HEALTH FIRST INDIANA

Lake County Health Department
2900 West 93rd Ave., Crown Point, IN 46307 | Phone: 219-755-3655

HEALTH FIRST INDIANA GRANT APPLICATION

Under Indiana law, the Lake County Health Department ("LCHD") is empowered to grant money from their allocated Health First Indiana ("HFI") funds to external organizations which agree to complete Core Public Health Services ("CPHS") and work toward completion of the required Key Performance Indicators ("KPIs").

Health First Indiana Website: https://www.in.gov/healthfirstindiana/
Public health services are most effective when provided by local health departments (LHDs) that are positioned to meet the needs of their communities. These core services outline the initiatives and activities at the heart of public health that are the critical framework of any local health department. Some are required by law, and some are offered by many health departments. Every Hoosier deserves access to these foundational public health services no matter where they live.

LHDs, with support from partners and community stakeholders, determine needs of the community, and implement accessibility strategies, including addressing social determinants of health, in all aspects of planning, operations, and core services. The Indiana Department of Health surveyed each local health department to determine how these core services are provided across Indiana. Click below to see a snapshot of each core service.

Please fill out the attached proposal in its entirety and include any necessary and appropriate documents.

- The KPI's listed throughout this proposal application are not comprehensive. They are current guidelines and metrics that have been enumerated by the Indiana Department of Health (IDOH), however, they are in flux.
- If your program fills the purpose as enumerated in the "Purpose" chart of Section 2 below, but the deliverables from Section 5 do not match up directly with your program metrics, list them separately under the "Deliverables" section of this application.

1. ORGANIZATION

1.1. Name of Organization: Hope Alliance of NWI

1.2. Contact Name and Title: Kelly Peck Program Coordinator

1.3. Address: 111 W 35th Ct. Griffith, IN. 46319

1.4. Phone: 708-837-4424

1.5. Fax: _____

1.6. Email: Hopealliancenwi@gmail.com

1.7. Name of Proposed Program: BRIDGE TO HOPE: Harm Reduction in Action

1.8. Target Population: Our project targets individuals most impacted by substance use, health disparities, and unhoused across Lake County, Indiana. We serve residents of low-income housing communities, individuals seeking emergency aid services (food pantries, soup kitchens), recovery homes, people accessing public health departments and Direct Street outreach.

a.

2. PROGRAM, PURPOSE, AND SCOPE

2.1. Name of Proposed Program: BRIDGE TO HOPE: Harm Reduction in Action

2.2. Program Purpose: The purpose of Bridge to Hope: Harm reduction in action is to reduce preventable deaths, improve community health outcomes, and build trust within underserved and high-risk communities across Lake County. We believe in meeting people where they are, we implement a street-level harm reduction model focused on preventing overdoses and saving lives by distributing Narcan, fentanyl, xylazine testing strips and training individuals, families, community members and organizations in it use. The program prioritizes health equity by offering services that reduce overdose risk, prevent the spread of HIV, Hepatitis C, and other substance-related infectious diseases, and promote the health and well-being of mothers, children, and families through prenatal and postnatal outreach, supplies and resource connection.

1. **Reduce Overdose Deaths**- Distribute naloxone (Narcan) and provide training to individuals, families, and community members to respond effectively to opioid overdoses.

2. **Prevent the spread of Infectious Disease-** Provide education, testing referrals, and harm reduction supplies (including safer use kits, condoms, and testing strips) **to** reduce

transmission of HIV, Hepatitis C, and other infections commonly transmitted through unsafe drug practices.

3.**Improve Access to Care and Resources-** Connect underserved individuals to medical, behavioral health, housing, prenatal/postnatal care, and recovery services through peer and community health worker support**.**

4.**Support Maternal and Infant Health-** Identify and assist pregnant and postpartum individuals—especially those facing housing instability or substance use—by providing direct outreach and linking them to critical health and social services.

5.**Engage Underserved Populations through Community Outreach-** Deliver mobile, street-level harm reduction services in collaboration with local partners, reaching people in motels, shelters, food pantries, public housing, and work release programs.

2.3. Scope of Program Services: *Bridge to Hope: Harm Reduction in Action* provides direct and street-based harm reduction services including overdose prevention, infectious disease education, safer use supplies, pregnancy tests, emergency contraceptives, resources, and maternal-child health support. Services are delivered by Certified Community Health Workers and Peer Recovery Coaches through direct outreach and partnerships with local health departments, shelters, recovery homes, food pantries, low-income housing authorities, and community organizations.

- FINANCIAL TERMS

2.4. Consideration. Total Program Amount Requested: $ 200,000

2.5. Breakdown of Total Program Amount Requested.

Program Cost Breakdown.)

Item Description	Price	Quantity	Total
Staff Salary & Fringe: (2) Program Coordinator Salary $15,000	$30,000	1 year	$30,000
Staff Salary & Fringe: (1) Program Director Salary $55,000	$55,000	1 year	$55,000
Contracted Services: outreach workers (3)	$75,000	1 year	$75,000
Contracted Service: Accountant (financial tracking, compliance reporting, and grant fund management)	$4,100	1 year	$4,100
Harm Reduction Supplies	$20,000	1 year	$20,000
Mileage Reimbursement	$2,300	1 year	$2,300
Phones & Communication	$3,600	1 year	$3,600
General Office/ Administrative Supplies	$2,500	1 year	$2,500
Equipment & software (2 laptops/tablets for staff use accessories)	$2,500	1 year	$2,500
Resource Materials (Printed resources guides, flyers, Brochures, cards)	$3000	1 year	$3000
Travel/ Training Events Overdose lifeline/ Harm reduction	$2000	1 year	$2000
		Total Amount	$200,000

2.6. Proposed Schedule of Payments.

(Sample Chart: Payment Schedule.)

Payment #	Due Date	Description	Amount
1	Due on contract signed	Payment for supplies	$10,000
2	30 days after contract is signed	Payment for the next Q1	$50,000
3	3months afterQ1 payment	Payment for the next Q2	$50,000
4	3months afterQ2 payment	Payment for the next Q3	$50,000
5	3 Months after Q3 Payment	Payment for the next Q4	$40,000

2.7. Payments.

2.7.1. Payment Information:

2.7.1.1. Any payment-related questions or concerns should be directed to Victoria Niemczura, Treasurer-708-932-9922.

2.7.1.2. The check or wire memorandum section must specify Health First Indiana.

2.7.2. Payments by Check. Payments will be made to Hope Alliance of NWI and mailed to: 111 W. 35TH CT GRIFFITH IN 46319

i. _____.

3. TERMS AND TERMINATION

3.1. Term. This Agreement shall be effective for a period not to exceed 1 Year. It shall commence on the date the contract is signed and shall remain in effect through the contract dates.

4. PROGRAM WORK PLAN.

4.1. Program Work Plan.

4.1.1. Program Objective. The objective of *Bridge to Hope: Harm Reduction in Action* is to reduce overdose deaths, prevent the spread of infectious diseases such as HIV and Hepatitis C, and improve maternal and community health by providing mobile, street-based harm reduction services. Through education, outreach, and direct support delivered by certified health workers and peer recovery coaches, the program aims to increase access to care, resources, and treatment for individuals most affected by substance use and health disparities in Lake County.

4.1.2. Program Goal(s).

Item	Goal	Strategy	Activities
1	At-risk individuals across Lake County will have increased access to harm reduction services, overdose prevention tools, and life-saving education to reduce overdose fatalities.	• Expand a network of trained outreach workers to deliver harm reduction services across Lake County. • Utilize Certified Peer Recovery Coaches (CAPRC II) and Certified Community Health Workers (CCHWs) to build trust with high-risk populations. • Partner with community organizations, healthcare providers, and recovery services to extend referral networks.	• Conduct weekly street outreach distributing naloxone kits, wound care supplies, HIV/HCV self-test kits, hygiene kits, and maternal health resources. • Host monthly overdose prevention and harm reduction education workshops open to the public. • Facilitate "train the trainer" sessions to empower community

		● Develop partnerships with first responders, hospitals, and recovery centers to facilitate immediate connections to care. ● Conduct naloxone training for community groups, families, and organizations in overdose-prone neighborhoods. ● Maintain data-driven service delivery by tracking outreach engagement, naloxone distribution, and overdose reversal reports monthly. ● Coordinate follow-up visits and referrals for individuals who engage with harm reduction services. ●	members to recognize and respond to overdoses. ● Provide HIV/HCV prevention supplies, testing referrals, and distribute self-test kits during mobile outreach events. ● Maintain ongoing data collection on demographics served, zip codes, reversals reported, referrals to treatment, and health screenings completed. ● Partner with community-based organizations to create referral pathways for housing, healthcare, food security, and recovery support. ● Conduct biannual community listening sessions to gather feedback and adapt outreach strategies to emerging needs.
2	Youth and families across Lake County will gain knowledge about substance misuse prevention, harm reduction strategies, and pathways to health through community education programs.	● Develop partnerships with local schools, youth organizations, and family service agencies. ● Incorporate culturally competent, trauma-informed education strategies into outreach efforts. ● Recruit professional speakers and facilitators to deliver community education sessions.	● Deliver community-based education sessions using evidence-informed prevention content. ● Organize quarterly community events focused on youth and family engagement. ● Collaborate with local schools to distribute prevention resources and host guest speaker events.
3	Expand access to health screenings, maternal and infant wellness services, and wraparound supports for vulnerable populations in Lake County.	● Integrate maternal and family health education into harm reduction outreach. ● Partner with health departments and clinics to facilitate access to HIV/HCV testing, prenatal care, and postpartum resources. ● Train outreach staff to identify and assist pregnant and parenting individuals needing referrals.	● Distribute maternal health resources (pregnancy tests, Plan B, referral cards) during outreach activities. ● Facilitate home visit referrals and connect families to maternal and infant wellness programs. ● Provide HIV/HCV self-testing kits and education on infectious disease

		● Implement targeted outreach to identify pregnant individuals early and connect them to prenatal care, harm reduction education, and family support services. ● Provide culturally responsive maternal health education that addresses barriers such as stigma, substance use, housing insecurity, and access to healthcare.	prevention. ● Track health screening and referral data for continuous quality improvement.
4	Strengthen public health messaging and community engagement through digital media outreach, resource distribution, and awareness campaigns targeting underserved communities.	● Create culturally responsive harm reduction messaging for targeted audiences. ● Expand public awareness about available services and harm reduction principles.	● Launch quarterly digital prevention and awareness campaigns. ● Track digital engagement metrics (reach, clicks, referrals to services). ● Create and distribute printed resource materials at events and during outreach activities. ● Maintain a dynamic online resource hub through Hope Alliance's website and social media channels.

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4.2. Scalability. Grantee will expand or restrict the Program Work Plan to further efforts that will result in fulfilling the Purpose and Scope of the Program before modifying Performance.

5. PERFORMANCE: DELIVERABLES, METRICS AND REPORTING.

5.1. Key Performance Indicators ("KPIs"). The Program will provide services that specifically address the KPIs for Core Public Health Services outlined in the Health First Indiana initiative. Program and Scope for Selected Core Service – select at least one KPI that pertains to the program objective in the first column:

#	Name	Scope

	Tobacco and Vaping Prevention and Cessation	Preventing and eliminating risk of disease due to tobacco use and vaping.
1	Trauma and Injury Prevention	Preventing harm due to injury and substance use and facilitating access to trauma care.
	Chronic Disease Prevention	Preventing and reducing chronic diseases such as obesity, diabetes, cardiovascular disease, and cancer.
1	Maternal and Child Health	Services focused on the health and well-being of mothers, children, and families, including prenatal care.
	Fatality Review	Analysis of data and potential causes of child deaths, fetal and infant mortality, and suicide/overdose fatality.
	Lead Case Management and Risk Assessment	Ensuring all children have access to blood lead level testing and appropriate clinical and environmental services if necessary.
	School Health Liaison	Assisting schools with resources to promote whole student health.
	Access and Linkage to Clinical Care	Facilitating access to essential healthcare services for all members of the community.
1	Infectious Disease Prevention and Control	Monitoring and managing the spread of diseases within a community.
	TB Prevention and Case Management	Preventing the spread of tuberculosis and ensuring appropriate access to care and resources for those who have TB.
	Immunizations	Providing vaccinations to children and adults to prevent the spread of infectious diseases.
	Health-Related Areas during Emergencies or Disasters	Planning and coordination for responding to public health emergencies and disasters.
	Vital Records	Providing accurate documentation of births, deaths, stillbirths, fetal deaths, adoptions, and biological parentage.
	Food Protection	Ensuring safety of food at the grower, wholesale, and retail levels.
	Environmental Health	Ensuring the safety of the physical environment to protect public health.

5.2. Metrics and Reporting

5.2.1. Definitions.

5.2.1.1. Deliverable: the quantifiable services to be provided at various steps in the Program to keep it on course. The deliverable provides a metric whose value can be tracked for state-level reporting.

5.2.1.2. Metric: a standard for measuring the value of the deliverable.

5.2.1.3. Value: the number or percentage of the metric that is being measured.

5.2.2. Reporting.[1]

5.2.2.1. Reporting Frequency: Monthly

CREATING A REPORT WITH METRICS

Based on which Core Service(s)/KPIs selected in Section 6.1 above, please review the sections in Appendix A and add all the metrics that apply in the report below. If you have a deliverable and a corresponding metric that is not listed, please add your own, if it aligns with the scope of the KPI.

FOR EXAMPLE:

- 1. If the KPI selected in Section 6.1 is: Tobacco and Vaping Prevention and Cessation, choose that KPI from the dropdown under the KPI Column
- 2. Then, review the corresponding Metrics from **Appendix A** (below) and add that to the Metric column.

3. Continue to fill in the Deliverable and Value columns.
*Add as many items as necessary for your program.

(Sample Report: Monthly Report.)

Item	KPI	Metric	Deliverable	Value
1	Tobacco and Vaping Prevention and Cessation	Number of youths provided education on the harms of vaping.	Class held at school.	# of people
2	Tobacco and Vaping Prevention and Cessation	Number of youths provided education on the harms of vaping.	Class held at event.	# of people
3	Chronic Disease Prevention	Number of people ages 12 to 18 enrolled in the cardiac health improvement exercise class.	Exercise class focused on improving cardiac health.	# of people
4	Chronic Disease Prevention	Number of people ages 18+ enrolled in the cardiac health improvement exercise class.	Exercise class focused on improving cardiac health.	# of people

APPENDIX A

Table of Contents:

[1] Reports are to be sent directly to Michelle Arnold at arnolml@lakecountyin.org.

A. Tobacco and Vaping Prevention and Cessation

Indiana witnessed an increase in youth e-cigarette use from 3.8% in 2012 to 19.8% in 2021 among high school students. Most e-cigarettes contain nicotine, which is highly addictive and can harm youth brain development. The first step in addressing tobacco and addictive nicotine prevention is building and maintaining a tobacco-free coalition that represents the whole community.

KPI

Number of counties that through a tobacco prevention and cessation coalition have a comprehensive program to address youth tobacco and addictive nicotine prevention.

LCHD is seeking to participate in a local tobacco control coalition. Additionally, the LCHD is seeking to create or adopt an existing tobacco prevention and cessation program that addresses tobacco and addictive nicotine prevention.

DELIVERABLES AND REPORTING: SAMPLE

Item	Name	Scope
A.	Tobacco and Vaping Prevention and Cessation	Preventing and eliminating risk of disease due to tobacco use and vaping.

Deliverable	Metric	Value
[Deliverable]	Number of individuals aged 13 years or older referred to Indiana Tobacco Quitline/Quit Now Indiana or other cessation resource.	[Number of people]

TOBACCO AND VAPING PREVENTION AND CESSATION METRICS

Metrics

- ☐ Number of individuals aged 13 years or older referred to Indiana Tobacco Quitline/Quit Now Indiana or other cessation resource.
- ☐ Number of youths provided education on the harms of vaping.
- ☐ Number of adults provided education on the harms of tobacco use and vaping.
- ☐ Number of school staff who have been trained to provide tobacco education.
- ☐ Number of schools providing vaping prevention education through local health department/school liaison.
- ☐ Number of schools providing nicotine dependence treatment resources through local health department/school liaison.
- ☐ Number of schools with updated/best practice policies through LHD/school liaison.
- ☐ Other – please add your own metric *only if it aligns with the scope and KPI of the Core Service.

B. Trauma and Injury Prevention

In Indiana, preventable injuries account for the leading cause of death in individuals aged 1-44 years (CDC WISQARS), notably poisonings and motor vehicle crashes. Identifying a leading cause of injury allows effective planning and prevention of those injuries and potential deaths.
KPI: Number of counties that identified a leading cause of injury and/or harm in their community and implemented a comprehensive, evidence-based program or activity for prevention.

KPI
Number of counties that identified a leading cause of injury and/or harm in their community and implemented a comprehensive, evidence-based program or activity for prevention.

LCHD is committed to identifying the leading cause of injury or harm in our community, and, subsequently implementing a comprehensive, evidence-based program(s) for the leading cause of trauma-related injury or death in Lake County, Indiana.

DELIVERABLES AND REPORTING: SAMPLE

Item	Name	Scope
B.	Trauma and Injury Prevention Overdose Prevention	Preventing harm or death

Deliverable	Metric: Training	Value
Narcan Distribution	Number Pass out to individuals, family members & local establishments	600 kits per month
Narcan Training	Number of trainings held with certification – pre & post surveys	3 monthly
Distribute Fentanyl & Xylazine test strips	Number distributed and educated how to use	600 per month
Overdose risk education	Number of people I educate at outreach	300 per month
Street Outreach	Number of outreach events held	4 per week
Community Partner Engagement	Number of referrals made	2 per week

TRAUMA AND INJURY PREVENTION METRICS

Metric: Training
- ☐ Number of people receiving Stop the Bleed training.
- ☐ Number of people receiving CPR training.
- ☐ Number of people educated and/or trained on vehicle passenger safety and seat belt use.
- ☐ Number of people educated or trained on RTV/ATV and golf cart passenger safety.

- ☐ Training & Education Number of people educated or trained on water safety (including swim lessons).
- ☐ Number of people educated about texting and safe driving (including impaired driving).
- ☐ Number of people educated about brain injury risks and safety practices.
- ☐ Number of people educated in fall prevention and home remedied for fall risks.
- ☐ Number of people educated and/or trained on substance use prevention.
- ☐ Number of people educated and/or trained on mental health and suicide prevention.
- ☐ Number of seniors participating in activities related to fall prevention.
- ☐ Number of certified peer recovery coaches in county with support of LHD.
- ☐ *Other – please add your own metric *only if it aligns with the scope and KPI of the Core Service.

TRAUMA AND INJURY PREVENTION METRICS– CONTINUED

Metric: Equipment

- ☐ Number of naloxone doses distributed
- ☐ Number of nalox-boxes in community
- ☐ Number of public-used sharps returns
- ☐ Number of child car seats distributed
- ☐ Number of bicycle helmets distributed

Metric: Equipment – Continued

- ☐ Number of firearm locks provided to families
- ☐ Number of people provided with infant safe sleep education, including families and professionals
- ☐ Number of infant sleep sacks provided to families
- ☐ Number of portable cribs provided to families
- ☐ *Other – please add your own metric *only if it aligns with the scope and KPI of the Core Service.

Metric: Referrals

- ☐ Number of people referred/linked to substance use/mental health treatment
- ☐ Number of women and children referred for active domestic violence assistance
- ☐ Number of women and children provided safe, anonymous transport to shelter for victims of domestic violence and interim care/assistance provided
- ☐ Number of women and children referred for assistance with physical and mental health recovery from domestic violence
- ☐ *Other – please add your own metric *only if it aligns with the scope and KPI of the Core Service.

C. Chronic Disease Prevention

Indiana ranks 12th highest in the US for adult obesity, with 2/3 of adults being overweight or obese. In Indiana, 1/3 of children are overweight or obese. Obesity is a common risk factor for many chronic diseases, including heart disease, cancer, and diabetes. A key step in addressing chronic disease and obesity prevention is building and maintaining a healthy community coalition that represents the whole community.

KPI

Number of counties that through a healthy community coalition have a comprehensive, evidence-based program to address obesity and obesity-related disease prevention.

LCHD is seeking a comprehensive, evidence-based program and/or promising practice(s) to address obesity and obesity-related disease prevention within our community.

DELIVERABLES AND REPORTING: SAMPLE

Item	Name	Scope
C.	Chronic Disease Prevention	Preventing and reducing chronic diseases such as obesity, diabetes, cardiovascular disease, and cancer.

Deliverable	Metric: Screening and Referrals	Value
[Deliverable]	Number of people screened for high blood pressure through local health department or partners.	[Number of people]

CHRONIC DISEASE PREVENTION

Metric: Screening and Referrals

- ☐ Number of people screened for high blood pressure through local health department or partners.
- ☐ Number of people identified with undiagnosed high blood pressure through local health department or partners
- ☐ Number of people screened with a hemoglobin A1c through local health department or partners
- ☐ Number of people identified with elevated hemoglobin A1c
- ☐ Number of people screened for diabetes risk factors through local health department or partners
- ☐ Number of people referred to or enrolled in a diabetes prevention program
- ☐ Number of people referred to or enrolled in a diabetes self-management education support program
- ☐ Number of people screened for high cholesterol through local health department or partners
- ☐ Number of people identified with high cholesterol
- ☐ Number of people screened for cancer through local health dept. activity (breast, colon cancer, etc.)
- ☐ Number of people screened for BMI
- ☐ Number of people referred to a weight treatment or obesity prevention program
- ☐ Number of people identified as having a BMI over 30
- ☐ Number of individuals with asthma who receive an in-home trigger assessment
- ☐ Number of people referred for chronic disease preventative care
- ☐ Number of people referred for cancer screening
- ☐ Number of people provided for cancer screening

☐ Number of people screening positive for food insecurity

CHRONIC DISEASE PREVENTION - CONTINUED

☐ Number of people referred to a food assistance program
☐ *Other – please add your own metric *only if it aligns with the scope and KPI of the Core Service.

Metric: Programming

☐ Number of adults participating in nutrition and physical activity education programming
☐ Number of seniors participating in nutrition and physical activity education programming
☐ Number of cancer risk reduction and prevention programs provided by the LHD
☐ Number of cancer survivorship related services provided (smoking cessation resources, cancer support groups, respite opportunities for caregivers)
☐ *Other – please add your own metric *only if it aligns with the scope and KPI of the Core Service.

D. Maternal and Child Health

Indiana ranks 41st in infant mortality, which is the death of an infant before the first birthday: in 2021, Indiana's infant mortality rate was 6.7 deaths per 1,000 live births, compared to the national rate of 5.4 deaths. Understanding causes of infant mortality helps drive education and action to prevent these deaths.

KPI
Number of counties with documented processes to refer families to needed services including contraceptive care, WIC, home visiting, prenatal care, substance use disorder treatment, and insurance navigation.

KPI
Number of counties at identified an opportunity to improve birth outcomes and implemented an evidence-based or promising program or activity to improve that birth outcome.

LCHD is seeking to implement an evidence-based or promising program or activity to improve birth outcomes in our communities.

LCHD is seeking to have a documented process to refer families to needed services including contraceptive care, WIC, home visiting, prenatal care, substance use disorder treatment, and insurance navigation.

DELIVERABLES AND REPORTING: SAMPLE

Item	Name	Scope
D.	Maternal and Child Health	Services focused on the health and well-being of mothers, children, and families, including prenatal care.

Deliverable	Metric: Prenatal Services (up to time of delivery)	Value
Pregnancy Test	Number of pregnancy tests provided	300 per month
Emergency Contraceptives	Number of Emergency Contraceptive supplied	25 per month
Feminine Hygiene products	Number of Hygiene products supplied	300 per month
Provide prenatal & Postnatal referrals	Provide **prenatal and postnatal educational materials and resource referrals** to 100% of identified clients	5 per month
Infant wellness	Number of supplies provided , safe sleep packs, hygiene, resources and referral	3 per month

MATERNAL AND CHILD HEALTH METRICS

Metric: Prenatal Services (up to time of delivery)

- ☐ Number of pregnancy tests provided
- ☐ Number of women referred to prenatal care
- ☐ Number of women provided prenatal services
- ☐ Number of women provided vitamins
- ☐ Number of women provided syphilis testing
- ☐ Number of women provided HIV testing
- ☐ Number of women provided hepatitis C testing
- ☐ Number of women provided chlamydia testing
- ☐ Number of women provided gonorrhea testing
- ☐ Number of women provided nutrition education
- ☐ Number of women provided nutrition support
- ☐ Number of women provided mental health/substance use disorder services

MATERNAL AND CHILD HEALTH METRICS – CONTINUED

Metric: Prenatal Services (up to time of delivery) - continued

- ☐ Number of women provided clinical care (from a healthcare provider, such as physician, nurse practitioner, clinic, midwife)
- ☐ Number of women provided immunizations, such as RSV, Tdap, flu
- ☐ Number of women provided other prenatal services
- ☐ Number of women referred to My Healthy Baby
- ☐ Number of women provided mental health/substance use disorder services
- ☐ Number of women referred to health/substance use disorder services
- ☐ Number of pregnancy tests provided
- ☐ *Other – please add your own metric *only if it aligns with the scope and KPI of the Core Service.

Metric: Postpartum Services (following delivery)

- ☐ Number of women referred to postpartum care
- ☐ Number of women provided postpartum services
- ☐ Number of women provided clinical care (state what services)
- ☐ Number of women provided mental health/substance use disorder services
- ☐ Number of women referred to health/substance use disorder services
- ☐ Number of women provided breastfeeding education or support
- ☐ Number of women referred to breastfeeding education or support
- ☐ Number of families referred to pediatric care
- ☐ Number of people provided with parenting classes/education
- ☐ Number of families referred to childcare assistance (such as Child Care and Development Fund "CCDF" program)
- ☐ *Other – please add your own metric *only if it aligns with the scope and KPI of the Core Service.

Metric: Health and Safety Services

- ☐ Number of people receiving child car safety seats
- ☐ Number of child car safety seats provided
- ☐ Number of car safety seat inspections provided
- ☐ Number of people provided safe sleep education
- ☐ Number of people receiving sleep sacks
- ☐ Number of cribs provided by LHD or partner
- ☐ Number of handle-with-care alerts issued

- ☐ Number of women and children referred for active domestic violence assistance
- ☐ Number of women and children provided safe, anonymous transport to shelter for victims of domestic violence and interim care/assistance provided
- ☐ Number of women and children referred for assistance with physical and mental health recovery from domestic violence
- ☐ Number of menstrual period products distributed
- ☐ *Other – please add your own metric *only if it aligns with the scope and KPI of the Core Service.

Metric: Community Assistance

- ☐ Number of people referred to substance use disorder treatment/support
- ☐ Number of people referred to/provided care through Mobile Integrated Health
- ☐ Number of referrals to housing supports or resources
- ☐ Number of families provided with utility/rent assistance
- ☐ Number of families screened or referred to developmental services, such as First Steps
- ☐ Number of people receiving life skills courses
- ☐ Number of families receiving home visiting services, such as a home visiting program
- ☐ Number of families referred to home visiting services, such as a home visiting program
- ☐ Number of youth and parent cafés hosted

MATERNAL AND CHILD HEALTH METRICS – CONTINUED

Metric: Community Assistance - continued

- ☐ Number of families referred to an insurance navigator or Medicaid
- ☐ *Other – please add your own metric *only if it aligns with the scope and KPI of the Core Service.

Metric: Contraception/STIs

- ☐ Number of people provided contraceptive education
- ☐ Number of women tested for STIs/HIV
- ☐ Number of women referred for STIs/HIV treatment
- ☐ Number of women treated for STIs/HIV
- ☐ *Other – please add your own metric *only if it aligns with the scope and KPI of the Core Service.

Metric: Food and Nutrition

- ☐ Number of women referred to WIC
- ☐ Number of families referred or connected to local food pantries
- ☐ *Other – please add your own metric *only if it aligns with the scope and KPI of the Core Service.

E. Fatality Review

Indiana ranks 41st in infant mortality, which is the death of an infant before the first birthday: in 2021, Indiana's infant mortality rate was 6.7 deaths per 1,000 live births, compared to the national rate of 5.4 deaths. Understanding causes of infant mortality helps drive education and action to prevent these deaths.

KPI
Number of counties with documented processes to refer families to needed services including contraceptive care, WIC, home visiting, prenatal care, substance use disorder treatment, and insurance navigation.

KPI
Number of counties at identified an opportunity to improve birth outcomes and implemented an evidence-based or promising program or activity to improve that birth outcome.

LCHD is seeking to implement an evidence-based or promising program or activity to improve birth outcomes in our community.

LCHD is seeking to have a documented process to refer families to needed services including contraceptive care, WIC, home visiting, prenatal care, substance use disorder treatment, and insurance navigation.

DELIVERABLES AND REPORTING: SAMPLE

Item	Name	Scope
E.	Fatality Review	Analysis of data and potential causes of child deaths, fetal and infant mortality, and suicide/overdose fatality.

Deliverable	Metric: Equipment/Resources	Value
[Deliverable]	Number of people provided with infant safe sleep education, including families and professionals	[Number of people]

FATALITY REVIEW METRICS

Metric: Equipment/Resources
- ☐ Number of people provided with infant safe sleep education, including families and professionals
- ☐ Number of infant sleep sacks provided to families
- ☐ Number of portable cribs provided to families
- ☐ Number of firearm locks provided to families
- ☐ Metric: Education
- ☐ Number of people trained in evidence-based suicide prevention training (QPR, ASIST, MHFA, etc.)
- ☐ Number of people educated about 988 and crisis resources
- ☐ Metric: Referrals/Screenings
- ☐ Number of Handle with Care (HWC) referrals (if HWC present in county)
- ☐ Number of individuals connected to grief and bereavement resources
- ☐ Number of childbearing-aged women screened for domestic violence risk
- ☐ Number of childbearing-aged women screened for social determinants of health

☐ Metric: Referrals/Screenings

FATALITY REVIEW METRICS - CONTINUED

Metric: Equipment/Resources - continued

☐ Number of schools in county with evidence-based anti-bullying programs and groups that support student mental health (e.g., Bring Change to Mind)
☐ Number of certified peer recovery coaches in county with support of LHD
☐ *Other – please add your own metric *only if it aligns with the scope and KPI of the Core Service.

F. Lead Case Management and Risk Assessment

As of January 1, 2023, Indiana health care providers are required to offer blood lead testing to all children under age 2 years. Through August 31, 2023, there has been a 21% increase in unique children tested for elevated blood lead levels, with 10,588 more blood lead tests reported, compared to the same time period in 2022. Comparing January-August, 2022 and January-August 2023, there is a 393% increase in confirmed elevated blood lead levels.

There is no safe level of lead for children and the developmental and neurological damage caused by lead exposure during childhood will last a lifetime.

KPI

Number of counties with access to a trained or licensed case manager and risk assessor in the county and offering weekly lead testing at a location in the county.

LCHD is seeking to have access to a trained or licensed case manager and risk assessor to conduct case management for children with elevated blood lead levels.

LCHD is seeking to offer weekly lead testing within our jurisdiction.

DELIVERABLES AND REPORTING: SAMPLE

Item	Name	Scope
F.	Lead Case Management and Risk Assessment	Ensuring all children have access to blood lead level testing and appropriate clinical and environmental services if necessary.

Deliverable	Metric: Testing	Value
[Deliverable]	Number of children tested for blood lead level	[Number of people]

LEAD CASE MANAGEMENT AND RISK ASSESSMENT METRICS

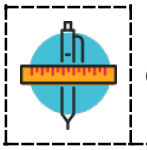
Metric: Testing

- ☐ Number of children tested for blood lead level
- ☐ Number of children identified with an elevated blood lead level (EBLL) above 3.5 µg/dL
- ☐ Number of children identified with an EBLL for whom case management was started
- ☐ Number of children with an EBLL that referred to developmental resource services (Head Start, etc.)
- ☐ *Other – please add your own metric *only if it aligns with the scope and KPI of the Core Service.

Metric: Home Services

- ☐ Number of homes of children with EBLLs at which the LHD was able to conduct a risk assessment
- ☐ Number of children identified with an EBLL whose homes had an identified lead hazard
- ☐ Number of individuals connected with financial assistance for home lead remediation services
- ☐ Number of families provided lead cleaning supplies
- ☐ Metric: Education
- ☐ Number of families provided lead education

- ☐ Number of health care providers or early childhood providers given lead testing/lead reduction education
- ☐ *Other – please add your own metric *only if it aligns with the scope and KPI of the Core Service.



G. School Health Liaison

Over 1 million students attend K-12 schools in Indiana, and school health liaisons support schools across the state. Research shows that healthier students learn better and have greater academic success, leading to a lifetime of better health outcomes. Providing access to health services, such as vision, hearing and dental screenings, while limiting youth risk behaviors, supports community, physical, and intellectual development that can continue into adulthood.

KPI

Number of counties partnering with schools, based on community need, to implement wellness policies and comprehensive strategies to promote student health.

LCHD is seeking to partner with schools, based on community needs, to support school wellness policies and promote comprehensive strategies to improve student health.

DELIVERABLES AND REPORTING: SAMPLE

Item	Name	Scope
G.	School Health Liaison	Assisting schools with resources to promote whole student health.

Deliverable	Metric: Screenings	Value
[Deliverable]	Number of children receiving vision screening through support of liaison	[Number of people]

SCHOOL HEALTH LIAISON METRICS

Metric: Screenings

- ☐ Number of children receiving vision screening through support of liaison
- ☐ Number of children receiving hearing screening through support of liaison
- ☐ Number of children receiving oral health screening through support of liaison

Metric: Education

- ☐ Number of schools requesting support with mental health education, resources through school liaison
- ☐ Number of children receiving supplemental nutrition education programming at school (such as CATCH or GOAL)
- ☐ Number of students receiving tobacco and vaping cessation education through LHD/school liaison
- ☐ Number of schools in county with supported evidence-based anti-bullying programs and groups that support student mental health (e.g., Bring Change to Mind)
- ☐ Number of schools partnering with school liaisons to provide health promotion and education for Trauma and injury prevention
- ☐ Number of schools partnering with school liaisons to provide health promotion and education for Nutrition

- ☐ Number of schools partnering with school liaisons to provide health promotion and education for Physical activity
- ☐ Number of schools partnering with school liaisons to provide health promotion and education for Child safety topics: safe sleep

SCHOOL HEALTH LIAISON METRICS - CONTINUED

Metric: Education - continued

- ☐ Number of schools partnering with school liaisons to provide health promotion and education for Child safety topics: car seat safety
- ☐ Number of schools partnering with school liaisons to provide health promotion and education for Child safety topics: bicycle/bike helmet safety
- ☐ Number of schools partnering with school liaisons to provide health promotion and education for Child safety topics: water safety
- ☐ Number of schools partnering with school liaisons to provide health promotion and education for Child safety topics: first aid
- ☐ Number of schools receiving emergency preparedness education (staff and students): Stop the Bleed
- ☐ Number of schools receiving emergency preparedness education (staff and students): CPR
- ☐ Number of schools receiving emergency preparedness education (staff and students): overdose/naloxone

Metric: LCHD Support

- ☐ Number of schools stocking emergency medications through LHD/school liaison: albuterol
- ☐ Number of schools stocking emergency medications through LHD/school liaison: epinephrine
- ☐ Number of schools stocking emergency medications through LHD/school liaison: naloxone
- ☐ Number of immunization given at LCHD/Liaison clinics for unique individuals
- ☐ Number of student support initiatives provided by school (or county) with support of LHD/school liaison: food pantries
- ☐ Number of student support initiatives provided by school (or county) with support of LHD/school liaison: clothing closets
- ☐ Number of student support initiatives provided by school (or county) with support of LHD/school liaison: general hygiene supplies
- ☐ Number of student support initiatives provided by school (or county) with support of LHD/school liaison: feminine hygiene supplies
- ☐ Number of student support initiatives provided by school (or county) with support of LHD/school liaison: weekend food bags

Metric: Referrals to Clinical Care

- ☐ Number of pediatric referrals for clinical care: obesity/overweight
- ☐ Number of pediatric referrals for clinical care: substance use disorder
- ☐ Number of pediatric referrals for clinical care: mental health services
- ☐ Number of pediatric referrals for clinical care: general
- ☐ Number of adult referrals for clinical care: hypertension
- ☐ Number of adult referrals for clinical care: diabetes
- ☐ Number of adult referrals for clinical care: obesity
- ☐ Number of adult referrals for clinical care: HIV
- ☐ Number of adult referrals for clinical care: hepatitis
- ☐ Number of adult referrals for clinical care: syphilis

- ☐ Number of adult referrals for clinical care: chlamydia
- ☐ Number of adult referrals for clinical care: gonorrhea
- ☐ Number of adult referrals for clinical care: substance use disorder
- ☐ Number of adult referrals for clinical care: mental health services
- ☐ Number of adult referrals for clinical care: general
- ☐ Number of individuals referred to insurance navigation or Medicaid/Medicare
- ☐ *Other – please add your own metric *only if it aligns with the scope and KPI of the Core Service.

H. Health-Related Areas during Emergencies/Disasters

Indiana ranks 41st in infant mortality, which is the death of an infant before the first birthday: in 2021, Indiana's infant mortality rate was 6.7 deaths per 1,000 live births, compared to the national rate of 5.4 deaths. Understanding causes of infant mortality helps drive education and action to prevent these deaths.

Preparedness saves lives by enduring timely and effective response to public health emergencies such as natural disasters and disease outbreaks, reduces impact of these emergencies by providing essential services such as medical care, food/water, and shelter, fosters resilience among individuals and communities by enhancing their ability to recover, and protects national security.

KPI

Number of counties that have updated* public health emergency response plans. *"Updated" is defined as conducting research on latest national and state best practices, incorporation of lessons learned and areas of improvement from real world events and exercises, and inclusion of preparedness and response partners in content validation.

LCHD is seeking to have an updated public health emergency response plan.

LCHD is seeking to exercise the current emergency response plan with community partners within a two-year timeframe.

DELIVERABLES AND REPORTING: SAMPLE

Item	Name	Scope
H.	Emergency Preparedness	Planning and coordination for responding to public health emergencies and disasters.

Deliverable	Metric	Value
[Deliverable]	Number of individuals that received medical countermeasure (vaccine, test, service) during public health related outbreak or emergency	[Number of people]

HEALTH-RELATED AREAS DURING EMERGENCIES/DISASTERS METRICS

- ☐ Number of individuals that received medical countermeasure (vaccine, test, service) during public health related outbreak or emergency
- ☐ Number of emergency preparedness drills/exercises conducted between the LHD and other preparedness partners

☐ *Other – please add your own metric *only if it aligns with the scope and KPI of the Core Service.

I. Immunizations

In 2023, 78% of all Indiana children had one measles-mumps-rubella (MMR) vaccine by age 35 months, compared to 89% in 2019. Community immunity against measles requires about 95% of a population to be vaccinated to prevent outbreaks. Providing accessible immunization services will help maintain robust immunization rates for disease prevention.

KPI

Number of counties that can vaccinate all individuals at time of service regardless of insurance status.

KPI

Number of counties with extended vaccination hours beyond routine business hours to meet the needs of the community/jurisdiction through the LHD or community partners.

LCHD is seeking to offer immunizations to all individuals in our jurisdiction regardless of insurance status.

LCHD is seeking to offer extended vaccination hours beyond routine business hours to meet the needs of the community (either through the LCHD or partner).

DELIVERABLES AND REPORTING: SAMPLE

Item	Name	Scope
I.	Immunizations	Providing vaccinations to children and adults to prevent the spread of infectious diseases.

Deliverable	Metric	Value
[Deliverable]	Number of children who received immunizations at the local health department or a contractor/partner of the LHD	[Number of people]

IMMUNIZATIONS METRICS

- ☐ Number of children who received immunizations at the local health department or a contractor/partner of the LHD
- ☐ Number of individuals connected with insurance navigation services
- ☐ Number of adults who received immunizations at the LHD or a contractor/partner of the LHD
- ☐ Number of vaccination clinics held off-site of primary LHD location
- ☐ *Other – please add your own metric *only if it aligns with the scope and KPI of the Core Service.

J. Access to and Linkage to Clinical Care

Some communities, such as those in rural areas, often face higher rates of chronic disease and limited access to health care. Access to public health services in all counties will enhance the health and well-being of all Hoosiers, reduce disease, and improve health outcomes.

KPI

Number of local health departments providing accessible, equitable clinical services, such as those related to communicable diseases, to meet the needs of the community.

KPI

Number of local health departments engaging with the local and state health delivery system to address gaps and barriers to health services and connect the population to needed health and social services that support the whole person, including preventive and mental health services.

LCHD is seeking to engage with local and state health partners to address gaps and barriers to health services in our community and connect the population to needed health and social services that support the whole person, including preventive and mental health services.

LCHD is seeking to provide accessible, equitable clinical services, such as those related to communicable disease, to meet the needs of the community.

DELIVERABLES AND REPORTING: SAMPLE

Item	Name	Scope
J.	Access to and Linkage to Clinical Care	Facilitating access to essential healthcare services for all members of the community.

Deliverable	Metric: Screening and Referrals	Value
[Deliverable]	Number of people screened for high blood pressure through local health department or partners	[Number of people]

ACCESS AND LINKAGE TO CLINICAL CARE METRICS

Metric: Screening and Referrals

- ☐ Number of people screened for high blood pressure through local health department or partners
- ☐ Number of people identified with undiagnosed high blood pressure through local health department or partners
- ☐ Number of people screened with a hemoglobin A1c through local health department or partners
- ☐ Number of people identified with elevated hemoglobin A1c
- ☐ Number of people screened for diabetes risk factors through local health department or partners
- ☐ Number of people referred to or enrolled in a diabetes prevention program
- ☐ Number of people referred to or enrolled in a diabetes self-management education support program
- ☐ Number of people screened for high cholesterol through local health department or partners
- ☐ Number of people identified with high cholesterol

ACCESS AND LINKAGE TO CLINICAL CARE METRICS - CONTINUED

Metric: Screening and Referrals - continued

- ☐ Number of people screened for cancer through local health department activity (breast, colon cancer, etc.)
- ☐ Number of people screened for BMI
- ☐ Number of people referred to a weight treatment or obesity prevention program
- ☐ Number of people identified as having a BMI over 30
- ☐ Number of individuals with asthma who receive an in-home trigger assessment
- ☐ Number of people referred for chronic disease preventative care
- ☐ Number of people referred for cancer screening
- ☐ Number of people provided for cancer screening
- ☐ Number of people screening positive for food insecurity
- ☐ Number of people referred to a food assistance program
- ☐ Number of people referred to the IDOH Breast and Cervical Cancer Program
- ☐ *Other – please add your own metric *only if it aligns with the scope and KPI of the Core Service.

Metric: Programming

- ☐ Number of adults participating in nutrition and physical activity education programming
- ☐ Number of seniors participating in nutrition and physical activity education programming
- ☐ Number of cancer risk reduction and prevention programs provided by the LHD
- ☐ Number of cancer survivorship related services provided (smoking cessation resources, cancer support groups, respite opportunities for caregivers)
- ☐ *Other – please add your own metric *only if it aligns with the scope and KPI of the Core Service.

K. Infectious Disease Prevention and Control

Infectious disease surveillance is essential to identify outbreaks and emerging infections, effectively and rapidly provide testing, treatment, and preventive measures, and monitor trends to inform prevention strategies. For example, nine out of ten individuals who are exposed to measles will become infected if they are not vaccinated. Prompt recognition of those exposed is essential so post-exposure vaccine can be given within 72 hours to prevent infection.

KPI

Number of counties that initiated a public health investigation within 24 hours for 95% of the immediately reportable conditions reported to them and within two business days for 85% of non-immediately reportable conditions reported to them.

LCHD is seeking to initiate case investigations for all immediately reportable conditions within 24 hours.

LCHD is seeking to initiate case investigations for all non-immediately reportable conditions within two business days.

DELIVERABLES AND REPORTING: SAMPLE

Item	Name	Scope
K.	Infectious Disease Prevention and Control	Monitoring and managing the spread of diseases within a community.

Deliverable	Metric: Disease Prevention and Control	Value
Safe use supplies	Number passed out at outreach	50
Condoms	Trach how many distributed	100
Sharps Containers	Number passed out	5 per month
Education	Play HIV bingo at local housing authority with usual number of 12 people per game	2 events per month
Testing referrals	Partner with community partners at events	2 events per month
Resources	Track referrals	10 per month
Educational material	Pass out brochures	300 oer month
HIV self tests	Upon request provide self tests	6 per month

INFECTIOUS DISEASE PREVENTION AND CONTROL METRICS

Metric: Disease Prevention and Control

Number of outbreaks (or suspected outbreaks) that were investigated

Number of outbreaks (or suspected outbreaks) in which the pathogen responsible for the outbreak was identified if known

Number of vaccinations given due to disease investigation interviews (e.g., hepatitis A, hepatitis B)

Metric: Testing

- ☐ Number of people provided HIV testing
- ☐ Number of people identified HIV testing
- ☐ Number of people provided hepatitis C testing
- ☐ Number of people identified hepatitis C testing
- ☐ Number of people provided syphilis testing
- ☐ Number of people identified syphilis testing
- ☐ Number of people provided chlamydia testing
- ☐ Number of people identified chlamydia testing

INFECTIOUS DISEASE PREVENTION AND CONTROL METRICS – CONTINUED

Metric: Testing- continued

- ☐ Number of people provided gonorrhea testing
- ☐ Number of people identified gonorrhea testing
- ☐ *Other – please add your own metric *only if it aligns with the scope and KPI of the Core Service.

Metric: Referrals and Treatment

- ☐ Number of referrals to counseling and/or care for: HIV
- ☐ Number of referrals to counseling and/or care for: hepatitis
- ☐ Number of referrals to counseling and/or care for: syphilis
- ☐ Number of referrals to counseling and/or care for: chlamydia
- ☐ Number of referrals to counseling and/or care for: gonorrhea
- ☐ Number of individuals treated for HCV/HIV/STI (not including syphilis)
- ☐ Number of individuals treated for syphilis
- ☐ *Other – please add your own metric *only if it aligns with the scope and KPI of the Core Service.

Metric: Community Outreach

- ☐ Number of people educated on HIV/HCV/STI
- ☐ *Other – please add your own metric *only if it aligns with the scope and KPI of the Core Service.

L. Tuberculosis (TB) Prevention and Case Management

An estimated 13 million people in the U.S. have latent tuberculosis infection (LTBI). Without treatment, one in 10 people living with LTBI will get sick with TB disease. Eliminating TB in the US requires expanding testing and treatment of LTBI. Testing for TB infection should be a routine and integral part of health care for patients with increased risk for TB. Each patient needs appropriate health care, treatment, and support services to reduce the spread of infection and development of drug resistance.

KPI

Number of counties with established partnerships for housing, food security, and interpretation services to assist in case management services for patients with TB and latent TB infection in their communities.

LCHD is seeking community partnerships for housing, food insecurity, and interpretation services to assist in case management for patients with TB and latent TB infection.

DELIVERABLES AND REPORTING: SAMPLE

Item	Name	Scope
L.	TB Prevention and Case Management	Preventing the spread of tuberculosis and ensuring appropriate access to care and resources for those who have TB.

Deliverable	Metric	Value
[Deliverable]	Number of people provided TB testing (IGRA or TST)	[Number of people]

TB PREVENTION AND CASE MANAGEMENT - METRICS

- ☐ Number of people provided TB testing (IGRA or TST)
- ☐ Number of people provided treatment for latent TB infection (LTBI)
- ☐ Number of people provided treatment for TB disease
- ☐ Number of Directly Observed Therapy (DOT) services provided
- ☐ Number of people supported with food/housing assistance
- ☐ Number of people educated on TB
- ☐ Number of B1 immigration reviews
- ☐ Number of referrals to wraparound services
- ☐ *Other – please add your own metric *only if it aligns with the scope and KPI of the Core Service.

M. Vital Records

In 2023, the Indiana General Assembly passed HEA 1457, which will allow a local health officer to issue a birth, death, or stillbirth certificate from the electronic registration system regardless of the location of the filing of the record. Planning is underway to implement this legislation statewide by Jan. 1, 2025. Natural disasters, such as floods and tornadoes, can damage or destroy vital records documents that Hoosiers need for identification. Adopting an emergency action plan in each county will ensure Vital Records services are available during a disaster.

KPI
Number of counties implementing birth certificates to all Hoosiers irrespective of their county of birth once the IDOH DRIVE system has appropriate functionality.

KPI
Number of counties able to offer Vital Records services without disruption to business continuity during natural disasters/emergencies.

DELIVERABLES AND REPORTING: SAMPLE

Item	Name	Scope
M.	Vital Records	Providing accurate documentation of births, deaths, stillbirths, fetal deaths, adoptions, and biological parentage.

Deliverable	Metric	Value
[Deliverable]	*Please add your own metric if it aligns with the scope and KPI of the Core Service.	[Number of people]

N. Food Protection

Indiana has 240 food inspectors responsible for inspecting over 32,000 retail food establishments statewide. The risk-based food inspection method is a data-informed best practice for conducting timely routine inspections based on menu type, facility history and follow-up inspections for any complaints or issues.

KPI

Number of counties that have developed a timely and professional risk-based food inspection standard operation procedure.

LCHD is seeking to have a timely, professional risk-based food inspection standard operating procedures.

DELIVERABLES AND REPORTING: SAMPLE

Item	Name	Scope
N.	Food Protection	Ensuring safety of food at the grower, wholesale, and retail levels.

Deliverable	Metric	Value
[Deliverable]	*Please add your own metric if it aligns with the scope and KPI of the Core Service.	[Number of people]

O. Environmental Public Health

Health and safety hazards may exist within housing and outdoor environments resulting in infection or injury. Examples include faulty plumbing systems, rodent or insect infestations, improper ventilation, pool inspections, onsite sewage system permits and inspections, and poor sanitation.

KPI
Number of counties responding to all housing and nuisance complaints within a timeframe determined by urgency or risk.

KPI
Number of counties with trained and licensed, if required, staff conducting required environmental inspections, such as onsite sewage, vector control, public and semi-public pools, and property-related complaints.

LCHD is seeking to have a trained or licensed staff conducting environmental inspections (onsite sewage systems, public/semi-public swimming pools, vector control, property-related complaints).

LCHD is seeking to have the ability to respond to all housing and nuisance complaints within a timeframe determined by urgency or risk.

DELIVERABLES AND REPORTING: SAMPLE

Item	Name	Scope
O.	Environmental Health	Ensuring the safety of the physical environment to protect public health.

Deliverable	Metric	Value
[Deliverable]	*Please add your own metric if it aligns with the scope and KPI of the Core Service.	[Number of people]