files/2967/hunger_study_2024_6.pdf

[23]U.S. Census Bureau, American Community Survey, DP04, 2023 5-year estimate. http://data.census.gov

[24]Coalition on Homelessness and Housing in Ohio, Housing Inventory Count and Point-in-Time Count, 2025. https://cohhio.org/boscoc/hicpit/

[25]BroadbandNow (2025). Ohio Internet Coverage & Availability in 2025. Retrieved from https://broadbandnow.com/Ohio

[26]FBI Crime Data Explorer, Data Discovery Tool, 2019-2023. https://cde.ucr.cjis.gov/LATEST/webapp/#/pages/explorer/crime/query *Rates calculated using population from ACS, DP05, 2023 5-year estimate

[27]U.S. Census Bureau, American Community Survey, S1401, 2023 5-year estimate. http://data.census.gov

[28]Ansari A. THE PERSISTENCE OF PRESCHOOL EFFECTS FROM EARLY CHILDHOOD THROUGH ADOLESCENCE. J Educ Psychol. 2018 Oct;110(7):952-973. doi: 10.1037/edu0000255. Epub2018 Mar 8. PMID: 30906008; PMCID: PMC6426150.

[29]United States Environmental Protection Agency, Research on Health Effects from Air Pollution. https://www.epa.gov/air-research/research-health-effects-air-pollution

[30]Centers for Disease Control and Prevention, Cigarette Smoking. https://www.cdc.gov/tobacco/about/index.html

[31]Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP). https://www.cdc.gov/nccdphp/divisions-offices/about-the-division-of-nutrition-physical-activity-and-obesity.html#:~:text=Poor%20nutrition%20and%20inadequate%20physical,%2C%20certain%20cancers%2C%20and%20depression.

[32]Ohio Cancer Incidence Surveillance System, Ohio Department of Health, 2025; U.S. Cancer Statistics, Centers for Disease Control and Prevention and National Cancer Institute, June 2024 (Note: 2017-2021 U.S. cancer incidence data was the most recent available at the time of this publication). https://odh.ohio.gov/know-our-programs/ohio-cancer-incidence-surveillance-system/data-statistics/data-statistics.

[33]Ohio Department of Health, Data Ohio Portal, 2020-2024 average, updated September 5, 2025. https://data.ohio.gov/wps/portal/gov/data/view/ohio_births *2024 data is considered preliminary at this time. These data were provided by the Ohio Dept. of Health. The Department specifically disclaims responsibility for any analyses, interpretations, or conclusions.

APPENDIX H: REFERENCES (CONTINUED)

The following reference list provides the sources for the secondary data that was collected for the CHNA in Summer 2025. The most up-to-date data available at the time was collected and included in the CHNA report. Please refer to individual sources for more information on years and methodology.

[34]Ohio Department of Health, Severe Maternal Morbidity and Racial Disparities in Ohio, 2016-2019, 2020. https://odh.ohio.gov/know-our-programs/pregnancy-associated-mortality-review/media/pamr-smm

[35]Ohio Department of Health, 2023 Ohio Unintentional Fall Deaths Among Older Adults. https://odh.ohio.gov/know-our-programs/violence-injury-prevention-program/injury-data

[36]U.S. Bureau of Labor Statistics, National Census of Fatal Occupational Injuries in 2023. https://www.bls.gov/news.release/pdf/cfoi.pdf

[37]Ohio Department of Health, Sexually Transmitted Diseases Data and Statistics, 2019-2023 Ohio Infectious Disease Status Reports. https://odh.ohio.gov/know-our-programs/std-surveillance/Data-and-Statistics

[38]Ohio Department of Health, Ohio HIV Surveillance Data Tables, 2023. https://odh.ohio.gov/know-our-programs/hiv-aids-surveillance-program/Data-and-Statistics

[39]State of Ohio Integrated Behavioral Health Dashboard. https://data.ohio.gov/wps/portal/gov/data/view/ohio-ibhd *Rates calculated using population from ACS, DP05, 2023 5-year estimate

[40]CDC. Adverse Childhood Experiences (ACEs) Risk and Protective Factors, 2024.https://www.cdc.gov/aces/risk- factors/index.html

[41]Ohio Department of Health, Information & Programs. Heart Disease, 2022. https://odh.ohio.gov/know-our-programs/heart-disease/heart-disease#:~:text=In%202022%2C%205.6%25%20of%20adults%20in%20Ohio,those%20with%20the%20lowest%20income%20and%20education.

[42]NCHS Data Query System. Coronary heart disease, heart attack/myocardial infarction [Internet]. Hyattsville (MD): National Center for Health Statistics; c2025 [cited 2025 Nov 13]. Available from: https://www.cdc.gov/nchs/dqs/index.html.

[43]Ohio Behavioral Risk Factor Surveillance System: 2023 Annual Report. Chronic Disease, Violence, and Injury Epidemiology Section, Bureau of Health Improvement and Wellness, Ohio Department of Health, 2025.

[44]Ohio State Highway Patrol, Dashboards & Statistics. OSTATS Crash Dashboard, 2024. https://statepatrol.ohio.gov/dashboards-statistics/ostats-dashboards/crash-dashboard

[45]Ohio Department of Job & Family Services, Ohio Labor Market Information. Ohio Unemployment Rates August 2025. https://ohiolmi.com/Home/LAUS/LAUSHome

[46]Centers for Medicare and Medicaid Services, Data.CMS.gov. Mapping Medicare Disparities by Population, 2023. https://data.cms.gov/tools/mapping-medicare-disparities-by-population

[47]Ohio Environmental Protection Agency, Division of Drinking and Ground Waters. 2024 Consumer Confidence Reports. https://epa.ohio.gov/divisions-and-offices/drinking-and-ground-waters/drinking-and-ground-waters

[48]Fulton County Health Department. Private Water System Water Sample Test data, 2024.

[49]Ohio Department of Education and Workforce, School Report Cards. District Graduation Rates 2024-2025. https://reportcard.education.ohio.gov/home

[50]Ohio Chronic Disease Atlas 2025: Maps of Chronic Disease Prevalence, Mortality, Risk Factors, and Non-Medical Health Factors by County. Ohio Department of Health, August 2025.

[51]2023 Ohio Infant Mortality Report. Columbus, OH: Ohio Department of Children and Youth. 2024.

[52]Ohio Department of Health, Data Ohio Portal. Ohio Infant Mortality Scorecard, 2024 10 - 2025 09. Updated November 9, 2025. https://data.ohio.gov/wps/portal/gov/data/view/ohio-infant-mortality-scorecard

[53]Ohio Department of Children & Youth, Early Care and Education Programs, 2025. https://childcaresearch.ohio.gov/ *Rates calculated using population estimates from U.S. Census Bureau, American Community Survey, DP05, 2023 5-year estimate.

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