

Community Health Implementation Plan—Crown Point

Franciscan St. Anthony Health-Crown Point

2016-2018

Community Health Improvement Plan

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Executive Summary of CHNA

The Community Health Needs Assessment (CHNA) is designed to provide an understanding of the current health status and needs of the residents in the communities served by Franciscan St. Anthony Health-Crown Point (FSAH-Crown Point). This report meets the current Internal Revenue Service's requirement for tax-exempt hospitals, which is based on the Patient Protection and Affordable Care Act of 2010. More importantly, this document assists FSAH-Crown Point in providing essential services to those most in need. Based on the findings in this report, FSAH-Crown Point will develop a three year strategic plan on meeting community health needs as capacity and resources allow.

This report focuses on Lake County, the location of most of FSAH-Crown Point patient residences. Because Indiana's a home rule state, data by zip code is limited. Based on the primary survey of residents in the county, some zip code level data was attainable and shows small nuances between the county of Lake and the city of Crown Point.

Lake County faces several challenges due to its socioeconomic factors, built environment, industry types, and geographical location. Using mixed methods to evaluate the primary and secondary data, the following health-related issues are top concerns:

1. Physical Activity and Nutrition: Obesity, diabetes management, arthritis, and cardiovascular conditions all score highly in incident rates and perception of need. A common theme amongst all of these clinical issues is the lack of physical activity and proper nutrition. Concerns about public safety, lack of built environment, and access to healthy food also contribute to this issue.
2. Behavioral Health: Suicide rates are higher than the state average. National data indicates of the reported completed suicides, many more are unreported due to the listed cause of death. Substance abuse rates are also quite high, especially with alcohol and opiates. Stress, depression, and poor mental health rates also contribute to poor chronic disease management, obesity, and self-satisfaction.
3. Access to Health Care: Cost of co-pays, deductibles, medications, and durable medical equipment are reported most frequently as barriers to clinical care. The county does have a portion designated as health professions shortage area due to low income populations. In addition, there is a shortage of providers, or long waits to see a primary care provider.
4. Lung and Colorectal Cancers: With a higher than state average smoking rate and poor air quality, lung cancer rates are high. Colorectal cancer screening rates are low, as are prostate screenings, and incident rates are high.
5. Infant Mortality: Smoking during pregnancy, low clinical care visits, and high infant mortality rates show the need for improved access and services for pregnant women and their families.
6. Asthma: Perhaps linked to the poor air quality in the county and high tobacco use rates, asthma rates are high and management is poor, especially in children.
7. Senior Services: There is a noted lack of services for the older population, including activities, specialized health care, and transportation

Franciscan St. Anthony Health-Crown Point

A trusted leader in providing faith-based, integrated health care, FSAH-Crown Point is a full-service, acute-care medical center. Our facilities have undergone major expansions and construction designed to meet the growing healthcare needs of our surrounding communities.

FSAH-Crown Point is a member of the Mishawaka, Ind.-based Franciscan Alliance, one of the largest Catholic health care systems in the Midwest with 14 growing hospitals, approximately 20,000 employees and a number of nationally recognized Centers of Health Care Excellence.

FSAH-Crown Point is located in Lake County, 1201 South Main Street, Crown Point, IN 46307. The CEO of FSAH-Crown Point is Barbara Anderson.

The FSAH- Crown Point statistics include:

FSAH Services	
Annual Outpatient Visits	183,849
Annual Emergency Department Visits	30,428
Annual Surgical Procedures	6,421
Births	1,610
Employees	1,300
Volunteers	XX
Total Physicians (includes Franciscan Physician Network and affiliated doctors)	375
Average length of patient stay	4.68

FSAH- Crown Point- Services include:

Anticoagulation Clinics	Gastrointestinal Services	OBGYN	Surgical Services
Audiology	Gynecologic Surgery	Occupational Health	Urgent Care
Behavioral Health	Heart & Vascular	Orthopedics	Women's Health/OBGYN
Breast Health	Home Health Care	Outpatient Services	WorkingWell
Cancer Care	Hospitalists	Palliative Medicine	Wound Care
Colon and Rectal Surgery	Imaging	Pediatrics	
Da Vinci Robotic Surgery	Incontinence Care	Primary Care Physicians	
Diabetes Care	Infusion Services	Pulmonary Medicine	
Dietitians	Intensive Care Unit	Registered Dietitians	
Ear, Nose, and Throat	Interventional Radiology	Rehabilitation Services	
Electrophysiology Lab	Joint & Spine Care	Respiratory Care	
Emergency Medicine	Laboratory Services	Robotic Surgery	
Employee Assistance Program	Lymphedema Services	Senior Services	
Family Doctor	Mammography	Sleep Disorders	
Franciscan ExpressCare	Massage Therapy	Sports Medicine	
Franciscan Point	Nuclear Medicine	Stroke Care	

The FSAH-Crown Point mission is To Continue Christ's Ministry in our Franciscan Tradition. Values include:

<u>Respect for Life</u>
The gift of life is so valued that each person is cared for with such joy, respect, dignity, fairness and compassion that he or she is consciously aware of being loved.

Fidelity to Our Mission
Loyalty to and pride in the health care facility are exemplified by members of the health care family through their joy and respect in empathetically ministering to patients, visitors and co-workers.

Compassionate Concern
In openness and concern for the welfare of the patients, especially the aged, the poor and the disabled, the staff works with select associations and organizations to provide a continuum of care commensurate with the individual's needs.

Joyful Service
The witness of Franciscan presence throughout the institution encompasses, but is not limited to, joyful availability, compassionate, respectful care and dynamic stewardship in the service of the Church.

Christian Stewardship
Christian stewardship is evidenced by just and fair allocation of human, spiritual, physical and financial resources in a manner respectful of the individual, responsive to the needs of society, and consistent with Church teachings.

Top Health Needs and FSAH-Crown Point Selections

Based on the CHNA, several priority health needs, including social determinants of health, were identified. Per IRS guidelines, the table below provides a list of the priority needs, which needs FSAH-Crown Point will commit to working on, and justification of why the other needs were not selected. Selection of priority health needs were based on the magnitude, impact, feasibility, cost, and partnerships.

Health Need	Description	FSAH-Crown Point Priority?	Justification/Explanation
Physical Activity and Nutrition	Obesity, diabetes management, arthritis, and cardiovascular conditions all score highly in incident rates and perception of need. A common theme amongst all of these clinical issues is the lack of physical activity and proper nutrition.	Yes	Physical activity and nutrition education will be integrated into the Diabetes Prevention Program.
Behavioral Health	Suicide, poor mental health days, depression, and substance abuse all rank highly in the community.	Some-what	Stress, depression, and poor mental health rates also contribute to poor chronic disease management, obesity, and self-satisfaction. This will be addressed in educational programming.
Access to Health Care	The county does have a portion designated as health professions shortage area due to low income populations. In addition, there is a shortage of providers, or long waits to see a primary care provider.	Yes	The St. Clare Clinic will be expanded to offer additional services.

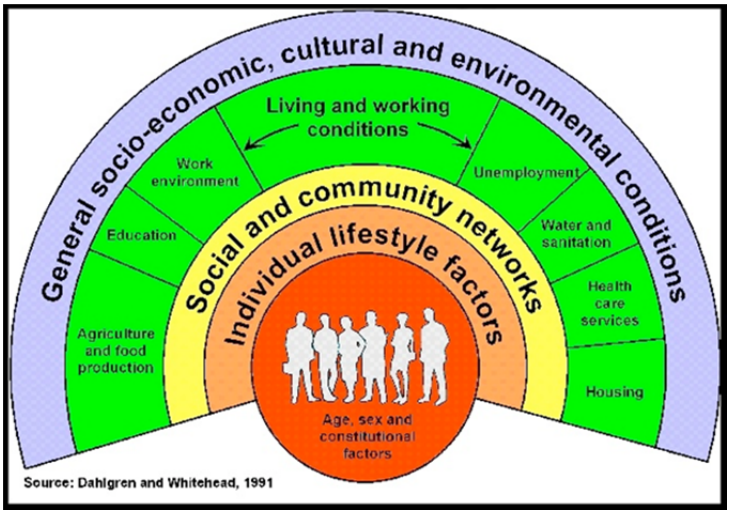
Lung and Colorectal Cancers	With a higher than state average smoking rate and poor air quality, lung cancer rates are high. Colorectal cancer screening rates are low, as are prostate screenings, and incident rates are high.	No	Other Franciscan Alliance hospitals in the county will focus attention on reducing cancer.
Infant Mortality	Smoking during pregnancy, low clinical care visits, and high infant mortality rates show the need for improved access and services for pregnant women and their families.	Not as a priority	Services are provided as a standard of care for patients.
Asthma	Perhaps linked to the poor air quality in the county and high tobacco use rates, asthma rates are high and management is poor, especially in children.	No	Other Franciscan Alliance hospitals in the county will focus attention on asthma and respiratory care.
Senior Services	There is a noted lack of services for the older population, including activities, specialized health care, and transportation	Yes	A fall prevention program will be implemented for those in the service area.

Approach and Methodology

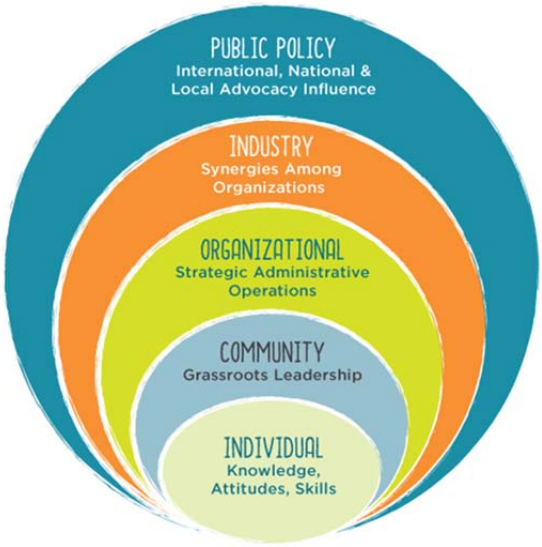
Principles and Methodology

In determining community health interventions for the selected priority health needs, health equity, sustainability, and consideration of the social determinants of health are key priniciples. While most interventions focus on the individual lifestyle factors, knowledge, skills, and behaviors, consideration of the cultural and environmental contexts are just as important. FSAH-Crown Point acknowledges that true change comes with major shifts in all areas. Therefore, while this report documents interventions that are mostly at the individual efforts, participating in collective impact is also vital.

The models below represent the need for multiple interventions:



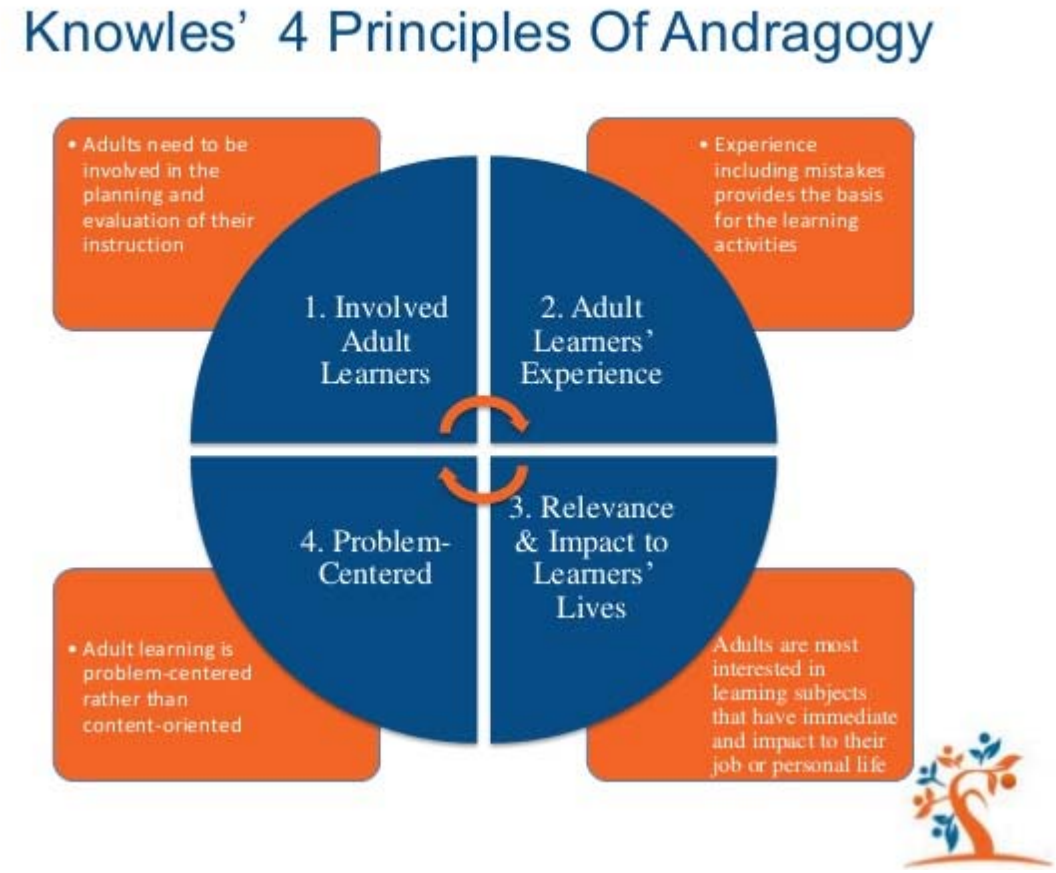
Social Determinants of Health



Socio-Ecological Model

Intervention Design

Interventions implemented by FSAH-Crown Point are person-centered and designed to create lasting change. Malcolm Knowles' Principles of Andragogy provides the frame work (image courtesy of eLearning Industry):



While this model is based on educational programming, it applies to all types of interventions. For example, in the provision of clinical care or medication assistance, participants not only receive the care or medication, they also learn to better manage their own health or access components of the health system or assistance program. Reflection, teach-back, and communication techniques are utilized to empower the participant to move beyond a one-time interaction or assistance.

Evidence Base

FSAH-Crown Point uses evidence-based practices in planning interventions whenever possible, as these programs have been thoroughly tested and proven efficacy. When evidence-based programs are not available, best practices and documented research guides the development and implementation of the intervention.

Evaluation

Implementation activities presented in this document will be evaluated to the fullest extent. Using Kirkpatrick's model as a guide, evaluation of not only the program, but its impact and results will be reviewed. This process allows for changes to be made to improve the program on an ongoing basis. While it can be difficult to determine the exact

cause of individual behavior change, biometrics, post-follow up surveys, and other methods will be used to capture qualitative and quantitative data. The model below (image courtesy of LeanLearn) notes the type of evaluation that will be used:



Documentation

Documentation of interventions, including financial resources, supplies, staff time, and individuals served, will be collected internally through CBISA Plus, a software product of Lyons Software. Annually, results will be published in an external document housed on the hospital's website.

Implementation Plans

2013-2016 Results

In the 2013-2016 cycle, FSAH Crown Point had two priority areas. The following table reviews the previous priority areas, results, and future efforts:

Priority	Results	Continuation?	Future Efforts
Diabetes Education	Clinical data supports positive behavioral changes and biometrics within individuals of the Diabetes	Yes	While the data supports positive results, the program has opportunity for expansion to Pre-

	Education programs offered through St. Clare Health Clinic.		Diabetes through the CDC's Diabetes Prevention Program. The clinic will be expanding services and anticipates an increase in educational opportunity.
Cardiovascular Health	The goal in this area also included an increase in screening, implementation of best clinical practices, weight loss, and diabetes prevention.	Indirectly through programs	While cardiovascular health specifically is not included in the implementation plan, a comprehensive physical activity and nutrition program will address the root cause of many cardiovascular conditions including but not limited to diabetes, tobacco use and obesity.

2016-2018 Implementation Plan

Three priority areas have been identified for the 2016-2018 timeframe—diabetes prevention and management, fall prevention, and access to healthcare.

The following plans document the anticipated activities and outcomes.

Date Created: 5/16/2016			Date Updated:
Goal	To decrease incident rates of diabetes and complications from diabetes		
HP 2020 Alignment:	D-1, D-5, D-14		
Other Alignment:	Cardiovascular and Diabetes Initiative, Indiana Healthy Weight Initiative, American Diabetes Association; CDC		
Comments:			
PERFORMANCE MEASURES How will we know that we're making a difference?			
	Indicator	Source	Frequency
Short Term:	Biometric data DPP evaluation/data	Participant data	Quarterly
Intermediate Term:	Improvement in management/behavioral strategies by participants	Pre/Post Test; biometric data	Annually
Long Term:	Reduction of incident rates of diabetes Reduction of complications from diabetes in ED and Inpatient	Indiana Hospital Association	3-5 years

2016

OBJECTIVES	
Objective #1:	Implement the CDC DPP program in the Crown Point Service Area
Evidence Base:	CDC; ISDH

ACTION PLAN

Action	*Target Date*	*Resources Needed*	*Team*	*Anticipated Product/Result*	*External Partners*	*Progress Notes*
Implement one DPP program with a target of 10 participants	8/31/2016	Facility; instructors; marketing	Julie Maller, Chris Mallers, Amy Pleasant, Amy Delaney	Improvement in participant biometric data	YMCA	

OBJECTIVES	
Objective #2:	Implement diabetes education programs for St. Clare patients with low income
Evidence Base:	ADA

ACTION PLAN

Action	*Target Date*	*Resources Needed*	*Team*	*Anticipated Product/Result*	*External Partners*	*Progress Notes*
Provide four classes for St. Clare patients focused on pre-diabetes, diabetes management, nutrition, and/or physical activity	12/31/2016	education for RN	Julie Mallers, Debbie Jordan, Quinessa Bell, Cyndi Maiko	Clinical outcomes trending toward goals as set by ADA and JNC 8	FSAH-CP, FPN, YMCA, ISBH, Wise Woman	
Develop evaluation protocol	8/31/2016	Evaluation	Julie Mallers, Debbie Jordan, Quinessa Bell, Cyndi Maiko	Evaluation	FPN, YMCA, ISBH, Wise Woman	
Market program to patients	12/31/2016	Materials	Julie Mallers, Debbie Jordan, Quinessa Bell, Cyndi Maiko	Participants	FSAH-CP, FPN, YMCA, ISBH, Wise Woman	

2017

OBJECTIVES						
Objective #1:	Implement the CDC DPP program in the Crown Point Service Area					
Evidence Base:	CDC; ISDH					
ACTION PLAN						
Action	*Target Date*	*Resources Needed*	*Team*	*Anticipated Product/Result*	*External Partners*	*Progress Notes*
Implement two DPP program with a target of 10 participants in each session.	12/31/2017	Facility; instructors; marketing	Julie Maller, Chris Mallers, Amy Pleasant, Amy Delaney	Improvement in participant biometric data	YMCA	
OBJECTIVES						
Objective #2:	Implement diabetes education programs for St. Clare patients with low income					
Evidence Base:	ADA					
ACTION PLAN						
Action	*Target Date*	*Resources Needed*	*Team*	*Anticipated Product/Result*	*External Partners*	*Progress Notes*
Provide six classes for St. Clare patients focused on pre-diabetes, diabetes management, nutrition, and/or physical activity	12/31/2017	education for RN	Julie Mallers, Debbie Jordan, Quinessa Bell, Cyndi Maiko	Clinical outcomes trending toward goals as set by ADA and JNC 8	FSAH-CP, FPN, YMCA, ISBH, Wise Woman	
Market program to patients	12/31/2017	Materials	Julie Mallers, Debbie Jordan, Quinessa Bell, Cyndi Maiko	Participants	FSAH-CP, FPN, YMCA, ISBH, Wise Woman	

2018

OBJECTIVES						
Objective #1:	Implement the CDC DPP program in the Crown Point Service Area					
Evidence Base:	CDC; ISDH					
ACTION PLAN						
Action	*Target Date*	*Resources Needed*	*Team*	*Anticipated Product/Result*	*External Partners*	*Progress Notes*
Implement two DPP program with a target of 10 participants in each session.	12/31/2018	Facility; instructors; marketing	Julie Maller, Chris Mallers, Amy Pleasant, Amy Delaney	Improvement in participant biometric data	YMCA	
OBJECTIVES						
Objective #2:	Implement diabetes education programs for St. Clare patients with low income					
Evidence Base:	ADA					
ACTION PLAN						
Action	*Target Date*	*Resources Needed*	*Team*	*Anticipated Product/Result*	*External Partners*	*Progress Notes*
Providesix classes for St. Clare patients focused on pre-diabetes, diabetes management, nutrition, and/or physical activity	12/31/2018	education for RN	Julie Mallers, Debbie Jordan, Quinessa Bell, Cyndi Maiko	Clinical outcomes trending toward goals as set by ADA and JNC 8	FSAH-CP, FPN, YMCA, ISBH, Wise Woman	
Market program to patients	12/31/2018	Materials	Julie Mallers, Debbie Jordan, Quinessa Bell, Cyndi Maiko	Participants	FSAH-CP, FPN, YMCA, ISBH, Wise Woman	

Date Created: 5/18/2016						Date Updated:
Goal:	To increase the number of those who are uninsured able to access primary care					
HP 2020 Alignment:	AHS-3; AHS-5					
Other Alignment:						
Comments:						

PERFORMANCE MEASURES How will we know that we're making a difference?			
	Indicator	Source	Frequency
Short Term:	Reduction in hospital readmissions through the Transitions Clinic at St. Clare Health Clinic	EPIC	quarterly
Intermediate Term:	Increase the number of insured individuals that have routine preventive services with an established Primary Care Provider.	EPIC BRFSS County Health Rankings	Annually
Long Term:	Improvement of individuals with good physical health days Improvement of chronic disease management scores	BRFSS County Health Rankings	3-5 years

2016

OBJECTIVES	
Objective #1:	To establish a Transitions Clinic at St. Clare Health Clinic
Evidence Base:	Patient centered medical home model with medical and social services; Joint Commission; AHRQ

ACTION PLAN

Action	*Target Date*	*Resources Needed*	*Team*	*Anticipated Product/Result*	*External Partners*	*Progress Notes*
Develop and implement Transitions Clinic	10/31/2016	Epic traing, credentialing of NP's, collaborative physician agreement	Julie Mallers, MaryJo Spearson, Dr. Foriet, Barb Anderson, Dr. MCMorrmick	Transitions clinic will see patients discharged from the hospital unable to get in with their physician within 48 hours.	FPN, physicians, ACO	In Early phase of credentaling
Promote Clinic and services	10/31/2016	Marketing materials	Julie Mallers, MaryJo Spearson, Dr. Foriet, Barb Anderson, Dr. MCMorrmick	Transitions clinic will see patients discharged from the hospital unable to get in with their physician within 48 hours.	FPN, physicians, ACO	
Develop evaluation system for patients using the clinic	10/31/2016	N/A	Julie Mallers, MaryJo Spearson, Dr. Foriet, Barb Anderson, Dr. MCMorrmick	Evaluation data	FPN, physicians, ACO	

Objective #2:	Expand services of St. Clare Health Clinic to the underinsured and HIP 2.0 patients
Evidence Base:	Indiana State Department of Health; CHC-Look Alike Guidance

ACTION PLAN

Action	*Target Date*	*Resources Needed*	*Team*	*Anticipated Product/Result*	*External Partners*	*Progress Notes*
Accept HIP 2.0 patients at St. Clare Health Clinic with NP's as Primary Panel Providers	7/1/2016	EPIC, FPN, credentialing	St. Clare Health Clinic/ FPN	Increase the number of individuals receiving primary care through HIP 2.0	HIP 2.0	Fully in progress
Marketing and advertising of expansion	6/1/2016	PR	St. Clare Health Clinic/ FPN			
Develop evaluation strategies	7/1/2016	N/A	St. Clare Health Clinic/ FPN	Evaluation Data		

OBJECTIVES

Objective #3:	Develop a navigation program to assist patients through preventive healthcare
Evidence Base:	CMS, AHRQ, Indiana State Department of Health

ACTION PLAN

Action	*Target Date*	*Resources Needed*	*Team*	*Anticipated Product/Result*	*External Partners*	*Progress Notes*
Train a Navigator to provide education and resources to patients regarding preventive services, screening, lifestyle modifications, access to healthcare, and social resources.	7/1/2016	ISDH grant for Navigator	St. Clare Case Manager, BCCP, HIP Navigator	Increased utilization of preventive healthcare services		
Develop resources for patients, including worksheets, brochures, and other materials	7/1/2016	ISDH grant for Navigator	St. Clare Case Manager, BCCP, HIP Navigator	Patient materials		
Develop an evaluation strategy, establish number of potential patients	7/1/2016	ISDH grant for Navigator	St. Clare Case Manager, BCCP, HIP Navigator	Evaluation report		

2017

OBJECTIVES

Objective #1:	To establish a Transitions Clinic at St. Clare Health Clinic
Evidence Base:	Patient centered medical home model with medical and social services; Joint Commission; AHRQ

ACTION PLAN

Action	*Target Date*	*Resources Needed*	*Team*	*Anticipated Product/Result*	*External Partners*	*Progress Notes*
Contue to serve patients that are unable to follow up with their physician with in 48 -72 hours of discharge; increase usage by 10%	12/31/2017	Additional staffing for St. Clare Health Clinic, NP, MA, hospitalist	St. Clare / Case Management/ Nursing / Hospitalist	Reduce readmissions and assist patients with Chronic disease management	Physicians	

OBJECTIVES	
Objective #2:	Expand services of St. Clare Health Clinic to the underinsured and HIP 2.0 patients
Evidence Base:	Indiana State Department of Health; CHC-Look Alike Guidance

ACTION PLAN						
Action	*Target Date*	*Resources Needed*	*Team*	*Anticipated Product/Result*	*External Partners*	*Progress Notes*
Continue to offer primary services to HIP 2.0 patients with focus on best practices evidence based order sets and preventive care; increase usage by 10%	12/31/2017	EPIC, FPN, credentialing	St. Clare Health Clinic/ FPN	Increase the number of individuals receiving primary care through HIP 2.0	HIP 2.0	

OBJECTIVES	
Objective #3:	Develop a navigation program to assist patients through preventive healthcare
Evidence Base:	CMS, AHRQ, Indiana State Department of Health

ACTION PLAN						
Action	*Target Date*	*Resources Needed*	*Team*	*Anticipated Product/Result*	*External Partners*	*Progress Notes*
Continue to Navigate patients through access to healthcare and primary care, social services, and other resources; increase usage by 10%	12/31/2017	ISDH grant for Navigator	St. Clare Case Manager, BCCP, HIP Navigator	Increased utilization of preventive healthcare services		

2018

OBJECTIVES	
Objective #1:	To establish a Transitions Clinic at St. Clare Health Clinic
Evidence Base:	Patient centered medical home model with medical and social services; Joint Commission; AHRQ

ACTION PLAN						
Action	*Target Date*	*Resources Needed*	*Team*	*Anticipated Product/Result*	*External Partners*	*Progress Notes*
Contue to serve patients that are unable to follow up with their physician with in 48 -72 hours of discharge; increase usage by 10%	12/31/2018	Additional staffing for St. Clare Health Clinic, NP, MA, hospitalist	St. Clare / Case Management/ Nursing / Hospitalist	Reduce readmissions and assist patients with Chronic disease management	Physicians	

OBJECTIVES	
Objective #2:	Expand services of St. Clare Health Clinic to the underinsured and HIP 2.0 patients
Evidence Base:	Indiana State Department of Health; CHC-Look Alike Guidance

ACTION PLAN						
Action	*Target Date*	*Resources Needed*	*Team*	*Anticipated Product/Result*	*External Partners*	*Progress Notes*
Continue to offer primary services to HIP 2.0 patients with focus on best practices evidence based order sets and preventive care; increase usage by 10%	12/31/2018	EPIC, FPN, credentialing	St. Clare Health Clinic/ FPN	Increase the number of individuals receiving primary care through HIP 2.0	HIP 2.0	

OBJECTIVES	
Objective #3:	Develop a navigation program to assist patients through preventive healthcare
Evidence Base:	CMS, AHRQ, Indiana State Department of Health

ACTION PLAN						
Action	*Target Date*	*Resources Needed*	*Team*	*Anticipated Product/Result*	*External Partners*	*Progress Notes*
Continue to Navigate patients through access to healthcare and primary care, social services, and other resources; increase usage by 10%	12/31/2018	ISDH grant for Navigator	St. Clare Case Manager, BCCP, HIP Navigator	Increased utilization of preventive healthcare services		

Date Created: 5/17/2016						Date Updated:
Goal:	To reduce falls and related injuries in older adults					
HP 2020 Alignment:	IVP-1.2; IVP 1.3					
Other Alignment:	CDC					
Comments:						

PERFORMANCE MEASURES How will we know that we're making a difference?			
	Indicator	Source	Frequency
Short Term:	Number of participants in Stepping On program; transfer of learning in program	Program facilitators Pre-post evaluation program	Post-program
Intermediate Term:	Reduce number of falls in targeted population	EPIC Program participant tracking	Annually
Long Term:	Reduction of unintentional injury in service area Reduction of deaths due to unintential injury in service area Reduction of hospitalizations due to unintentional injury in service area	Indiana Hospital Association data EPIC	3-5 Years

2016

OBJECTIVES	
Objective #1:	Implement the Stepping On program for 420 individuals annually
Evidence Base:	Stepping On, CDC

ACTION PLAN

Action	*Target Date*	*Resources Needed*	*Team*	*Anticipated Product/Result*	*External Partners*	*Progress Notes*
Develop marketing materials for participant recruitment	8/31/2016	Marketing materials	Stepping On team	Materials	YMCA, FPN, pharmacies, University of St. Francis, allied health professionals, EMS	
Provide training for program staff	8/31/2016	Training Materials	Stepping On team	Trained Staff	YMCA, FPN, pharmacies, University of St. Francis, allied health professionals, EMS	
Determine evaluation strategies	8/31/2016	N/A	Stepping On team	Evaluation data	YMCA, FPN, pharmacies, University of St. Francis, allied health professionals, EMS	
Recruit and provide program to participants into program	12/31/2016	Training Materials	Stepping On team	Participants	YMCA, FPN, pharmacies, University of St. Francis, allied health professionals, EMS	

2017

OBJECTIVES						
Objective #1:	Implement the Stepping On program for 420 individuals annually					
Evidence Base:	Stepping On, CDC					
ACTION PLAN						
Action	*Target Date*	*Resources Needed*	*Team*	*Anticipated Product/Result*	*External Partners*	*Progress Notes*
Recruit and provide program to participants into program	12/31/2017	Training Materials	Stepping On team	Participants	YMCA, FPN, pharmacies, University of St. Francis, allied health professionals, EMS	

2018

OBJECTIVES						
Objective #1:	Implement the Stepping On program for 420 individuals annually					
Evidence Base:	Stepping On, CDC					
ACTION PLAN						
Action	*Target Date*	*Resources Needed*	*Team*	*Anticipated Product/Result*	*External Partners*	*Progress Notes*
Recruit and provide program to participants into program	12/31/2017	Training Materials	Stepping On team	Participants	YMCA, FPN, pharmacies, University of St. Francis, allied health professionals, EMS	