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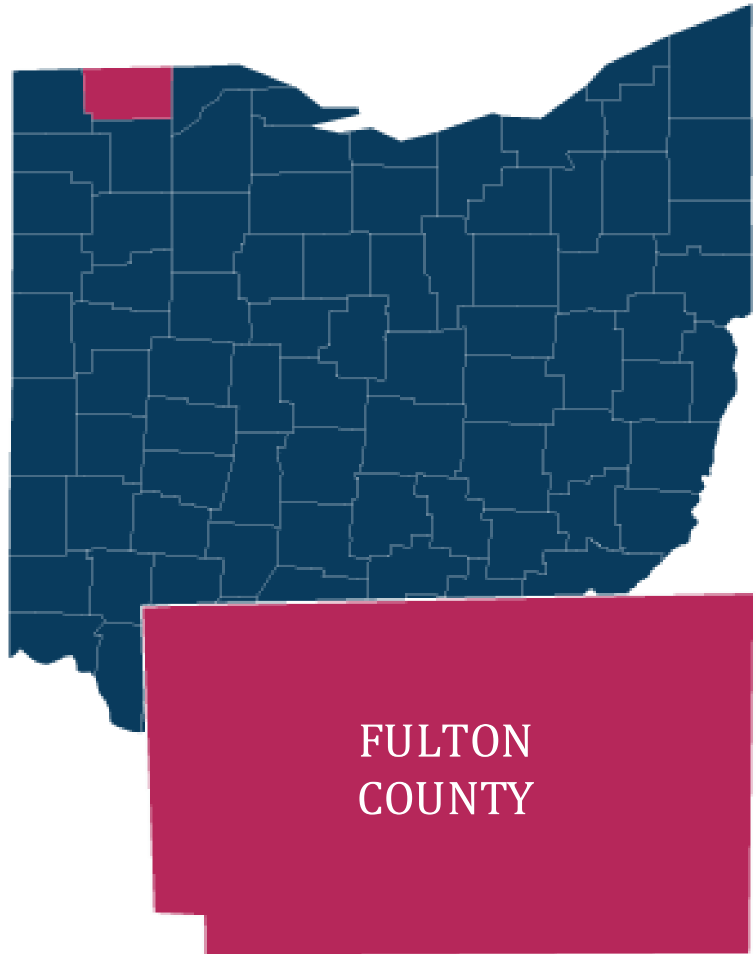


2026-2029 FULTON COUNTY IMPLEMENTATION STRATEGY/ COMMUNITY HEALTH IMPROVEMENT PLAN

PUBLISHED MAY 2026

TABLE OF CONTENTS

Note from Fulton County Partners for Health …… 3

Contributors & Partner Organizations …… 4

Introduction …… 5

What is an Implementation Strategy/Improvement Plan? …… 5

Overview of the Process …… 6

Defining the Fulton County Service Area …… 7

Fulton County At-a-Glance …… 8

Step 1: Plan and Prepare for the Implementation Strategy/Improvement Plan …… 9

Step 2: Prioritize and Select Health Needs to Address …… 11

Priority Health Needs for Fulton County …… 15

Step 3: Consider & Select Approaches to Address Priority Health Needs …… 16

Priority Area 1: Behavioral Health …… 17

Priority Area 2: Chronic Diseases …… 18

Current Resources Addressing Priority Health Needs …… 19

Steps 4-6: Develop, Adopt, & Implement Implementation Strategy/Improvement Plan …… 21

Next Steps …… 22

Evaluation of Impact …… 22

Health Needs that Will Not be Addressed …… 22

Appendices …… 23

Appendix A: IRS Implementation Strategy Requirements Checklist …… 23

Appendix B: PHAB CHIP Checklist …… 25

Appendix C: References …… 27

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 Health 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 community's needs and prioritizing those needs for impact. In 2025, Fulton County Partners for Health partnered with Moxley Public Health and community-based organizations to conduct comprehensive Adult and Youth Community Health Needs Assessments (CHNAs) to identify priority health issues and evaluate the overall current health status of the health department and hospital's service area. These findings were then used to develop an Implementation Strategy (IS)/Community Health Improvement Plan (CHIP) to describe the response to the needs identified in the CHNA reports.

The 2026-2029 Fulton County IS/CHIP would not have been possible without the help of numerous Fulton County organizations, acknowledged on the following pages. It is vital that assessments such as this continue, so partners know where to direct resources and how to use them in the most advantageous ways.

The goals of public health can only be accomplished through community members' commitment to themselves and to each other. Fulton County Partners for Health believes that together, Fulton County can be a thriving community of health and well-being at home, work, school, and play.

Importantly, this report could not exist without the contributions of individuals in the community who participated in interviews and completed the community member survey. Fulton County Partners for Health is grateful for those individuals who are committed to the health of the community and took the time to share their health concerns, needs, behaviors, praises, and suggestions for future improvement.

Sincerely,

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

Patricia A. Finn, MBA
CEO
Fulton County Health Center

CONTRIBUTORS

Fulton County Partners for Health would like to recognize the following organizations for their involvement in this process through their participation in the IS/CHIP strategy selection meeting.

Behavioral Health: Arrowhead Behavioral Health, Community Education for Development (Fayette), Educational Service Center NWO, FAST – Fayette, Four County ADAMhs Board, Fulton County Board of DD, Fulton County Family & Children First Council, Fulton County Health Center, Fulton County Health Department, Fulton County OSU Extension Office, Maumee Valley Guidance Center, New Home Development, NORTA, Ohio Guidestone, Recovery Services of Northwest Ohio, The Ridge Project, Village of Fayette, Wauseon Public Library

Chronic Diseases: Continental Plaza, Fulton County Health Center, Fulton County Health Department, Fulton County Job & Family Services, Fulton County Senior Center, NOCAC, NORTA, Cecily Rohrs, Triangular Processing

PARTNER ORGANIZATIONS

The following organizations have partnered with Fulton County Partners for Health to participate in the IS/CHIP activities detailed in this report through their involvement in local coalitions and work groups.

Behavioral Health

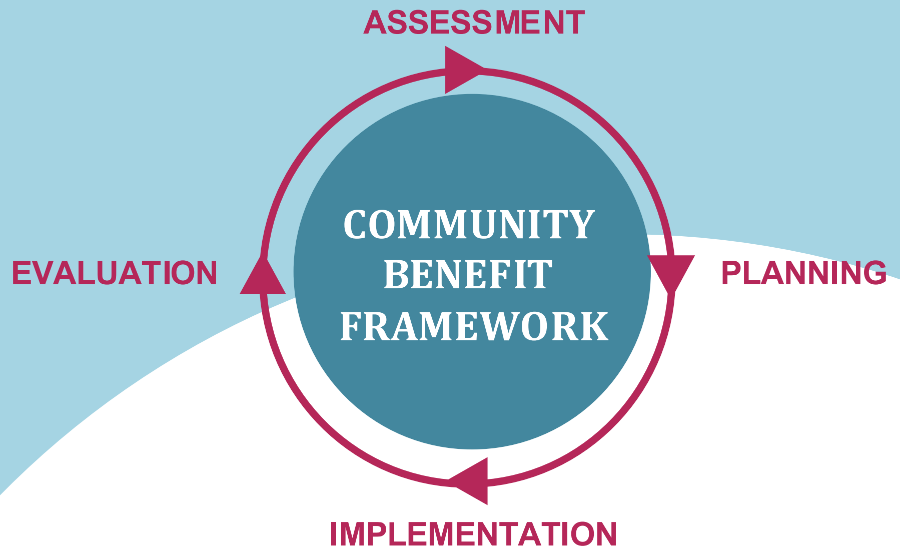
- Adult Probation
- Archbold Police Department
- Center for Child and Family Advocacy
- Community Education for Development (Fayette)
- Continental Plaza
- Crossroads Church
- Dept of Public Safety – School Safety
- Fayette CDC
- Four County ADAMhs Board
- Four County Career Center – CBI
- Fulton County Board of Developmental Disabilities/Early Intervention
- Fulton County Drug Court
- Fulton County Family & Children First
- Fulton County Health Center
- Fulton County Health Department
- Fulton County JFS/CPS
- Fulton County Juvenile Court
- Fulton County Sheriff's Office
- MAN Unit
- Maumee Valley Guidance Center
- New Horizons Academy
- NWOESC
- Ohio Guidestone
- Recovery Services of NWO
- The Ridge Project
- Trinity Lutheran – Delta
- Unison Health
- United Way
- Village of Archbold
- Wauseon Exempted Village School
- Wauseon Police Department
- Worthington Industries
- YMCA/NWO
- YWCA Childcare Resource and Referral
- YWCA Hope Center

Chronic Diseases

- Community Pregnancy Center
- Continental Plaza
- Four County ADAMhs Board
- Fulton County Board of Developmental Disabilities/Early Intervention
- Fulton County Family First Council
- Fulton County Free Clinic
- Fulton County Health Center
- Fulton County Health Department
- Fulton County JFS/CPS
- Fulton County Senior Center
- Health Partners of Western Ohio
- Henry County Transportation Network
- Maumee Valley Planning Organization
- NOCAC
- The Open Door
- Toledo/Lucas County Care Net
- Triangular Processing
- United Way

INTRODUCTION

WHAT IS AN IMPLEMENTATION STRATEGY (IS)/ IMPROVEMENT PLAN (CHIP)?



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

Fulton County PARTNERS FOR HEALTH
Building a Healthy Community

OVERVIEW
OF THE PROCESS

In order to develop an IS/CHIP, Fulton County Partners for Health followed a process that included the following steps:

STEP 1: Plan and prepare for the IS/CHIP.

STEP 2: Use CHNA data to select and prioritize health needs, disparities, and social determinants of health to address.

STEP 3: Consider and select strategies and goals to address prioritized health needs, disparities, and social determinants of health with community partners.

STEP 4: Develop a written and public IS/CHIP report.

STEP 5: Adopt the IS/CHIP.

STEP 6: Implement the IS/CHIP.

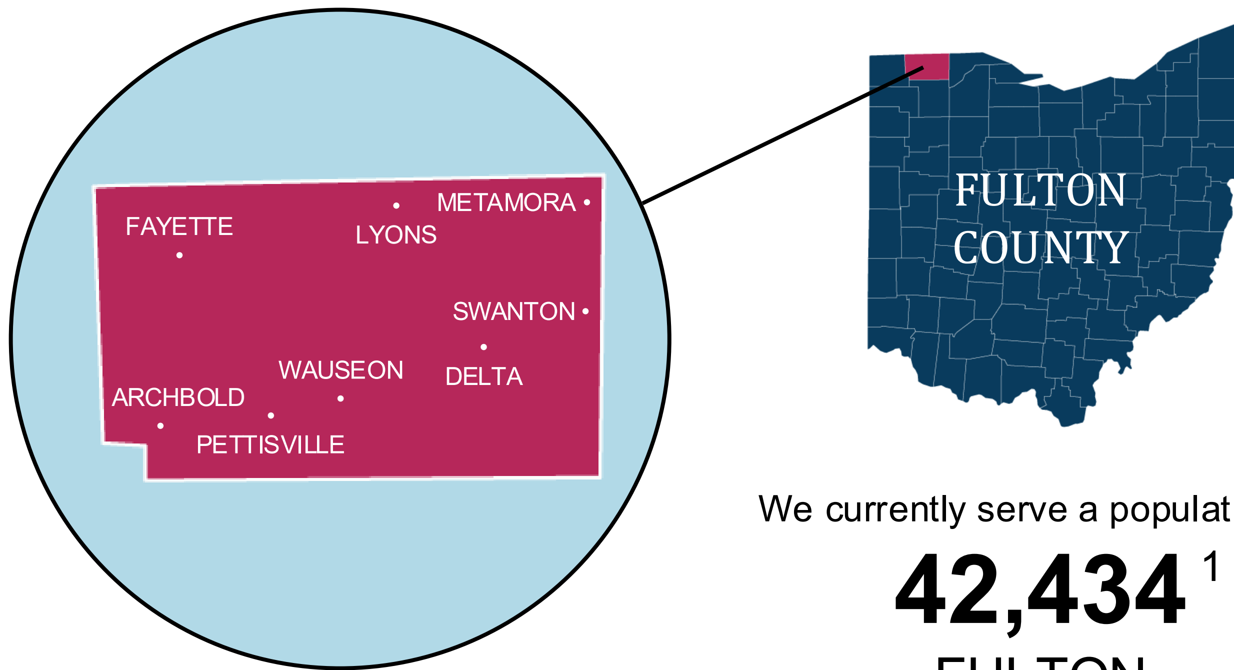
Within each step of this process, the guidelines and requirements of both the state and federal governments are followed precisely and systematically.

Of note: This IS/CHIP report is a living document that will be updated regularly throughout the cycle.

The 2026-2029 Fulton County IS/CHIP meets all IRS and Public Health Accreditation Board (PHAB) regulations.

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 [1]

FULTON COUNTY

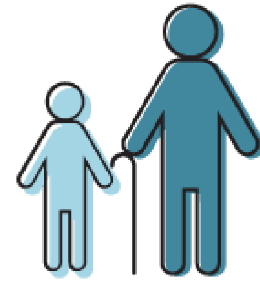
FULTON COUNTY SERVICE AREA	
GEOGRAPHIC AREA	**ZIP CODE**
Archbold	43502
Delta	43515
Fayette	43521
Lyons	43533
Metamora	43540
Pettisville	43553
Swanton	43558
Wauseon	43567

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**).[2]

The life expectancy in Fulton County of **76.4 years is 1.2 years longer** than it is for the state of Ohio.[2]



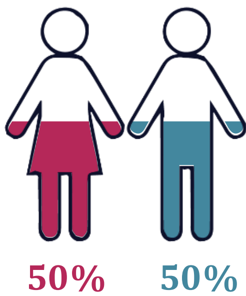
Youth ages 0-18 and seniors 65+ make up

42% of the population

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

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

50% of Fulton County residents are **women** (vs. 51% for Ohio).[1]



7%

of Fulton County and Ohio residents are **veterans**.[3]

4% of Fulton County residents **do not speak English as their first language** (vs. **8%** for Ohio).[3]

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

There is a **higher proportion of White residents and Hispanic/Latino residents** in Fulton County than in the state of Ohio.[1]

	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%

STEP 1

PLAN AND PREPARE FOR THE IMPLEMENTATION STRATEGY/ IMPROVEMENT PLAN

In this step, Fulton County Partners for Health:

- ✓ Determined who would participate in the development of the IS/CHIP
- ✓ Engaged board and executive leadership
- ✓ Reviewed the Community Health Needs Assessment

Fulton County PARTNERS FOR HEALTH
Building a Healthy Community

PLAN AND PREPARE

Secondary and primary data were collected to complete the 2025 Fulton County Adult and Youth Community Health Needs Assessments (available at: https://fultoncountyhealthdept.com/data-resources/health-assessments & https://fultoncountyhealthcenter.org). Secondary data was collected from a variety of local, county, and state sources to present community demographics, social determinants of health, healthcare access, birth characteristics, leading causes of death, chronic disease, health behaviors, mental health, substance use, and preventive practices. The analysis of secondary data yielded a preliminary list of significant health needs, which then informed primary data collection.

Primary data were collected through key informant interviews with **20** experts from various organizations serving Fulton County, and included leaders and representatives of medically underserved, low-income, and minority populations, or local health or other departments or agencies. **10** interviews were also conducted with adult allies who work with the youth population in Fulton County.

A community member survey was distributed via a QR code and link, with **501** responses. The survey responses (from community members) were used to prioritize the health needs, answer in-depth questions about the health needs in the county, and identify health disparities present in the community. Additionally, a youth survey was conducted in the local schools, and **681** responses were received.

Finally, there were **3** adult focus groups, **1** youth focus group, and **4** youth listening sessions held in Fulton County, representing a total of **32** adult community members from priority populations and **95** local youth. The primary data collection process was designed to validate secondary data findings, identify additional community issues, solicit information on disparities among subpopulations, ascertain community assets potentially available to address needs, and prioritize health needs. More details on methodology can be found in the 2025 Fulton County Adult and Youth Community Health Needs Assessments.

> “*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)

STEP 2

USE CHNA DATA TO SELECT AND PRIORITIZE HEALTH NEEDS, DISPARITIES, AND SOCIAL DETERMINANTS OF HEALTH TO ADDRESS

In this step, Fulton County Partners for Health:

- ✓ Selected priority health needs for the IS/CHIP based on the findings from the Community Health Needs Assessment

OVERVIEW OF THE PROCESS

Ohio Department of Health (ODH) Framework

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

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.

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.

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.

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

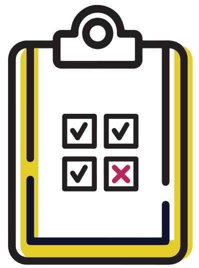
All Ohioans achieve their full health potential
- Improved health status
- Reduced premature death

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.*

ADDRESSING THE HEALTH NEEDS: RANKING OF ADULT HEALTH NEEDS

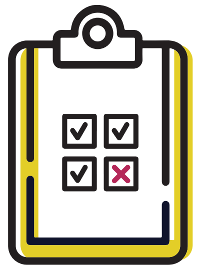


The 2025 Adult Community Health Needs Assessment (CHNA) identified the following significant health needs from an extensive review of the primary (community survey, interviews, and focus groups) and secondary data (existing data). The significant health needs were ranked as follows through the community member survey (501 responses from community members).

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%

ADDRESSING THE HEALTH NEEDS: RANKING OF YOUTH HEALTH NEEDS

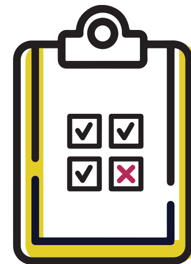


The 2025 Youth Community Health Needs Assessment (CHNA) identified the following significant health needs from an extensive review of the primary (youth survey, interviews with adult allies for youth, youth focus group, and youth listening sessions) and secondary data (existing data). The insights gained from the interviews, focus group, and listening sessions helped guide how health needs were ranked. The rankings below were based on the frequency of mentions in the interview analysis, as well as the focus group and listening sessions, with higher-frequency needs becoming priority in the ranking.

COMMUNITY CONDITIONS RANKING FROM ADULT ALLY INTERVIEWS & YOUTH FOCUS GROUPS
#1 Access to Healthcare
#2 Education
#3 Social Determinants of Health
#4 Addiction and Substance Misuse
#5 Nutrition and Physical Activity
#6 Tobacco and Nicotine Use
#7 Violence and Safety

HEALTH OUTCOMES RANKING FROM ADULT ALLY INTERVIEWS & YOUTH FOCUS GROUPS
#1 Mental health
#2 Sexual Health
#3 Unintentional Injuries

PRIORITY HEALTH NEEDS FOR FULTON COUNTY

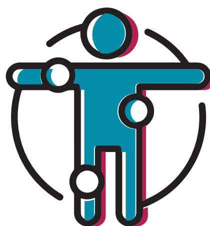


From the health needs assessed, Fulton County Partners for Health chose health needs that considered the health department, hospital, and community partners' capacity to address community needs, the strength of community partnerships, and those needs that correspond with the health department, hospitals, and community partners' priorities. **The priority health needs that will be addressed in the 2026-2029 Implementation Strategy (IS)/Improvement Plan (CHIP) are:**

1 BEHAVIORAL HEALTH

- Fulton County has a **suicide rate** of **13 per 100,000 people**, compared to 15 per 100,000 for Ohio.[4]
- **5% of Fulton County youth** survey respondents reported having **attempted suicide**, compared to 6% of Ohio youth.[5]
- The rate of **binge or heavy drinking** is **higher** among Fulton County adult survey respondents than in Ohio overall (20% vs. 16%).[6]
- While both Fulton County* **adult and youth smoking rates,** as well as **youth e-cigarette use** rates, are **performing better** than the Healthy People 2030 targets, **vaping** emerged as a **top issue** in the interviews and focus groups.

2 CHRONIC DISEASE



- The **top two leading causes of death** in Fulton County are **heart disease** and **cancer**. For both, Fulton County has a **slightly higher** crude mortality rate per 100,000 than Ohio.[4]
- Both adult (48%) and youth (29%) **obesity rates in Fulton County*** are **higher** than for Ohio overall (36% for adults and 18% for youth).[5, 6]
- **81%** of Fulton County youth* **do not meet** the recommended **daily vegetable intake**.
- **17%** of adult community survey respondents **have not had a routine checkup** within the past year.

**As reported in the 2025 Fulton County adult and youth surveys.*

STEP 3

CONSIDER AND SELECT STRATEGIES AND GOALS TO ADDRESS PRIORITIZED HEALTH NEEDS, DISPARITIES, AND SOCIAL DETERMINANTS OF HEALTH WITH COMMUNITY PARTNERS

In this step, Fulton County Partners for Health:

✓ Selected (with community partners) approaches, strategies, and goals to address the Fulton County prioritized health needs, health disparities, and social determinants of health

Fulton County PARTNERS FOR HEALTH
Building a Healthy Community

#1 Priority Area: Behavioral Health

Includes mental health, substance use disorder (SUD), tobacco/nicotine use, adverse childhood experiences (ACEs), access to care, and community awareness.

STRATEGIES

By 2029, increase awareness of mental health resources.	By 2029, increase mental health programs in schools and the community.	By 2029, increase awareness of health and safety concerns of substance use.

ACTION STEPS

- Implement a behavioral health awareness campaign with targeted efforts for priority populations
- Increase referrals/opportunities for obtaining behavioral health treatment
- Promote opportunities for outdoor facility use and its benefits for mental health
- Invite participation from the business and economic development sector to the mental health table/coalition to target health of employees
- Explore availability of mental health services in schools
- Create programs to promote early response to emerging mental health concerns, including parent education programs
- Address stigma and reluctance to seek help
- Educate community on the health and safety concerns of vaping
- Educate community on the health and safety concerns of cannabis use

PRIORITY POPULATIONS

While this priority affects the entire community, targeted strategies will focus on populations that experience greater risk or barriers to health, including:
Youth, parents of youth, veterans, construction & trades, farmers, immigrants, low-income population, employees/working adults

DESIRED OUTCOMES AND OVERALL IMPACT OF STRATEGIES

Through the activities listed above, we aim to **increase** or **improve** the following measures:

- ↑ Mental health
- ↑ Education & awareness on mental health & substance use
- ↑ Access and utilization of mental health & substance abuse care
- ↑ Quality of life

Through the activities listed above, we aim to **decrease** or **reduce** the following measures:

- ↓ Mental health stigma
- ↓ Substance misuse
- ↓ Mental health & substance use ER visits
- ↓ Overdose deaths
- ↓ Deaths by suicide

ALL FULTON COUNTY SERVICE AREA RESIDENTS ACHIEVE THEIR FULL HEALTH POTENTIAL

*Please see page 4 for the complete list of Behavioral Health partners.

#2 Priority Area: Chronic Disease

Includes routine check-ups, nutrition, physical health/exercise, preventive care/ practices, access to care, and community awareness.

STRATEGIES

By 2029, increase the number of adults who have a routine checkup.

By 2029, improve adult and youth nutrition and physical health through increasing fruit and vegetable consumption and increasing physical activity.

By 2029, reduce heart disease and diabetes through increasing awareness and increasing the number of adults having routine checkups and being screened.

ACTION STEPS

- Structure a joint marketing communication plan
- Participate in Regional Transportation Network
- Promote trails, parks, and community fitness programs
- Promote Medical Weight Management at FCHC
- Support community garden implementation by providing toolkit and support
- Implement Serving Up MyPlate in schools
- Provide screenings at community events
- Provide toolkit to workplaces to promote routine checkups
- Provide chronic disease education support to local providers and community
- Create resources in multiple languages

PRIORITY POPULATIONS

While this priority affects the entire community, targeted strategies will focus on populations that experience greater risk or barriers to health, including:

Youth, older adults, residents with lower incomes, men

DESIRED OUTCOMES AND OVERALL IMPACT OF STRATEGIES

Through the activities listed above, we aim to **increase** or **improve** the following measures:

- ↑ Access to healthcare
- ↑ Use of preventive services
- ↑ Adults screened for heart disease & diabetes
- ↑ Fruit & vegetable consumption
- ↑ Physical activity

Through the activities listed above, we aim to **decrease** or **reduce** the following measures:

- ↓ Avoidable ER visits
- ↓ Chronic disease rates
- ↓ Heart disease, including hypertension & high cholesterol
- ↓ Diabetes, including pre-diabetes
- ↓ Obesity rates

ALL FULTON COUNTY SERVICE AREA RESIDENTS ACHIEVE THEIR FULL HEALTH POTENTIAL

*Please see page 4 for the complete list of Chronic Disease partners.

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
- T.A.C.K.L.E.

Community & Social Services

- Area Office on Aging of Northwestern Ohio, Inc
- Boy Scouts of America
- Community Pregnancy Center
- Faith-Based Youth Groups
- Fayette Community Development Corporation (CDC)
- Fulton County 4-H

Community & Social Services Cont.

- Fulton County Child Support Enforcement Agency
- Fulton County Job & Family Services
- Fulton County Probate Court
- Fulton County Senior Center
- Girl Scouts of America
- Hands of Grace
- Heritage Girls
- Lutheran Social Services
- Shalom Counseling and Meditation Center
- Social Security Office
- United Way of Fulton County
- Veterans Affairs

Education

- Archbold Area Schools
- English for Speakers of Other Languages at Four County Career Center
- Evergreen Local Schools
- Fayette Local Schools
- Four County Career Center
- Fulton County Head Start Program
- Fulton County Ohio State University Extension
- Help Me Grow
- Pettisville Local Schools
- Pike-Delta-York Local Schools
- Swanton Local Schools
- Wauseon Exempted Village School District

Employment

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

Food Insecurity

- Christ United Methodist Church
- FISH
- Fulton County Alano Club
- 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
- Four County ADAMhs Board
- Fulton County Health Center Outpatient Behavioral Health
- Healthy Choices Caring Communities
- Live Vape Free
- Maumee Valley Guidance Center
- Ohio Guidestone
- Ohio Tobacco Quit Line
- Project DAWN
- Recovery Services of Northwest Ohio
- 9-1-1
- 988 Suicide and Crisis Lifeline

Nutrition & Physical Health

- Alzheimer's Association NW Ohio Chapter
- American Lung Association
- Community Parks & Recreation
- Fulton County Health Center Diabetes & Nutrition Education
- Fulton County Health Center Medical Weight Management
- Fulton County Special Olympics
- Multiple Sclerosis Society, Northwestern Ohio Chapter

Transportation

- FISH
- Four County ADAMhs Board
- Fulton County Job & Family Services
- Fulton County Senior Center
- Hands of Grace
- Northwest Ohio Mobility
- St Vincent DePaul
- Triangular Processing

STEPS 4-6

DEVELOP A PUBLIC IMPLEMENTATION STRATEGY/IMPROVEMENT PLAN REPORT, AND ADOPT AND IMPLEMENT THE PLAN

In this step, Fulton County Partners for Health will:

- ✓ Develop a public IS/CHIP report to show the community the plan for health improvement
- ✓ Adopt and agree on the IS/CHIP
- ✓ Make a plan to implement, update and sustain the IS/CHIP

Fulton County
PARTNERS
FOR HEALTH
Building a Healthy Community

FULTON COUNTY NEXT STEPS

The Community Health Needs Assessment (CHNA) and this resulting Implementation Strategy (IS)/ Improvement Plan (CHIP) identify and address significant community health needs and help guide improvement activities. This IS/CHIP explains how Fulton County Partners for Health plans to address the selected priority health needs identified by the CHNA. The IS/CHIP is an evolving and ongoing process. Organizations interested in contributing to one or more of the strategies are invited to reach out to any of the contacts listed below to learn how to get involved with the ongoing process of community health improvement.

This IS/CHIP report was adopted by Fulton County Health Department and Fulton County Health Center leadership in May 2026.

This report is widely available to the public on the following websites:

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

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

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

EVALUATION OF IMPACT

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

ADDITIONAL HEALTH NEEDS NOT DIRECTLY ADDRESSED

Since Fulton County Partners for Health cannot directly address all the health needs present in the community, we will concentrate our resources on those health needs where we can effectively impact our region, given our areas of focus and expertise. Taking existing organization and community resources into consideration, Fulton County Partners for Health will not directly address the remaining health needs identified in the CHNA, including but not limited to access to childcare, education, transportation, income/poverty, employment, food insecurity, housing/homelessness, maternal/infant/child health, internet/Wi-Fi access, crime/violence, environmental conditions, injuries, and HIV/AIDS and STIs. We will continue to look for opportunities to address community needs where we can make a meaningful contribution. Community partnerships may support other initiatives that Fulton County Partners for Health cannot independently lead in order to address the other health needs identified in the 2025 CHNA.

APPENDIX A

INTERNAL REVENUE SERVICE (IRS) REQUIREMENTS CHECKLIST: IMPLEMENTATION STRATEGY

Meeting the IRS Requirements for the Implementation Strategy

The Internal Revenue Service (IRS) requirements for an Implementation Strategy serve as the official guidance for IRS compliance. The following pages demonstrate how this IS/CHIP meets those IRS requirements.

Fulton County PARTNERS FOR HEALTH
Building a Healthy Community

APPENDIX A:
IRS IMPLEMENTATION STRATEGY REQUIREMENTS CHECKLIST

INTERNAL REVENUE SERVICE REQUIREMENTS FOR IMPLEMENTATION STRATEGIES				
YES	**PAGE #**	**IRS REQUIREMENTS CHECKLIST**	**REGULATION SUBSECTION NUMBER**	**NOTES/ RECOMMENDATIONS**
✓	4, 16-22	(2) Description of how the hospital facility plans to address the health needs selected, including: i. Actions the hospital facility intends to take and the anticipated impact of these actions; ii. Resources the hospital facility plans to commit; and iii. Any planned collaboration between the hospital facility and other facilities or organizations in addressing the health need.	(c)(2) (c)(2)(i) (c)(2)(ii) (c)(2)(iii)	
✓	22	(3) Description of why a hospital facility is not addressing a significant health need identified in the CHNA. *Note: A "brief explanation" is sufficient. Such reasons may include resource constraints, other organizations are addressing the need, or a relative lack of expertise to effectively address the need.*	(c)(3)	
✓	Throughout report	(4) For those hospital facilities that adopted a joint CHNA report, a joint IS may be adopted that meets the requirements above. In addition, the joint IS must: i. Be clearly identified as applying to the hospital facility; ii. Clearly identify the hospital facility's role and responsibilities in taking the actions described in the IS and the resources the hospital facility plans to commit to such actions; and iii. Include a summary or other tool that helps the reader easily locate those portions of the strategy that relate to the hospital facility.	(c)(4) (c)(4)(i) (c)(4)(ii) (c)(4)(iii)	Strategies that the hospital is collaborating on are indicated throughout the report and in the detailed improvement plan (living document).
✓	3, 22	(5) An authorized body adopts the IS on or before the 15th day of the fifth month after the end of the taxable year in which the CHNA was conducted and completed, regardless of whether the hospital facility began working on the CHNA in a prior taxable year. **Exceptions (if applicable):** **Transition Rule (if applicable):**	(c)(5)	

APPENDIX B

PUBLIC HEALTH ACCREDITATION BOARD (PHAB) CHECKLIST: IMPROVEMENT PLAN (CHIP)

Meeting the PHAB Requirements for the CHIP

The PHAB Standards & Measures serve as the official guidance for PHAB national public health department accreditation and include requirements for the completion of Community Health Assessments (CHAs) and CHIPs for local health departments. The following page demonstrates how this IS/CHIP meets the PHAB requirements.

Fulton County PARTNERS FOR HEALTH
Building a Healthy Community

APPENDIX B:
PHAB COMMUNITY HEALTH IMPROVEMENT PLAN (CHIP) REQUIREMENTS CHECKLIST

PUBLIC HEALTH ACCREDITATION BOARD (PHAB) REQUIREMENTS FOR CHIPs			
YES	**PAGE #**	**PHAB REQUIREMENTS CHECKLIST**	**NOTES/ RECOMMENDATIONS**
✓	 16-18 16-18 4, 16-18 19-20 22	**MEASURE 5.2.1 A: Adopt a community health improvement plan.** 1. A community health improvement plan (CHIP), which includes all of the following: a. Health priority(ies). b. Measurable objective(s) for each priority. c. Improvement activity(ies) for each objective with designated timeframes **and** organization(s) or individuals(s) accepting responsibility. d. Identification of the assets or resources that will contribute to successful implementation. e. Description of the process used to track the status of the actions taken to implement CHIP strategies or activities.	A detailed improvement plan (living document) has been developed that includes strategies, SMART objectives, annual activities, indicators, partners, and priority populations.
		MEASURE 5.2.2 A: Collaborative implementation and revision of the community health improvement plan. 1. Community health improvement plan (CHIP) activity or strategy implemented. a. The Documentation Form must indicate the priority and objective the CHIP strategy or activity example addresses. If the health department's role in implementation is not clear in the documentation, describe it on the Documentation Form. b. If the plan was adopted less than a year before it was submitted to PHAB, the health department may document implementation from an earlier CHIP. Documentation must demonstrate the linkage between the activities or strategies and the previous CHIP. While the prior CHIP may be older than 6 years, the implementation must have occurred within the past 6 years. 2. Revisions to the current community health improvement plan (CHIP), in collaboration with partners, or the process used for revisions.	Implementation activities will be monitored and documented over the cycle. Progress will be reported in the next CHA/CHNA report.
		MEASURE 5.2.3 A: Address factors that contribute to the higher health risks and poorer health outcomes experienced by specific population(s). 1. Implementation of a strategy to address factors that contribute to specific populations' higher health risks and poorer health outcomes. a. Each example must specify the data used to inform the strategy, the specific populations(s) the strategy was designed to reach, and factor(s) that were addressed; this information may be included on the Documentation Form. b. One example must address environmental impacts, built environment, **or** other infrastructure changes.	Implementation activities will be monitored and documented over the cycle. Progress will be reported in the next CHA/CHNA report.

APPENDIX C

REFERENCES

APPENDIX C: REFERENCES

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

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

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

[4]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

[5]Ohio Healthy Youth Environments Survey (OHYES!), Entire State Report 2023-2024.

[6]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.

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