Background and Rationale:					
Goal 1: Develop programs to help reduce obesity and the related health conditions					
Objective A:	**Action Steps**	**Accountability**	**Timeframe**	**Impact will be measured and evaluated through these indicators:**	**Status**
Improve access and education related to fresh, affordable, healthy food					
	Continue to offer nutrition education and screenings in the community	FCFP, PSU Extension, Food Basket, Head Start, Tri-State	Ongoing	FCFP screenings every 6 months, pre/post assessments after any class, number of classes and screenings, Tri-State (% of 3-17 yr olds with BMI percentile and counseling them on nutrition and physical activity)	
	Meet with Food Basket to determine how to best provide support to ensure residents have acccess to affordable healthy food	FCMC	2019	this is a first step - then plan classes or outreach efforts based on their level of interest - could help market their programs, or creatively get people in the community food/remove barriers	
	Meet with Giant (grocery store) to see if they will do healthy food shoping days, cooking classes, etc.	FCMC	2020	depending on outcome could track number of classes, pre/post assessement, healthy shopping days,	
	Continue to offer and promote monthly cooking classes at the wellness center in collaboration with referrals from PCP	FCMC	2019-2020	attendance at classes, number scripts from PCP, assess pre/post knowledge, possibly measured changes in behavior/eating habits	
	Collaborate with Cura Hospitality to offer nutrition education for the community	FCMC	2020	number of classes, number attend, pre/post assessment	
	Continue to offer resource and referral to patients on available food pantries and nutriton education programs	Tri-State	ongoing	# prescribe physical activity, nutrition counseling	

Objective B:	Action Steps	Accountability	Timeframe	Impact will be measured and evaluated through these indicators:	Status
Increase opportunities for physical activity and recreation throughout the communtiy and educate on available opportunities	Continue to assess community needs and interest and expand offerings at the Wellness Center to meet these needs	FCMC, School District is also doing programs	2019	needs survey every 6 months to include satisfaction with new programs, track participation	
	Partner with the Chamber of Commerce to create a community calender of upcoming opportunities	FCMC, FCFP, Chamber of Commerce	2020	track clicks on links	
	Partner with Chambers/Tourist agencies to develop a brochure or resource document that list all available opportunities for physical activity and recreation in the community that FCMC and parnters can help promote	Chambers of Commerce or local Tourism Agency - check with Wendy at Community Action to see if what she is doing includes this	2021	# brochures distributed, community connections made	

Background and Rationale:					
Goal 2: Improve access and care coordination for behavioral health services					
Objective A:	**Action Steps**	**Accountability**	**Timeframe**	**Impact will be measured and evaluated through these indicators:**	**Status**
Increase awareness of available services	Collaborate to develop a county-wide marketing plan to increase knowledge within the community on access to behavioral health services which might include reintroduction of Flip Your Card (brochure)	Mental health providers - MHA, TrueNorth, TMCA, FCFP, Tri-State, FCMC	December-19	the development of a marketing plan by end of 2019	
	Implement county-wide marketing plan	Mental health providers - MHA, TrueNorth, TMCA, FCFP, Tri-State, FCMC	Begin to implement plan in 2020	# of brochures distributed	
	Increase the number of providers who participate in Summer Kick-off (drug free)	FCMC, Tri-State	June 2019 and every year after	# people attending, # providers participating, # providers who indicate person learned of them from this event	
Objective B:	**Action Steps**	**Accountability**	**Timeframe**	**Impact will be measured and evaluated through these indicators:**	**Status**
Improve treatment, support and care coordination	Increase care coordination practices for individuals in recovery	SAAFE / FCFP - HRSA, Gaudenzia, FBH, True North, Franklin/Fulton D&A	September-19	Reduce fatal and non-fatal overdose numbers (tracked #)	
	Develop workforce initiative for individuals in recovery (establish who needs to come to table, then determine what are protocols/procedure/criteria then can recruit employers/employees				
	Actively support Individuals in Recovery through workforce initiative that includes collaboration with local employers	SAAFE / FCFP - HRSA, Gaudenzia, FBH, True North, Franklin/Fulton D&A, Company Businesses	April-20		

	Continue to integrate behavioral health care into primary care and collaborate with True North to provide those services both on site as well as stand alone services, continue to identify gaps in continuuim	Tri-State			
Support Care Coordination -	• Nurse Navigator - TMCA • Mobile Psych Nurse – Martha Swope – both counties				
Objective C:	**Action Steps**	**Accountability**	**Timeframe**	**Impact will be measured and evaluated through these indicators:**	**Status**
Improve access for commercial insurance and Medicare individuals	Collaborate with individuals to gather information from providers to assist with understanding barriers.	(Jen Amerihealth Mercy/Caritas reachout, Missy/Gen – Medicare issues)			
Objective D:	**Action Steps**	**Accountability**	**Timeframe**	**Impact will be measured and evaluated through these indicators:**	**Status**
Minimize barriers (including stigma) to accessing available services	Create a stigma reduction campaign related to OUD/SUD treatment	SAAFE- HRSA			
	Support the nationwide annual Walk the Walk to sustain and increase awareness across all counties served	MHA	October 2019 and every year after	# participants, #agencies sponsoring	
	Work with local providers and review existing data to identify barriers consumers are experiencing related to compliance with				
	Olmstead plan - (Jim Gilbert county rep) to update, projects that are occuring. Dozens of surveys in Fulton County on quality of life	Gen Harper			
	PCCD Case Manager				
Objective E:	**Action Steps**	**Accountability**	**Timeframe**	**Impact will be measured and evaluated through these indicators:**	**Status**
Work collaboratively to address youth risk behaviors as identified in the PAYS data	Refer to PAYS workplan for detailed action steps for items below:				
	Reduce Youth Alcohol Use and Misuse	FCFP		# students sign pledge where applicable, 2019 PAYS survey	Prom Promise Assembly for 2019 in all 3 school districts
	To Reduce Bullying Behaviors	FCFP		2019 PAYS survey	
	Parental Attitudes Favorable Towards Anti-Social Behaviors	FCFP		2019 PAYS survey	

Background and Rationale:					
Goal 3: Develop a full continuum of aging services to meet the needs of older persons in Fulton County					
Objective A:	**Action Steps**	**Accountability**	**Timeframe**	**Impact will be measured and evaluated through these indicators:**	**Status**
Continue to explore options for developing senior living services/assisted living on FCMC campus	Explore the requirements for applying for CMS' NOFA - for community navigation of services for seniors			Research on CMS's NOFA completed by [date] Apply for CMS's NOFA by [date]	
	Investigate and visit best practice senior living/ assisted living facilities connected to hospital campuses.	FCMC	2020	# of facilities visited and date of visit	
Objective B:	**Action Steps**	**Accountability**	**Timeframe**	**Impact will be measured and evaluated through these indicators:**	**Status**
Continue to integrate hospice into the continuum of aging services	Continue to work with Spirit Trust Luthern, Grane Hospice and heartland , offering hospice services to the aging population	FCMC	2021	# of hospice services offered each year	
Objective C:	**Action Steps**	**Accountability**	**Timeframe**	**Impact will be measured and evaluated through these indicators:**	**Status**
Revamp the senior services collaboration to include Bedford/Huntingdon/Fulton Area Agency on Aging and Franklin/Fulton Mental Health to increase education, awareness, and services available to aging adults in the community	Re-engage the members of the senior workgroup	FCFP (note FCMC is part of this partnership)	2019	# members, # meetings, report to Commissioners	
	Evaluate Meals on Wheels program to determine the level they are providing healthy meals and providing food that meets any dietary restrictions	FCFP (note FCMC is part of this partnership)	2020	completing evaluation to understand program and determine next steps for 2021	

	Determine advocacy approach to address challenges with senior transportation	FCFP (note FCMC is part of this partnership)	2021	approach developed in 2021 with strategies implemented in upcoming years	

Background and Rationale:					
Goal 4: Increase access to prevention and ongoing manangement of chronic conditions					
Objective A:	**Action Steps**	**Accountability**	**Timeframe**	**Impact will be measured and evaluated through these indicators:**	**Status**
Improve education and access to existing services	Ensure resource document is up to date and handout to all patients identified with a chronic condition	Tri-State	Update		
	Collaborate with local EMS to ensure they have educational materials on managing chronic conditions as well as available services in the community (possibly develop checklist for them to use)	FCMC	Summer 2022	# meetings and/or # materials handed out	
	Market the new diaylsis program provided by dialysis care center at FCMC.	FCMC	Summer 2019	# patients, #social media posts, ads - track where they found out about us, click through rates	
	Continue 6-week long educational session "Living Well"	FCMC and Tri-State			
Objective B:	**Action Steps**	**Accountability**	**Timeframe**	**Impact will be measured and evaluated through these indicators:**	**Status**
Increase preventative services available in the community	Increase awareness of prevenative screenings by developing a handout of recommended screenings by age to distribute	FCMC	Fall 2019	#distributed, increase in screening following distribution	
	Develop No Shave November Event for Prostate Health (part of Healthy Sportsman)	FCMC	Fall 2020	# attendees, increase in screenings	
	track & assure at every visit that patient has received all preventive screenings according to standard care protocols.	Tri-State		report annually % receiving preventive screenings	
Objective C:	**Action Steps**	**Accountability**	**Timeframe**	**Impact will be measured and evaluated through these indicators:**	**Status**

Expand case management for chronic conditions	Recruit staff to work with patients after discharge through transitions of care to ensure they are following up with PCP, compliant with medications, etc.	FCMC	2020	develop tool for the staff to use to track follow up and compliance	
	Continue to offer care coordination and case management services to patients with chronic conditions	Tri-State			
	Collaborate with mental health managed care to help support their nurse navigator who is supporing consumers with high mental health as well as high physical health needs	Partnership			
	Working with cardiology and transitions of care nurse on decreasing hospital reeadmissionis for patients which CHF	FCMC	2019-2020	track #readmissions	
	Collaborate with cancer treatment providers to established oncology services at FCMC campus	FCMC	2020-2021	successful in bringing on oncologist	
	Continue to offer navigation support for women's health (broaden focus to all cancer screenings)	FCMC	2020-2021	#screenings, # letters sent	
	Determine how to offer navigation support for men's health that will replicate current women's health services	FCMC	2020-2021	#screenings, # letters sent	
Objective D:	**Action Steps**	**Accountability**	**Timeframe**	**Impact will be measured and evaluated through these indicators:**	**Status**
Continue to provide community education and screenings related to chronic conditions (i.e. diabetes, coronary heart disease)	Continue to implement standard care protocol and manage patients with chronic disease	Tri-State		% hypertensive patients with BP<140/90, % diabetic patients ages 18-75 with HBa1C >9, % lipid therapy for CAD, % aspirin therapy for IVD	
	Ensure all adult patients are screened for pre-hypertension and pre-diabetes and that those identified at a high risk level receive follow up and care coordination	Tri-State		track all identified patients to ensure receiving standard protocols	
	Provide ongoing education at community diabetes forums offered by Diabetes Educator	FCMC		#participants, #pre-diabetic, diabetic	

	Resume monthly diabetes education programs for Tri-State patients	FCMC	January 2020	# referred, # 1-1 counseling, pre/post assessment	
	Evaluate current education programs and screenings to determine value, need and ability to expand in other areas (Southern Huntingdon and Mercersburg)	FCMC	June 2019	evaluation completed and then next steps determine, if feasible will track new locations and numbers seen	
	Continue to provide health screenings, education and referrals and collaborate with PCP to determine tracking mechanism and follow up	FCMC and Tri-State	January-20	track #people at each station, # total	