

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: Prenatal Well
- 1.2. Contact Name and Title: Maya Dominique MD, MPH, FACOG, Executive Director
- 1.3. Address: 235 W. 75th Ave Merrillville, IN 46410
- 1.4. Phone: 316-371-2019
- 1.5. Fax: _____
- 1.6. Email: mdominique@prenatalwell.org
- 1.7. Name of Proposed Program: Early connect: Community-Based Prenatal Safety Net Program
- 1.8. Target Population (ex: at-risk population of Lake County, IN; high school students, teenagers): Lake County pregnant individuals excluding Gary, IN and East Chicago, IN residents who are at risk of initiating prenatal care late (after 10 weeks gestation) or not at all

1.

2. PROGRAM, PURPOSE, AND SCOPE

- 2.1. Name of Proposed Program: Early connect: Community-Based Prenatal Safety Net Program
- 2.2. Program Purpose.

The purpose of the Early Connect: Community-Based Prenatal Safety Net Program is to reduce maternal and infant morbidity and mortality in Lake County by increasing early engagement in prenatal care among underserved and at-risk populations. Facilitated by Prenatal Well, the program addresses one of the county's most urgent public health challenges—delayed initiation of prenatal care—by identifying pregnant individuals early through strategic healthcare partnerships and connecting them to comprehensive care within 48 to 72 hours of referral. Through a combination of timely clinical access, education, transportation assistance, nutritional support, and integrated social services, Early Connect empowers patients, improves birth outcomes, and supports Lake County's maternal health equity goals.

- 2.3. Scope of Program Services: Provide a 1 or 2-sentence summary of services that are within the scope the program and how the services will be provided within the scope of the project [ex: educating on obesity prevention through cooking demonstrations and meal planning.):

Early Connect provides rapid prenatal care coordination, transportation assistance, trimester-specific education, nutritional support, and access to over 100 community-based resources for pregnant individuals at risk of delayed care. These services are delivered through a hybrid model of in-person and virtual support, ensuring timely, patient-centered care beginning within 48–72 hours of referral and continuing through postpartum.

2. FINANCIAL TERMS

2.4. Consideration. Total Program Amount Requested: \$ 200,000.00

2.5. Breakdown of Total Program Amount Requested. : **See attached budget**

2.6. Proposed Schedule of Payments:

Payment #	Due Date	Description	Amount
1	10/01/2025	Payment for the first 25 attendees and programming	\$\$\$ 50,000
2	01/01/2026	Payment for the next 25 attendees and programming	\$\$\$ 50,000
3	04/01/2026	Payment for the next 25 attendees and programming	\$\$\$ 50,000
4	07/01/2026	Payment for the next 25 attendees and programming	\$\$\$ 50,000

2.7. Payments.

2.7.1. Payment Information:

2.7.1.1. Any payment-related questions or concerns should be directed to Otis Dominique, Operations Director odominique@prenatalwell.org 773-443-3074 _____.

2.7.1.2. The check or wire memorandum section must specify : Attn: Otis Dominique - Operations Director_.

2.7.2. Payments by Check. Payments will be made to Prenatal Well _____ and mailed to: 235 W. 75th Ave Merrillville, IN 46410

3. TERMS AND TERMINATION

3.1. Term. This Agreement shall be effective for a period not to exceed 12 months

. It shall commence on this 10/1/2025 and shall remain in effect through 10/1/2026.

4. PROGRAM WORK PLAN.

4.1. Program Work Plan.

4.1.1. Program Objective. The Early Connect program aims to reduce maternal and infant morbidity and mortality in Lake County by rapidly connecting pregnant individuals to comprehensive prenatal care within 48–72 hours of referral. Through clinical coordination, education, nutritional support, transportation assistance, and integrated social services, the program improves birth outcomes and promotes maternal health equity.

4.1.2. Program Goal(s). [List each goal with the corresponding strategy and activities.]

3.

	Goal	Strategy	Activity
1	Increase early engagement in prenatal care (within the first 10 weeks of pregnancy).	Establish a rapid referral pipeline from community detection sites.	<ul style="list-style-type: none"> - Partner with ERs, urgent cares, and ultrasound clinics to identify early pregnancies. - Intake referrals and schedule prenatal visits within 48–72 hours.
2	Improve maternal and fetal health outcomes through continuous, holistic prenatal support.	Provide comprehensive, ongoing education and care coordination.	<ul style="list-style-type: none"> - Deliver trimester-specific education modules. - Track and support prenatal appointments, labs, and ultrasounds. - Educate on risk factors and warning signs during pregnancy.
3	Reduce disparities in access to prenatal services for underserved and at-risk populations.	Offer transportation, virtual support, and culturally relevant outreach.	<ul style="list-style-type: none"> - Provide Uber gift cards for appointments. - Offer telehealth-based check-ins and virtual education. - Meet patients at preferred community locations.

4	Empower patients through education and social support.	Integrate personalized education, postpartum preparation, and social service navigation.	<ul style="list-style-type: none"> - Assign a maternal health advocate to each participant. - Provide monthly pregnancy and postpartum classes. - Coordinate referrals to over 100 partners.
5	Improve maternal nutrition and reduce complications associated with poor prenatal diet.	Incorporate nutrition education and food access into care plans.	<ul style="list-style-type: none"> - Enroll participants in bi-weekly pregnancy food box program. - Require monthly nutrition education class attendance.
6	Use data to improve program delivery and track outcomes.	Implement a secure data collection system and continuous evaluation process.	<ul style="list-style-type: none"> - Maintain EMR and outcome tracking system. - Monitor metrics (referrals, visit attendance, birth outcomes, satisfaction). - Conduct patient surveys.

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.

In alignment with the expectations of the grant, Prenatal Well is committed to continuously improving the Early Connect: Community-Based Prenatal Safety Net Program to achieve its stated goals of increasing early prenatal care engagement and reducing maternal and infant morbidity and mortality in Lake County. If performance challenges arise, the program will first focus on adjusting and refining the activities within the Work Plan before modifying expected outcomes or performance metrics.

1. Adjusting Program Activities:

- If participant enrollment is below targets (e.g., fewer referrals than anticipated), we will expand outreach efforts by increasing partnerships with additional

community organizations, urgent care centers, and ultrasound clinics. Additionally, we will explore targeted outreach strategies aimed at underserved communities, such as mobile health initiatives or more localized, culturally relevant marketing.

- If participant engagement in services (e.g., education, nutrition programs) is lower than expected, we will revise our approach by enhancing communication, increasing incentives for participation, or offering more flexible options such as additional virtual or mobile-based education sessions.
- If service utilization is inadequate, we will identify barriers (e.g., transportation, scheduling conflicts) and refine the service delivery model. This might include expanding transportation options or implementing more personalized care coordination to ensure participants access necessary resources.

2. Monitoring and Reporting:

- We will continuously monitor participant enrollment, service engagement, and health outcomes to identify trends early. This will include regular check-ins with partner organizations and real-time data tracking via our electronic medical record (EMR) system.
- We will track program metrics such as the number of prenatal visits attended, referral completion rates, and patient satisfaction. These will serve as the basis for any proposed adjustments to the Work Plan.

3. Modifying Performance Metrics:

- Should adjustments to the program's activities (e.g., referral processes, outreach strategies) not result in improved performance, we will consider modifying performance metrics, but only after giving ample time for the modified Work Plan to show impact. Any proposed modifications will be data-driven, aiming to ensure that goals remain realistic while maintaining the program's integrity and overall objectives.

4. Feedback Loop:

- The program will implement a feedback loop with participants and community partners to gain insight into any barriers or challenges they face, ensuring that solutions are responsive to their needs. This feedback will guide the ongoing adjustments to the Work Plan to ensure that we can meet both the purpose and scope of the program effectively.

By focusing on refining the Work Plan first, we will ensure that any modifications are actionable, responsive, and lead to improvements in program performance before any adjustments are made to overall outcome targets.

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.
	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.
	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.
	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.

#	Name	Scope
	Tobacco and Vaping Prevention and Cessation	Preventing and eliminating risk of disease due to tobacco use and vaping.
	Trauma and Injury Prevention	Preventing harm due to injury and substance use and facilitating access to trauma care.
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	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.
	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.
	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: Quarterly

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

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.

APPENDIX A

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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 adults educated about the harm of tobacco use and vaping during pregnancy and in the postpartum period

Item	KPI	Metric	Deliverable	Value
1	Tobacco and Vaping prevention and Cessation	Number of individuals aged 13 years or older referred to Indiana Tobacco Quitline/Quit Now Indiana or other cessation resource	<p>During intake and trimester-specific education sessions, all participants aged 13 and older (including pregnant individuals) will be screened for tobacco or vaping use.</p> <p>Participants identified as tobacco/vape users will be provided brief counseling and a</p>	25

			<p>warm handoff referral to the Indiana Tobacco Quitline (1-800-QUIT-NOW) or Quit Now Indiana via digital or paper referral forms.</p> <p>Maternal health advocates will follow up to confirm referral completion and offer continued support or additional referrals as needed.</p> <p>Track and report the number of individuals aged 13+ referred to Quit Now Indiana or other cessation resources through EMR documentation and monthly case management logs.</p>	
2	Tobacco and Vaping prevention and Cessation	Number of adults educated about the harm of tobacco use	Tobacco and vaping education will be embedded into trimester-specific prenatal classes and educational sessions	90

		and vaping during pregnancy and in the postpartum period	<p>provided via telehealth or in-person meetings.</p> <p>Educational content will include specific harms of prenatal and postpartum exposure (example: increased risk of miscarriage, low birth weight, SIDS, and secondhand smoke impacts).</p> <p>Printed materials and interactive tools will be provided, and documentation of education delivery will be included in the participant's file</p> <p>Deliver evidence-based tobacco and vaping harm education to at least 90 pregnant and adults, documented via signed education acknowledgment forms and EMR entries, with pre- and post-education survey data collected for evaluation.</p>	
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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	Preventing harm due to injury and substance use and facilitating access to trauma care.
	Deliverable	Metric: Training
	[Deliverable]	Value
		Number of people receiving Stop the Bleed training.
		[Number of people]

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

Item	KPI	Metric	Deliverable	Value
1.	Trauma and Injury Prevention: Training	Number of people educated and/or trained on substance use prevention.	Enrolled participants will receive evidence-based education on substance use prevention, including risks associated with substance use during pregnancy, impacts on maternal and infant health, and available community support resources. Education will be conducted through individual counseling sessions and facilitated group workshops utilizing validated substance use prevention curricula (ex.	90

			<p>SAMHSA's "Substance Use in Pregnancy Toolkit").</p> <p>Education will be provided within the trimester educational session by certified addiction specialists or maternal health educators.</p> <p>Educate at least 90 individuals on substance use prevention. Participant attendance and engagement will be documented through sign-in sheets and session feedback surveys. All educational sessions will be tracked through electronic medical records (EMR) and aggregated in quarterly performance reports.</p>	
2.	Trauma and Injury Prevention: Training	Number of people educated on mental health and suicide prevention.	<p>Participants will receive education on mental health awareness, recognizing signs of depression, anxiety, and suicidal ideation, and strategies for accessing immediate support.</p> <p>Educational sessions will include suicide prevention techniques, such as QPR (Question, Persuade, Refer), tailored specifically to pregnant individuals and their support networks.</p>	50

			<p>Educational sessions will be facilitated monthly by mental health professionals or certified maternal health educators.</p> <p>Educate at least 50 individuals on mental health and suicide prevention strategies.</p>	
<p>3.</p>	<p>Trauma and Injury Prevention</p>	<p>Referral- Number of women and children referred for active domestic violence assistance</p>	<p>During the initial intake and at regular check-ins, all participants will be screened using a validated domestic violence screening tool (ex: HITS or the WAST tool).</p> <p>If domestic violence is disclosed or suspected, maternal health advocates will make immediate referrals to local domestic violence crisis organizations that provide emergency shelter, legal assistance, and safety planning.</p> <p>The referral process will be confidential and trauma-informed, with the participant's safety prioritized throughout.</p> <p>Refer at least 20 women and/or children experiencing or at risk of domestic violence to active crisis intervention or shelter services. Referrals will be tracked in the EMR and</p>	<p>20</p>

			confirmed through case notes and monthly reporting logs.	
4.	Trauma and Injust Prevention	Referral- Number of women and children referred for assistance with physical and mental health recovery from domestic violence	<p>Following the initial crisis referral, participants will be assessed for ongoing needs in physical and mental health recovery, including trauma therapy, support groups, primary care, and psychiatric services.</p> <p>Maternal health advocates will partner with trauma-informed mental health providers, federally qualified health centers (FQHCs), and women's health clinics to provide appropriate referrals.</p> <p>Follow-up will be built into case management to ensure engagement with recovery services and identify any ongoing barriers.</p> <p>Refer at least 15 women and/or children to trauma-informed physical or mental health recovery services following domestic violence exposure. All referrals will be documented in the participant record with follow-up confirmation logged by case managers.</p>	15



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
	[Deliverable]	Value
		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.

Item	KPI	Metric	Deliverable	Value
1.	Chronic Disease Prevention- Screening and referrals	Screening and Referrals -Number of people screened for high blood pressure through local health department or partners	<p>Participants will be offered blood pressure screenings during intake and in-person prenatal visits in partnership with local health department nurses or clinical partners.</p> <p>Screenings will also be available during visits at Prenatal Well and partners.</p> <p>Provide blood pressure screenings to at least 90 individuals through in-clinic visits and in person visits at Prenatal Well. Results will be recorded in participant files and monthly screening logs.</p>	90

2.	Chronic Disease Prevention-Screening and referrals	Number of people screened for diabetes risk factors through local health department or partners	<p>All participants will complete a diabetes risk assessment during enrollment and receive education about gestational diabetes.</p> <p>Those with identified risk factors will be referred for testing through clinical partners or the local health department.</p> <p>Screen at least 90 individuals for diabetes risk factors using a standardized tool, with follow-up referrals tracked through care coordination notes and EMR entries.</p>	90
3.	Chronic Disease Prevention-Screening and referrals	Number of people referred to or enrolled in a diabetes prevention program	<p>Individuals identified as high-risk for Type 2 diabetes (based on BMI, history, or screenings) will be referred to local or virtual Diabetes Prevention and Education Programs.</p> <p>Prenatal Well will establish referral partnerships with existing DPPs in Lake County.</p>	25

			Refer at least 25 eligible participants to a Diabetes Prevention Program, with referral outcomes tracked through case manager follow-up and documented in referral logs	
4.	Chronic Disease Prevention-Screening and referrals	Number of people referred to or enrolled in a diabetes self-management education support program	<p>Participants with a gestational or pre-existing diabetes diagnosis will be referred to local DSMES providers for support with blood sugar control, medication management, and lifestyle change.</p> <p>Referrals will be part of routine pregnancy care coordination.</p> <p>Refer at least 20 participants with diabetes diagnoses to DSMES programs, with confirmation of enrollment and participation documented by program staff.</p>	20
5.	Chronic Disease Prevention-	Number of people screened for BMI	Height and weight data	90

	<p>Screening and referrals</p>		<p>will be collected at intake or from initial prenatal provider records to calculate BMI for each participant.</p> <p>Participants with high or low BMI will receive tailored nutrition and physical activity education and referrals as needed.</p> <p>Collect BMI data for at least 90 program participants during intake or first trimester and document results in the EMR for program tracking and follow-up.</p>	
<p>6.</p>	<p>Chronic Disease Prevention-Programming</p>	<p>Number of adults participating in nutrition and physical activity education programming</p>	<p>All participants will be enrolled in trimester-specific nutrition education, including monthly classes and bi-weekly food box pickup/delivery with healthy eating guides.</p> <p>Physical activity recommendations appropriate for pregnancy will be included, with referrals to prenatal fitness classes or walking groups as appropriate.</p> <p>Engage at least</p>	<p>20</p>

			20 adults in structured nutrition and physical activity education through virtual or in-person sessions, tracked through sign-in sheets, digital participation logs, and food box distribution records.	
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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
[Deliverable]		Number of pregnancy tests provided	[Number of people]

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**
- Number of pregnancy women enrolled in nutrition program
- Number of women provided bi-weekly nutrition boxes

Item	KPI	Metric	Deliverable	Value
1.	Maternal Child Health- Prenatal Services	1. umber of women referred to prenatal care	Every pregnant participant is referred to a prenatal care provider within 48–72 hours of a positive pregnancy test. Refer at least 90 women to prenatal care providers and document referrals through EMR and care coordination logs.	90
2.	Maternal Child Health- Prenatal Services	2. umber of women provided prenatal	Participants receive ongoing prenatal care navigation, screenings, trimester education, and	75

		services	wraparound services Provide comprehensive prenatal services to at least 75 women, with participation tracked through service logs and case notes.	
3.	Maternal Child Health- Prenatal Services	Number of women provided nutrition support	Participants receive bi-weekly pregnancy nutrition food boxes and monthly nutrition education. Deliver nutrition support (food boxes + classes) to at least 20 women, with sign-in logs and delivery receipts maintained	20
4.	Maternal Child Health- Prenatal Services	Number of women provided other prenatal services	Includes prenatal labs coordination, transportation, social service referrals, and trimester education. Provide at least 75 women with additional prenatal services beyond clinical care, tracked in case management files.	75
5.	Maternal Child Health- Prenatal Services	Number of women referred to My Healthy Baby	All eligible participants are screened and referred to Indiana's My Healthy Baby program. Refer at least 50 women to My Healthy Baby, confirmed via referral	50

			system documentation.	
6.	Maternal Child Health- Postpartum Services	Number of women referred to postpartum care	<p>Maternal health advocates coordinate postpartum care appointments before discharge or within two weeks postpartum.</p> <p>Refer at least 60 postpartum participants to follow-up care, documented in discharge planning records.</p>	60
7.	Maternal Child Health- Postpartum Services	Number of women provided postpartum services	<p>Includes care coordination, emotional support, and postpartum health screening via telehealth or in-person visits.</p> <p>Provide postpartum services to at least 50 women, tracked through EMR entries and postpartum contact logs.</p>	50
8.	Maternal Child Health- Postpartum Services	Number of women provided clinical services (postpartum exams, postpartum depression screening and lactation support)	<p>Referrals and support for postpartum physical exams, depression screening (EPDS), blood pressure checks, and lactation consults.</p> <p>Ensure at least 50 women receive postpartum clinical services, with participation tracked via follow-up confirmations and clinical partner</p>	50

			reports.	
9.	Maternal Child Health-Postpartum Services	Number of women referred to mental health/substance use disorder services	<p>Screen for behavioral health needs and substance use during and after pregnancy, with referrals to treatment providers as needed.</p> <p>Refer at least 15 women to behavioral health or substance use recovery programs, with follow-up documented.</p>	15
10.	Maternal Child Health-Postpartum Services	Number of women provided breastfeeding education or support	<p>Include breastfeeding education during each trimester and offer virtual or in-person lactation support postpartum.</p> <p>Provide breastfeeding education to at least 50 women, tracked via class rosters and postpartum check-ins.</p>	50
11.	Maternal Child Health-Postpartum Services	Number of women referred to breastfeeding education or support	<p>Referral to certified lactation consultants or community-based breastfeeding support groups.</p> <p>Refer at least 30 women to breastfeeding support services, with referrals logged and confirmed by service providers.</p>	30
12.	Maternal Child Health-Postpartum	Number of families referred to pediatric care	Assist families in selecting a pediatric provider and making the	50

	Services		<p>first well-baby appointment.</p> <p>Refer at least 50 families to pediatric care providers before delivery or within 2 weeks postpartum, documented in care plans.</p>	
13.	Maternal Child Health- Postpartum Services	3. umber of people provided with parenting classes/education	<p>Offer trimester-specific parenting modules and postpartum education, including newborn care and safe sleep.</p> <p>Provide parenting education to at least 75 individuals, tracked through attendance logs and course completions.</p>	75
14.	Maternal Child Health- Health And Safety Services	Number of people provided safe sleep education	<p>Safe sleep training is incorporated into prenatal education in the third trimester and reinforced postpartum.</p> <p>Deliver safe sleep education to at least 75 participants, confirmed through sign-in sheets and educational material distribution.</p>	75
15.	Maternal Child Health- Community Assistance	Number of referrals to housing supports or resources	Screen participants for housing insecurity and connect them to	30

			<p>emergency housing, shelters, or long-term support.</p> <p>Refer at least 30 families to housing resources, with documentation included in referral logs and follow-up notes.</p>	
16.	Maternal Child Health-Community Assistance	4. Number of families referred to home visiting services	<p>Participants are referred to Nurse-Family Partnership, Healthy Families, or other home visiting programs based on eligibility.</p> <p>Refer at least 50 families to home visiting programs, tracked via secure referral systems</p>	50
17.	Maternal Child Health-Contraception	Number of people provided contraceptive education	<p>Offer education on postpartum contraception options during third trimester and again at postpartum check-ins.</p> <p>Deliverable:</p> <p>Provide contraceptive education to at least 90 individuals, with documentation in EMR and case manager</p>	90

			education logs.	
18.	Maternal Child Health-Food and Nutrition	5. number of women referred to WIC	<p>All eligible participants are referred to WIC at intake or during first trimester.</p> <p>Refer at least 90 women to WIC, tracked through referral forms and confirmation from WIC liaisons.</p>	90
19.	Maternal Child Health- Food and Nutrition	6. number of families referred or connected to local food pantries	<p>Families facing food insecurity are referred to local food pantries or mobile food distribution partners.</p> <p>Refer or connect at least 50 families to food pantries, with logs maintained in the referral database.</p>	50



E. 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
	[Deliverable]	Value
		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; waiting for faith answer

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.

Item	KPI	Metric	Deliverable	Value
1.	Access and Linkage to Clinical Care- Screening and referrals	Number of people screened for high blood pressure through local health department or partners	<p>During the intake process or at clinic visits, all participants are offered blood pressure screening using digital monitors. Blood pressure is a routine prenatal measure, and abnormal results trigger a referral for clinical follow-up.</p> <p>Tracking Method: Blood pressure values are recorded in the secure Electronic</p>	90

			<p>Medical Record (EMR) or intake form. Abnormal values are flagged for follow-up.</p> <p>Screen at least 90 participants for high blood pressure; data tracked through intake documentation and community health partner logs</p>	
2.	Access and Linkage to Clinical Care-Screening and referrals	Number of people screened for diabetes risk factors through local health department or partners	<p>All participants are screened for diabetes risk factors (e.g., family history, BMI) during their initial health history intake or through labs ordered by their OB provider.</p> <p>Risk factors are assessed using standardized screening tools and documented in the EMR or prenatal care intake record.</p> <p>Screen at least 90 participants for diabetes risk factors and document results and referrals through EMR or case manager notes.</p>	90
3.	Access and Linkage to Clinical Care-Screening and referrals	Number of people referred to or enrolled in a diabetes prevention program	<p>Participants identified as high risk for type 2 diabetes or gestational diabetes are referred to local Diabetes Prevention Programs (DPPs) in partnership</p>	25

			<p>with local clinics, FQHCs, or community-based organizations .</p> <p>Referrals are logged in case manager files with follow-up confirmation calls or documentation from the partner agency.</p> <p>Refer or enroll at least 25 participants in a DPP or diabetes education resource; referrals verified through documented follow-up.</p>	
4.	Access and Linkage to Clinical Care-Screening and referrals	Number of people screened for BMI	<p>BMI is calculated at the time of intake using height and weight collected via clinical assessments. It's a required component of maternal nutritional screening and used to guide education and support.</p> <p>BMI is recorded directly in the EMR and case management system.</p> <p>Deliverable: Screen 90 % of enrolled participants for BMI; all results maintained in the client health record.</p>	90
5.	Access and Linkage to	Number of people screening positive		90

	Clinical Care-Screening and referrals	for food insecurity	<p>A validated two-question food insecurity screening tool (The hunger vital sign) is included in the intake packet and administered by maternal health advocates.</p> <p>Responses are recorded in the EMR or database. A “positive” screen (yes to one or more questions) is automatically flagged for referral.</p> <p>Screen all enrolled participants; track those who screen positive; results entered into case tracking system.</p>	
6.	Access and Linkage to Clinical Care-Screening and referrals	Number of people referred to a food assistance program	<p>Participants who screen positive for food insecurity are referred to WIC, local food pantries, or enrolled in Early Connect’s bi-weekly pregnancy nutrition food box program.</p> <p>Referrals are logged and followed up through case notes and confirmations from community partners.</p> <p>Refer at least 50 individuals or families to a food assistance program; track through referral logs and food</p>	50

			box delivery records.	
7.	Access and Linkage to Clinical Care-Programming	Number of adults participating in nutrition and physical activity education programming	<p>All enrolled participants receiving bi-weekly food boxes are invited to monthly virtual or in-person classes on healthy pregnancy nutrition, physical activity, and postpartum wellness.</p> <p>Attendance is logged manually or electronically through registration forms or virtual participation logs.</p> <p>Engage at least 20 adults in structured nutrition and physical activity education; attendance and participation recorded by program educators.</p>	20

