2024 Implementation Strategy

GOAL 1 – Increase awareness and prevention of Lyme disease and diabetes						
OBJECTIVES	**ACTION STEPS**	**ACCOUNTABILITY**	**TIMEFRAME**	**BUDGET**	**IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS**	**Data July – December 2024**
Increase awareness of Lyme Disease and available community resources	Continue educational program for informing the community both in person and virtually	Katie Donald	2-3 Sessions Annually	$1,000	Attendance at events- virtual and in person	PAH holds a monthly Wellness Connection Seminar. These topics very from month to month.
	Connect people to resources	Katie Donald	March-November annually	-	With online resources, we are able to see the traffic to the specific pages on the website through the analytics. Through social media we can also track the amount of people that have been engaged, exposed, etc.	Continuing to provide
	Resources available in lobby, website, handed out at events	Katie Donald	March-November annually	$1,000	The measurement will be the rate of the turnover of materials.	Measuring the turn over of materials is continuing to be tracked.
Conduct annual blood screening program	Continue to offer the testing program annually	Katie Donald Ben Hughes Jackie Sansig	1 per year, generally in the spring	$10,000	Completion of Event followed by an evaluation of participants.	Event completed.

2024 Implementation Strategy

GOAL 1 – Increase awareness and prevention of Lyme disease and diabetes						
OBJECTIVES	**ACTION STEPS**	**ACCOUNTABILITY**	**TIMEFRAME**	**BUDGET**	**IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS**	**Data July – December 2024**
	Identify strategy to track percentage of attendees who follow up with Punxsutawney Area Hospital physicians and results over time	Katie Donald	Annually prior to screening event	-	Evaluation will be completed by referrals based on attendees of the event who sought care from Punxsutawney Area Hospital Physicians.	This will be completed in 2025.
	Create an opt out button to gain permission to track data in conjunction with registration.	Katie Donald	Annually prior to screening event	-	When registering participants will have the ability to not participate in our more comprehensive follow up.	Completed.
	Re-establish structural relationships with PCPs for the blood screening participants.	Katie Donald Shelly Young	Annually prior to screening event	-	Annually PCP's will be asked to participate in program.	This will be completed in 2025. The event happened in July 2024 so we had already gotten their participation in the event established.

2024 Implementation Strategy

GOAL 1 – Increase awareness and prevention of Lyme disease and diabetes						
OBJECTIVES	**ACTION STEPS**	**ACCOUNTABILITY**	**TIMEFRAME**	**BUDGET**	**IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS**	**Data July – December 2024**
	Expand current comprehensive blood screening program using evidence-based methodologies to address diabetes, heart disease and obesity rates in the region; by strengthening provider partnerships and targeting education to high risk patients.	Katie Donald Ben Hughes	Annually	-	Attendance at events, number of targeted emails opened, information view on the website.	2024 Completed
	Survey physicians/ providers to strengthen collaborative efforts with stakeholders in blood screening	Katie Donald Shelly Young	Annually post screening event.	-	Evaluation of a survey	2024 Completed

2024 Implementation Strategy

GOAL 1 – Increase awareness and prevention of Lyme disease and diabetes						
OBJECTIVES	**ACTION STEPS**	**ACCOUNTABILITY**	**TIMEFRAME**	**BUDGET**	**IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS**	**Data July – December 2024**
	program.					
Provide education to the community	Continue to provide Wellness Connection Seminars on relevant topics related to Lyme Disease and Diabetes	Katie Donald	Monthly on different topics	$1,000 per event	# seminars and topic # attend each seminar	Monthly seminars with total number of attendees is being tracked.

Goal 2: Increase awareness and prevention of Cardiovascular Disease (heart disease, high blood pressure, etc.)						
OBJECTIVES	**ACTION STEPS**	**ACCOUNTABILITY**	**TIMEFRAME**	**BUDGET**	**IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS**	**Data July – December 2024**
Decrease readmissions through better chronic care management	Discharge planning – risk factor scores of 10 and above the patient is scheduled for an appointment within 7 days with their primary care provider; they get a discharge phone call within 72 hours – they look at med management, meeting with their physician; any home equipment. If they didn't go home with home health would they benefit for home health.	Deanna Beveridge Patti Dinsmore	Evaluate on a quarterly basis annually.	-	Evaluate follow up measures by direct conversations with patients and document findings.	Evaluation measures are continuing.

2024 Implementation Strategy

Goal 2: Increase awareness and prevention of Cardiovascular Disease (heart disease, high blood pressure, etc.)						
OBJECTIVES	**ACTION STEPS**	**ACCOUNTABILITY**	**TIMEFRAME**	**BUDGET**	**IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS**	**Data July – December 2024**
	Create a process to track and verify patients participation in their chronic care management with PCP. Validation of participation would be completed by creating a process to track and verify with individual providers in an effective way but timely way. This process would be created to ensure the follow up with patients and their PCP.	Deanna Beveridge Patti Dinsmore	Ongoing	-	Measured by evaluating the process of track/ verify by analyzing the data collected.	Data is reviewed quarterly.

2024 Implementation Strategy

Goal 2: Increase awareness and prevention of Cardiovascular Disease (heart disease, high blood pressure, etc.)						
OBJECTIVES	**ACTION STEPS**	**ACCOUNTABILITY**	**TIMEFRAME**	**BUDGET**	**IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS**	**Data July – December 2024**
Community Blood Screening	Provide Supplemental information to patients, including blood pressures, heart disease screening questionnaire, provision of nutritional information.	Katie Donald Mandy Caylor	Monthly	$5,000peryear in printing	Rate of disbursement.	Completed for 2024.
	After event, wrap around events on what did the test results mean, how to lower your cholesterol, diet and nutrition	Katie Donald Deanna Beveridge Amy Behrendt	Post screening event annually.	-	Identifying key issues and establishing events surrounding the topics.	Completed for 2024.
	Track the number of users over a five-year period	Katie Donald Ben Hughes	Post screening event annually.	-	Analyzing the data collection is complete.	Ongoing analysis.

2024 Implementation Strategy

Goal 2: Increase awareness and prevention of Cardiovascular Disease (heart disease, high blood pressure, etc.)						
OBJECTIVES	**ACTION STEPS**	**ACCOUNTABILITY**	**TIMEFRAME**	**BUDGET**	**IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS**	**Data July – December 2024**
	Meet 2x annually with PCP to discuss needs of the community based on information gathered from The blood screening.	Katie Donald	2xAnnually	-	Completion of meetings.	Completed for 2024.
Promote the hospital's Congestive Heart Failure Clinic and increase the Number of patients utilizing the clinic annually	Educate hospital staff, physicians and new cardiologist about the benefits of the hospital's Congestive Heart Failure Clinic	Katie Donald Michael Kascmar, CRNP Tom Moore	Quarterly Updates, Annually	$1,000 a year for promotional informational printing	Evaluated by the number of connections made to providers and staff regarding the services that are available.	Delays based on CHF providers employment status changing with PAH.
	Send notice to providers and provide follow up – success stories	Katie Donald	Quarterly Updates, Annually	$1,000peryear in postage	Completing the mailings both email and US Mail.	Identifying stories.
Reach out to the American Heart	Create a dialogue and relationship with the Regional and	Katie Donald	Quarterly Connections, Annually	-	Measured by having and analyzing the dialogue.	Ongoing establishment of relationship.

2024 Implementation Strategy

Goal 2: Increase awareness and prevention of Cardiovascular Disease (heart disease, high blood pressure, etc.)						
OBJECTIVES	**ACTION STEPS**	**ACCOUNTABILITY**	**TIMEFRAME**	**BUDGET**	**IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS**	**Data July – December 2024**
Association to support their regional and national initiatives	national					
	American Heart Association in order to stay abreast of latest news and offerings					Ongoing visits to the American Heart Association Website.
	Deliver Educational Programs utilizing technology including an introduction to telemedicine.	Katie Donald Michael Kascmar, CRNP Tom Moore	Quarterly Programs, Annually	-	Measured by the number of programs that will be available to for patients and community members.	Cardio was featured at the Women's Clinic in October of 2024.
	Implement the use of the registry of high-risk patients to increase PCP follow-ups.	Katie Donald Shelly Young	Quarterly Updates, Annually	-	By using clinicians to evaluate and working directly with PCP's, establish a registry. It will be measured by its usefulness and 'completeness'.	In progress.

2024 Implementation Strategy

Goal 2: Increase awareness and prevention of Cardiovascular Disease (heart disease, high blood pressure, etc.)						
OBJECTIVES	**ACTION STEPS**	**ACCOUNTABILITY**	**TIMEFRAME**	**BUDGET**	**IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS**	**Data July – December 2024**
	Make American Heart Association resources available to patients and share their resources with patients with appropriate	Katie Donald	Ongoing	$1,000 per year	# resources distributed?	500 hard copy, informational packets distributed.
Manage high risk population	Continue to enroll blood screening participants in the blood pressure/ high risk monitoring program.	Katie Donald Ben Hughes	During the screening event, Annually	$5,000 per year	Adding additional participants.	Blood screening was completed in July of 2024.
	Increase clinical information provided to referring physicians for patients identified as high risk.	Katie Donald Michael Kascmar, CRNP	Quarterly Updates, Annually	$500 per year	Evaluating the material to send and the amount of times connections were made.	Completed post Blood Screening. Connections made were tracked through emails sent to participants.

2024 Implementation Strategy

Goal 2: Increase awareness and prevention of Cardiovascular Disease (heart disease, high blood pressure, etc.)						
OBJECTIVES	**ACTION STEPS**	**ACCOUNTABILITY**	**TIMEFRAME**	**BUDGET**	**IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS**	**Data July – December 2024**
	Create a tracking system to connect high risk patients with physician follow ups	Ben Hughes Shelly Young	Quarterly, Annually	-	By using clinicians to evaluate and working directly with PCP's, establish a registry. It will be measured by its usefulness and 'completeness'.	In progress.
Provide education to the community	Continue to provide Wellness Connection Seminars on relevant topics related to Cardiovascular Disease	Katie Donald	Monthly on different topics	$1,000 per event	# seminars and topic # attend each seminar	Women's Health Fair featured Heart Health, 60 attendees

2024 Implementation Strategy

Goal 3: Position the hospital and community to respond to the National Opioid Crisis by using evidence-based practices and research while partnering to ensure efficacy.						
OBJECTIVES	**ACTION STEPS**	**ACCOUNTABILITY**	**TIMEFRAME**	**BUDGET**	**IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS**	**Data July – December 2024**
Identify health and human service in the local region to partner	Create a resource guide with local contacts for professionals	Katie Donald	Ongoing	-	Measured by the number of materials that created, dispersed, and/or utilized.	1,500 informational pieces distributed
Online resources made available through the hospital's webpage	Redesign of the webpage to adequately provide educational resources.	Katie Donald	Quarterly Updates, Annually	-	The completion of updates on the website of the necessary links.	Materials identified but not added to the website.
	Identify web-based resources	Katie Donald	Quarterly Updates, Annually	-	Find web-based resources and create a connection to them using the pah.org website.	Ongoing.
	Post links through the webpage	Katie Donald	Quarterly Updates, Annually	-	Measured by the engagement of the posts-include post interaction.	Measurement in progress.
Connect to regional Players for better collaboration Of services	Identify key contacts in Law enforcement/Clearfield Jefferson Drug and Alcohol/Punxsutawney EMS,IRMC resources	Katie Donald Ben Hughes	Quarterly Updates, Annually	-	By making the key connections and Establishing a relationship.	Connections made with CJDAC. PREP employee in the PAH facility.

2024 Implementation Strategy

Goal 3: Position the hospital and community to respond to the National Opioid Crisis by using evidence-based practices and research while partnering to ensure efficacy.						
OBJECTIVES	**ACTION STEPS**	**ACCOUNTABILITY**	**TIMEFRAME**	**BUDGET**	**IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS**	**Data July – December 2024**
Provide Resource list physicians and Providers in the region	Create a resource list For providers in Conjunction with IRMC To establish a cohesive PMCN resource list.	Katie Donald Deanna Beveridge Patti Dinsmore Gary Carnahan	Quarterly Updates, Annually	-	Completion of list creation and assessing its substance.	Completed but ongoing.
State Data provided Through the webpage And shared with collaborative partners	Notice to collaborative Partners of available resources	Katie Donald Deanna Beveridge Patti Dinsmore Gary Carnahan	Quarterly Updates, Annually	$500 per year	Completion of connection being made to Partners yearly.	Completed but ongoing.
Collaborative grant identified	Research Opportunities with key stakeholders	Katie Donald	Quarterly Updates, Annually	-	Research on a regular basis the grants and funding sources that are available to assist With the goal.	Ongoing.
Create a PMCN Strategy to improve regional efforts	PMCN strategic plan to Identify opioid as a priority	Ben Hughes Paula Spack Jack Sisk Dr. Clark Simpson	Annually prior To PMCN reorganizational meeting	-	Confirmation that PMCN has it in their plan.	Confirmed

2024 Implementation Strategy

Goal 3: Position the hospital and community to respond to the National Opioid Crisis by using evidence-based practices and research while partnering to ensure efficacy.						
OBJECTIVES	**ACTION STEPS**	**ACCOUNTABILITY**	**TIMEFRAME**	**BUDGET**	**IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS**	**Data July – December 2024**
Create Opioid Strategy document to address local needs.	Planning document Created Shared with Collaborative partner and Opioid stakeholders.	Paula Spack Gary Carnahan Dr. Bryan Dempsey	Quarterly Updates, Annually	-	Completion of planning documents with is Created collaboratively.	Currently being created.

Goal 4: Improve access to mental health services and supports						
OBJECTIVES	**ACTION STEPS**	**ACCOUNTABILITY**	**TIMEFRAME**	**BUDGET**	**IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS**	**Data July – December 2024**
ER expansion project	Determine the necessary components needed to assist with the care of mental health patients arriving in the ED In process of construction and need to revaluate what will work in our space	Ben Hughes Patti Dinsmore Dr. Clark Simpson Dr. Bryan Dempsey	First Quarter 2025	$5,000	Evaluate and determine the functionality needed to care for mental health patients through real life visits.	Evaluation of number of patients identified and being reviewed for work flow in the new ED.
Develop a database of available community services	Create a database of resources of to assist patients with outpatient and other services.	Patti Dinsmore Brenda Cooper Katie Donald	First Quarter 2025, updated monthly	-	The creation of the database with a comprehensive guide to resources.	Completed but ongoing.
Establish relationship with IRMC for new behavioral health unit	Education on available services to hospital staff	Paula Spack Mandy Caylor	Quarterly	-	Completed yes/no	Not completed
	Establish referral process and process to direct admit to IRMC based on bed availability	Gary Carnahan Paula Spack	First Quarter 2025	-	Completed yes/no	Not completed
	Determine marketing strategy and approach	Katie Donald	First Quarter 2025	$10,000	Completed marking plan	No completed
Expand services	• Establish internal	Discharge	Q4 2024	Beginning	# referrals	No referrals to date.

2024 Implementation Strategy

Goal 4: Improve access to mental health services and supports						
OBJECTIVES	**ACTION STEPS**	**ACCOUNTABILITY**	**TIMEFRAME**	**BUDGET**	**IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS**	**Data July – December 2024**
through IRMC's Integrated Behavioral Health Building	referral process/protocol • Market services	Planning	for services to go live Jan 2025	Jan 2025	# referrals admitted #direct transfer from ED # in each level of service Avg. length of stay Discharge disposition	The facility is not open yet.
Decrease the number of suicides	Complete creation and implementation of suicide risk assessment with patients	Gary Carnahan Paula Spack Deanna Beveridge Katie Donald	First Quarter 2025	-	# screened # at risk	In Progress.
	Create process to manage patient if screened and at risk	Gary Carnahan Paula Spack Deanna Beveridge Katie Donald	First Quarter 2025	-	# received follow up services and support	In Progress
Collaborate with Clearfield Jefferson Drug and Alcohol Commission to make the PREP Program available	Continue to market program	Katie Donald	Ongoing	$10,000	• Track referral to program based on what they are seeing o they track people placed into programs and pull data on those falling through the cracks who recovery specialist and can meet with o primary or secondary code related to SUD and not seeking as resource • maybe track referral and then those not in county • community member vs hospital referral	Ongoing.

2024 Implementation Strategy

Goal 4: Improve access to mental health services and supports						
OBJECTIVES	**ACTION STEPS**	**ACCOUNTABILITY**	**TIMEFRAME**	**BUDGET**	**IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS**	**Data July – December 2024**
	Provide required staff education	Mandy Caylor	Ongoing	-	# trained and on what	Completed.
Serve community need by Supporting IRMC's BH Outreach Program to connect emergency department BH patients with outpatient	Collaborate with Ambulatory Social Work to connect them to BH patients to address ED identified SDOH or other service need	Ambulatory Social Work	Ongoing		# of referrals to Ambulatory Social Work # connected to Ambulatory Social Work Compare ED visit rate on quarterly basis for BH patients connected to outreach services and those that are not (possibly pull connected with Ambulatory Social Work vs. didn't)	50 referrals to a new position in PPG as a social worker these were not all from the ED.
	Review ED logs weekly to identify patients appropriate for additional BH services and complete post-discharge phone calls	Ambulatory Social Work	ongoing		# of phone calls # social worker reaches # of patients who follow-up with PCP in 7 days post ED visit	Not completed, BH unit is not open at IRMC yet.

2024 Implementation Strategy

Goal 4: Improve access to mental health services and supports						
OBJECTIVES	**ACTION STEPS**	**ACCOUNTABILITY**	**TIMEFRAME**	**BUDGET**	**IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS**	**Data July – December 2024**
	Work with community providers to develop opioid prescribing guidelines	Ambulatory Social Work	ongoing		# providers adopting guideline # reduce dependence on opioids in offices following guidelines	Ongoing
Increase access to inpatient rehab	Form relationships with facilities in the region that can support patients in need.	Dr. Bryan Dempsey	ongoing	-	# connections made	3 connections made to other facilities.
Increase awareness of available services	Create a collaborative resource guide between PAH, IRMC, and ACMH with local contacts for professionals	Patti Dinsmore	First Quarter 2025 then ongoing	-	Creation of guide	Completed but ongoing.

GOAL 5 – Increase access to resources and health literacy						
OBJECTIVES	**ACTION STEPS**	**ACCOUNTABILITY**	**TIMEFRAME**	**BUDGET**	**IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS**	**Data July – December 2024**
Create community health resource directory	Collect information on available community resources and	Katie Donald	First Quarter 2025 then ongoing	$10,000	# screened # and type of need identified	Ongoing.

2024 Implementation Strategy

GOAL 5 – Increase access to resources and health literacy						
OBJECTIVES	**ACTION STEPS**	**ACCOUNTABILITY**	**TIMEFRAME**	**BUDGET**	**IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS**	**Data July – December 2024**
	create database for the community that will be available online and print copy to provide patients					
	Continue to ask inpatients question related to SDOH and if indicate a need provide resource guide and supplement food if they not food as need	Discharge Planning	Ongoing	-		In Progress.
	Evaluate possible staff need and approach to be able to follow up with those who identify a need	Katie Donald Paula Spack Gary Carnahan Patti Dinsmore	Ongoing	-		In Progress.
	Work to expand asking SDOH	Paula Spack Gary Carnahan Dr. Dempsey	Ongoing	-		In Progress.

2024 Implementation Strategy

GOAL 5 – Increase access to resources and health literacy						
OBJECTIVES	**ACTION STEPS**	**ACCOUNTABILITY**	**TIMEFRAME**	**BUDGET**	**IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS**	**Data July – December 2024**
	questions in the ER and hope person doing triage can do follow up and add this to what they would already ask	Deanna Beveridge Katie Donald				
Improve health literacy	Bring mobile wellness unit out into community to help increase access to preventative care	Katie Donald	Ongoing	$5,000	# locations mobile wellness unit was at # served by mobile wellness unit?	11 locations 1,000 ppl served
	Educate children at the Punxsutawney Area School District on health and wellness	Katie Donald	Ongoing	$1,000	# joint programs # children participating in programs	Wellness Days Grades 3-4-5-6 650 kids
	Partner with IUP and other organizations to increase knowledge or awareness of preventative care	Katie Donald Sarah Walker	Ongoing	$3,000	#partners #programs offered # participating in programs	3- IUP, Rotary, Chamber 8 Programs 550 ppl

2024 Implementation Strategy

GOAL 5 – Increase access to resources and health literacy						
OBJECTIVES	**ACTION STEPS**	**ACCOUNTABILITY**	**TIMEFRAME**	**BUDGET**	**IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS**	**Data July – December 2024**
	Assist patient who qualify for financial assistance or may be uninsured or underinsured	Finance Department	Ongoing	-	# assisted	50
	Ensure all print, digital and social messaging is accessible and written at a reading level the general population can read and understand	Katie Donald Mandy Caylor	Ongoing	-		Completed

2024 Implementation Strategy

GOAL 6 – Increase awareness and strategies to reduce obesity and maintain a healthy weight						
OBJECTIVES	**ACTION STEPS**	**ACCOUNTABILITY**	**TIMEFRAME**	**BUDGET**	**IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS**	**Data July – December 2024**
Provide education, resources and support to the community	Continue to provide Wellness Connection Seminars on relevant topics related to overweight, obesity and healthy weight	Katie Donald	Monthly on different topics	-	# seminars and topic # attend each seminar	Seminar 1 Attendee 60
	Create recipe guides	Dietician	Monthly	$1,000	Creation of guides	Ongoing
	Provide information on healthy shopping, reading food labels, etc.	Dietician	Monthly	-	# of resources provided	4 handouts
	Offer consults with Dietician	Dietician	Ongoing	-	# consults # lost weight Pounds lost	Not completed
	Collaborate with the school district to provide wellness days for students and faculty	Katie Donald	Quarterly	$1,000	#students participate #faculty participate	650 kids 26 facility

2024 Implementation Strategy

GOAL 6 – Increase awareness and strategies to reduce obesity and maintain a healthy weight						
OBJECTIVES	**ACTION STEPS**	**ACCOUNTABILITY**	**TIMEFRAME**	**BUDGET**	**IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS**	**Data July – December 2024**
	Collaborate with the school district to provide blood pressure and stress screening for teachers	Katie Donald	Quarterly	$1,000	#screened #high bp or high stress #connected to resources	70 12 12
	Provide education on the importance of exercise	Rehab Staff	Quarterly	-	#participate in education session	Not competed
	Partner for National Night Out and other community events and provide education on exercise and wellness where appropriate	Rehab Staff Pediatric Staff	Ongoing	$5,000	#events and topic # participating in events	2 Events Topic: Pediatric Wellness # participating: 400
Improve the quality of food available at PAH	Review menu and meals available through food service to ensure we are providing healthy meals and options	Dietician	Ongoing	-	# of menus reviewed	1 month's worth

2024 Implementation Strategy

GOAL 6 – Increase awareness and strategies to reduce obesity and maintain a healthy weight						
OBJECTIVES	**ACTION STEPS**	**ACCOUNTABILITY**	**TIMEFRAME**	**BUDGET**	**IMPACT WILL BE MEASURED AND EVALUATED THROUGH THESE INDICATORS**	**Data July – December 2024**
Collaborated with IRMC to provide bariatric services	Refer appropriate patients to services at IRMC	Primary Care Providers	Ongoing	-	#referrals #received services #received surgery Total pounds lost	35 referrals 20 services 4 surgeries Unknown