HEALTH FIRST INDIANA

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

HEALTH FIRST INDIANA GRANT APPLICATION

Franciscan HEALTH
FOUNDATION

APPLICATION FOR HEALTH FIRST INDIANA FUNDING
Lake County Health Department

1. ORGANIZATION

1.1. Name of Organization: Franciscan Health Foundation, Inc.

1.2. Contact Name and Title: Marcia Saunders, Grants Manager

1.3. Address: 3510 Park Place West, Mishawaka IN 46545

1.4. Phone: 574-273-5685 Office 269-816-4955 Cell

1.5. Fax: 574-273-3813

1.6. Email: marcia.saunders@franciscanalliance.org

1.7. Name of Proposed Program: Lake County Community Health Worker Program

1.8. Target Population (ex: at-risk population of Lake County, IN; high school students, teenagers): Pregnant and new mothers along with at-risk population of Lake County; and those with diabetes and cardiovascular disease.

2. PROGRAM, PURPOSE, AND SCOPE

2.1. Name of Proposed Program: Lake County Community Health Worker Program

2.2. Program Purpose. The purpose of this grant is to support the Grantee's Program, which aims to (ex: educate at-risk population of Lake County, IN on diabetes prevention):

The purpose of this grant is to support the Franciscan Health Community Health Worker (CHW) program. The CHW program will provide individual and group support to help residents connect with clinical care services, receive education on important health behaviors, and assist families with referrals and connection to vital services that improve health status. This program bridges the gap between community-wide initiatives and clinical navigation.

Franciscan Health proposes two CHW positions be piloted in the Lake County Health Department geographic area:

- Maternal Child Health Specialist, focused on reducing infant and maternal mortality and increasing childhood immunizations:
- Chronic Disease Prevention Specialist, which aims to assist at-risk mothers and children with healthcare and to provide residents referrals to clinical care for chronic disease prevention and management.

Lake County residents are concerned about these issues. In Franciscan Health's soon-to-be published Community Health Needs Assessment, residents in Lake County noted the following: 51% are concerned or very concerned about diabetes and cardiovascular disease; and 50% said the same of cancer. 37% of residents report that their doctor has recommended a diet to them,

from low or no salt and sugar to an increase in fruits and vegetables. However, over 24% of residents report that fruits and vegetables are too expensive and 56% indicate fresh fruits and vegetables are difficult to get. The same residents (39%) indicate that their household does not get enough food for three meals a day for each individual; while 36% share that they have difficulty preparing foods because of a disability or health condition, and 44% would like help with food samples and recipes. 40% of women indicated they would like to meet with someone regularly regarding pregnancy or parenting guidance; 35% report they would like more knowledge of what to expect during labor and delivery, and better ability to advocate for themselves and their babies; 37% reported they needed more knowledge of potential feelings and physical health immediately after delivery.

CHWs can provide education in any community, from Whiting to Schererville, on healthy choices, prevention, and management of diseases and conditions. In addition, CHWs help individuals find their way to existing services and resources and alert patients to new opportunities in the community as they arise.

CHWs will assist adults with risk factors for diabetes, cardiovascular disease, and obesity by teaching residents how to make healthy choices and accessing the resources available. This can add up to major, sustainable life changes. The right type of medical care at the right time isn't always easy to navigate, but it does ensure that health can be preserved and maintained. FH will assist Lake County residents with intensive programs including nutrition and healthy eating education.

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.):

FH is proposing to utilize Community Health Workers to implement an education and healthcare referral program. CHWs will provide nutrition education and cooking classes to prevent and reduce chronic disease and provide referrals to clinical care. CHWs will also focus on improving the parenting skills and knowledge of new and pregnant mothers with an emphasis on immunizations.

FINANCIAL TERMS

2.4. Consideration. Total Program Amount Requested: $128,000

2.5. Breakdown of Total Program Amount Requested.

Item Description	Price	Quantity	Total
Community Health Worker – Maternal Health	$ 51,000	1	$ 51,000
Community Health Worker – Fringe Benefits (17.5%)	8,925	1	8,925

Community Health Worker – At-risk Lake County residents	51,000	1	51,000
Community Health Worker – Fringe Benefits (17.5%)	8,925	1	8,925
Laptop	1,500	2	3,000
Community Education (speakers, educational events, immunization clinics)	5,000	1	5,000
		TOTAL AMOUNT	**$ 127,850**

2.6. Proposed Schedule of Payments.

Payment Schedule:

Payment #	Due Date	Description	Amount
1	12/1/2024	First Quarter – Program Payment	$ 35,850
2	03/1/2025	Second Quarter – Program Payment	32,000
3	06/1/2025	Third Quarter – Program Payment	30,000
4	09/1/2025	Fourth Quarter – Program Payment	30,000

2.7. Payments.

2.7.1. Payment Information:

2.7.1.1. Any payment-related questions or concerns should be directed to Priscillar Mudari, priscillar.mudari@franciscanalliance.org 574-273-3817.

2.7.1.2. The check or wire memorandum section must specify "Health First Lake County".

2.7.2. Payments by Check. Payments will be made to Franciscan Health Foundation, Inc. and mailed to: 3510 Park Place West, Mishawaka IN 46545

3. TERMS AND TERMINATION

3.1. Term. This Agreement shall be effective for a period not to exceed one year. It shall commence on this first day of December 2024 and shall remain in effect through November 30, 2025.

4. PROGRAM WORK PLAN.

4.1. Program Work Plan.

4.1.1. Program Objective. [For example: A prevention and control program with a strategic plan for tobacco and vaping prevention and cessation in order to prevent and eliminate the risk of disease due to tobacco use in vaping.]

An education and healthcare referral program utilizing Community Health Workers to prevent and reduce chronic diseases with an additional focus on the health and well-being of mothers, children, and families, including prenatal care and immunizations.

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

Item	Goal	Strategy	Activities
1	Provide at-risk mothers and children in Lake County with healthcare referrals and immunizations	Hire a Community Health Worker (CHW) to work specifically with new and pregnant mothers	• Host group education sessions for new and pregnant mothers to provide knowledge on how to care for their children and to be aware of services available. • Host Perinatal Mood and Anxiety Disorder (PMAD) classes focused on pregnant women's mental and physical health
2	Reduce the risk for diabetes, cardiovascular disease, and obesity for Lake County Adults	Hire a CHW to provide education to Lake County Adults	• Host education programs including nutrition, healthy eating, and cooking classes.
3	Increase the number of families with a Primary Care Physician	Hire CHW to provide referrals	• Provide CHW training and resources to establish relationships in community

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
1, 2	Trauma and Injury Prevention	Preventing harm due to injury and substance use and facilitating access to trauma care.
2	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.
1	Immunizations	Host immunization clinics in conjunction with other community events

3	Access and Linkage to Clinical Care	Facilitating access to essential healthcare services for all members of the community.
1	Immunizations	Providing vaccinations to children and adults to prevent the spread of infectious diseases.

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

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.

(Quarterly Report.)

Item	KPI	Metric	Deliverable	Value
1	Maternal Health	Number of women enrolled in PMAD class	PMAD class focused on pregnant women's mental and physical health	# of people
2	Maternal Health	Number of women enrolled in parenting and safe sleep classes	Parenting classes, safe sleep education	# of people
3	Chronic Disease Prevention	Number of adults enrolled in nutrition & healthy lifestyle classes	Nutrition and lifestyle class	# of people
4	Chronic Disease Prevention	Number of adults referred to a primary care physician	Appointment with PCP	# of people
5	Access to and Linkage to Clinical Care	Number of families referred to a Primary Care Physician	Families established with PCP	# of people

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

6	Immunizations	Number of families receiving immunization	Number of clinics hosted	# of people

Franciscan HEALTH FOUNDATION

APPENDIX A

Table of Contents:

A. 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:

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
Nutrition & lifestyle classes, appointment with primary care physician	Number of people attending nutrition and lifestyle classes	200

CHRONIC DISEASE PREVENTION

Metric: Screening and Referrals

X Number of people identified with elevated hemoglobin A1c
X Number of people referred to or enrolled in a diabetes prevention program
X Number of people referred to or enrolled in a diabetes self-management education support program
X Number of people identified with high cholesterol
X Number of people screened for BMI
X Number of people referred to a weight treatment or obesity prevention program
X Number of people identified as having a BMI over 30
X Number of people referred for chronic disease preventative care
X Number of people screening positive for food insecurity
X Number of people referred to a food assistance program

Metric: Programming

X Number of adults participating in nutrition and physical activity education programming

B. 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:

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
Classes held for pregnant women and new mothers	Number of women attending classes and number of classes held	150

MATERNAL AND CHILD HEALTH METRICS

Metric: Prenatal Services (up to time of delivery)
X Number of women referred to prenatal care
X Number of women provided prenatal services
X Number of women provided nutrition education
X Number of women provided nutrition support
X Number of women provided clinical care (from a healthcare provider, such as physician, nurse practitioner, clinic, midwife)
X Number of women provided other prenatal services
X Number of women referred to My Healthy Baby

Metric: Postpartum Services (following delivery)
X Number of women referred to postpartum care
X Number of women provided postpartum services

X Number of women provided mental health/substance use disorder services

Metric: Postpartum Services (following delivery) Continued

X Number of women provided breastfeeding education or support
X Number of women referred to breastfeeding education or support
X Number of families referred to pediatric care
X Number of people provided with parenting classes/education
X Number of families referred to childcare assistance (such as Child Care and Development Fund "CCDF" program)

Metric: Health and Safety Services

X Number of people receiving child car safety seats
X Number of child car safety seats provided
X Number of car safety seat inspections provided
X Number of people provided safe sleep education
X Number of people receiving sleep sacks
X Number of cribs provided by LHD or partner
X Number of women and children referred for active domestic violence assistance

Metric: Community Assistance

X Number of families screened or referred to developmental services, such as First Steps
X Number of families referred to an insurance navigator or Medicaid

Metric: Contraception/STIs

Metric: Food and Nutrition

X Number of women referred to WIC
X Number of families referred or connected to local food pantries

C. 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:

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

Deliverable	Metric	Value
Immunizations clinics held	Number of children receiving an immunization	200

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

D. 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:

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
	Number of people screened for high blood pressure through local health department or partners	100

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

- 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 people referred for chronic disease preventative care
- 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

Metric: Programming

- Number of adults participating in nutrition and physical activity education programming
- Number of seniors participating in nutrition and physical activity education programming