City of Bethlehem
Bureau of Health

Bethlehem, Pennsylvania
2019 Program Plans
Submitted for
Act 315 and Act 12 Funding

To
The Bureau of Community Health Systems
PENNSYLVANIA DEPARTMENT OF HEALTH
Harrisburg, Pennsylvania

Table of Contents

PART ONE
PERSONNEL MANAGEMENT

BOARD OF HEALTH
(As required in 16 P.S. § 12007)

Name	Category	Term of Office
Joseph F. Bacak, III, M.D.	Physician	1/21
Christopher Alia, M.D.	Physician	1/23
Natalie Bieber, D.O	Physician	1/22
Patty Zurick , R.N.	Nurse	1/20
Terry Marcincin, D.M.D.	Dentist	1/22

Meetings are publicly advertised and scheduled for 7:30A.M.on the second Friday of each month.

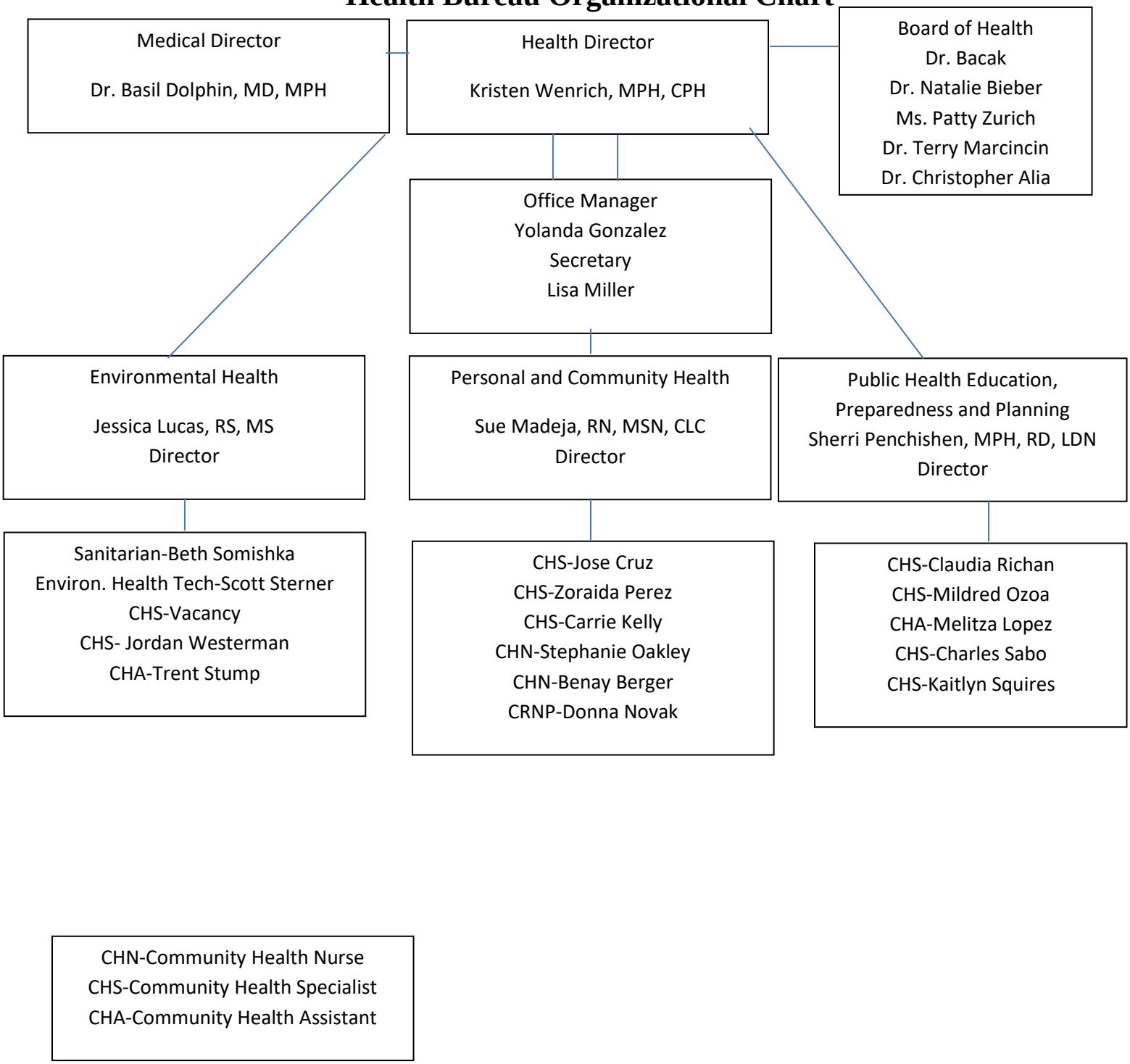
ADMINISTRATIVE AND SUPERVISORY
PERSONNEL AND SALARY
(As required in Chapter 15; §15.22, §15.23, §15.25)

Name	Position	Salary
Kristen Wenrich, MPH, CPH	Health Director	$93,402
Basil Dolphin, DO, MPH	Medical Director	Gratis
Sue Madeja, RN, MSN	Nursing Director	$88,536
Jessica Lucas, MS, RS, CP-FS	Environmental Health Director	$88,336
Sherri Penchishen, MPH, RDN, LDN, FAND	Director of Chronic Disease	$88,636
Yolanda Gonzalez	Office Manager	$56,788
Lisa Miller	Health Secretary	$40,717

Personnel Resource Summary
(As required in Chapter 15:§15.4 (a) 3, §15.24)

Functional Unit	Classification	#FTE	Salary
Administration	Health Director	1	$93,402
	Medical Director	.2	Gratis
	Office Manager	1	$56,788
	Health Secretary	1	$40,717
Personal Health Services	Nursing Director	1	$88,536
	Community Health Specialist	2.5	$130,203
	Community Health Nurse	3.0	$185,726
Chronic Disease, Health Education and Public Health Preparedness	Chronic Disease Director	1.0	$88,636
	Community Health Specialist	5.0	$256,164
Environmental Health Services	Director of Environmental Health	1.0	$88,336
	Sanitarian	1.0	$71,744
	Environmental Health Technician	1.0	$59,620
	Community Health Specialist	2.0	$104,442
	Community Health Assistant	1.0	$38,985
Total		18.7	$1,303,299

Health Bureau Organizational Chart



CHN-Community Health Nurse
CHS-Community Health Specialist
CHA-Community Health Assistant

PART TWO
FISCAL MANAGEMENT

BUDGET BY UNIT/ REVENUE BY SOURCE

2019

(As required in Chapter 15; Sections 15.4(a)1, 15.4(a)5)

BUDGET BY UNIT - FY 2019	BUDGET TOTAL	PERCENT
Administration and Support Services	$ 982,753.06	29.60%
Personal Health Services	$ 1,088,692.74	32.79%
Environmental Health Services	$ 1,248,723.66	37.61%
GRAND TOTAL	$ 3,320,169.46	100.00%

Revenue By Source 0	BUDGET TOTAL	PERCENT
Grants - Federal	$ 115,141.70	3.47%
Grants - State	$ 1,979,380.85	59.62%
Grants - Private	$ 8,500.00	0.26%
State Reimbursement (Act 315)	$ 371,491.51	11.19%
State Reimbursement (Act 12)	$ 33,854.00	1.02%
Fees & All Misc. License Fees	$ 226,292.00	6.82%
Local Allotment	$ 585,509.40	17.63%
GRAND TOTAL	$ 3,320,169.46	100.00%

Local Health Department Budget and Expenditure -

2019

Act 315/12: PA Code: Title 28, Chapter 15; Section 15.4(a)9

1	2		3	4	5	6
PROGRAM DESCRIPTIONS	**TOTAL FUNDS**		**EXCLUSION & GRANTS**	**SUBSIDY BASE**	**ACT 12**	**ACT 315**
Administrative/Support Services	$ 734,860.81		$ 160,000.00	$ 574,860.81	$ -	$ 371,491.51
Public Health Preparedness/MRC	$ 247,892.25		$ 247,892.25	$ -	$ -	$ -
TOTAL ADMINISTRATIVE	$ 982,753.06		$ 407,892.25	$ 574,860.81	$ -	$ 371,491.51
Personal Health Services	$ 106,329.99		$ -	$ 106,329.99		
Nursing/Clinical Mngt	$ 70,200.00		$ 56,092.00	$ 14,108.00	$ -	$ -
Electronic Health Records	$ 10,000.00		$ 10,000.00			
Tuberculosis	$ 6,451.30		$ 6,451.30	$ -	$ -	$ -
Immunization	$ 126,138.60		$ 126,138.60	$ -	$ -	$ -
HIV/AIDS/Communicable	$ 210,283.40		$ 210,283.40	$ -	$ -	$ -
Maternal Child Health	$ 146,350.00		$ 146,350.00	$ -	$ -	$ -
Highw ay Safety	$ 68,881.50		$ 68,881.50			
Chronic Disease Education	$ 45,450.00		$ 45,450.00	$ -	$ -	$ -
Safe and Healthy Communities	$ 208,607.95		$ 208,607.95			
Fall Prevention	$ 10,000.00		$ 10,000.00			
Healthy Women	$ 80,000.00		$ 80,000.00	$ -	$ -	$ -
TOTAL PERSONAL HEALTH	$ 1,088,692.74		$ 968,254.75	$ 120,437.99	$ -	$ -
Environmental Health Services	$ 205,314.51		$ 10,200.00	$ 195,114.51	$ 33,854.00	$ -
Food Safety	$ 108,941.60		$ 8,500.00	$ 100,441.60		
Lead/ Healthy Homes/ Home Visitation	$ 934,467.55		$ 934,467.55	$ -	$ -	$ -
TOTAL ENVIRONMENTAL HEALTH	$ 1,248,723.66		$ 953,167.55	$ 295,556.11	$ 33,854.00	$ -
SUM QUALIFYING HEALTH PROGRAM	$ 3,320,169.46		$ 2,329,314.55	$ 990,854.91	$ 33,854.00	$ 957,000.91

BUDGET BY UNIT/ REVENUE BY SOURCE

2018

(As required in Chapter 15; Sections 15.4(a)1, 15.4(a)5)

BUDGET BY UNIT - FY 2018	BUDGET TOTAL	PERCENT
Administration and Support Services	$ 932,554.31	38.99%
Personal Health Services	$ 966,253.17	40.40%
Environmental Health Services	$ 492,882.35	20.61%
GRAND TOTAL	**$ 2,391,689.83**	**100.00%**

Revenue By Source - FY 2018	BUDGET TOTAL	PERCENT
Grants - Federal	$ 189,527.80	7.92%
Grants - State	$ 1,041,221.51	43.53%
Grants - Private	$ 5,970.38	0.25%
State Reimbursement (Act 315)	$ 371,491.51	15.53%
State Reimbursement (Act 12)	$ 33,854.00	1.42%
Fees & All Misc. License Fees	$ 228,398.90	9.55%
Local Allotment	$ 521,225.73	21.79%
GRAND TOTAL	**$ 2,391,689.83**	**100.00%**

Local Health Department Budget and Expenditure -

Act 315/12: PA Code: Title 28, Chapter 15; Section 15.4(a)9

			2018			
PROGRAM DESCRIPTIONS	**TOTAL FUNDS**		**EXCLUSION & GRANTS (includes fees/revenues)**	**SUBSIDY BASE**	**ACT 12**	**ACT 315**
Administrative/Support Services	$ 716,893.68		$ 161,536.50	$ 555,357.18		$ 371,491.51
Public Health Preparedness/MRC	$ 215,660.63		$ 215,660.63		$ -	
TOTAL ADMINISTRATIVE	$ 932,554.31		$ 377,197.13	$ 555,357.18		$ 371,491.51
Personal Health Services	$ 128,752.66		$ -	$ 128,752.66		
Nursing/Clinical Mngt	$ 59,450.88		$ 56,284.80	$ 3,166.08		
Electronic Health Records	$ 10,823.63		$ 10,823.63			
Tuberculosis	$ 6,722.59		$ 6,722.59			
Immunization	$ 106,660.53		$ 106,660.53			
HIV/AIDS	$ 169,421.51		$ 169,421.51			
Maternal Child Health	$ 140,120.83		$ 140,120.83			
Highway Safety	$ 73,838.01		$ 73,838.01			
Chronic Disease	$ 78,364.94		$ 78,364.94			
Safe and Healthy Communities	$ 192,097.59		$ 192,097.59			
TOTAL PERSONAL HEALTH	$ 966,253.17		$ 642,236.83	$ 131,918.74		
Environmental Health Services	$ 249,872.92		$ 10,577.60	$ 239,295.32	$ 33,854.00	
Food Safety	$ 5,970.38		$ 5,970.38			
Lead/ Healthy Homes/ Home	$ 237,039.05		$ 237,039.05	$ -		
TOTAL ENVIRONMENTAL HEALTH	$ 492,882.35		$ 253,587.03	$ 239,295.32	$ 33,854.00	$ -
SUM QUALIFYING HEALTH PROGRAM	$ 2,391,689.83		$ 1,273,021.00	$ 926,571.24	$ 33,854.00	**$ 892,717.24**

HEALTH GRANTS 2018

Contract	Funding	Term of Contract	Amount
Healthy Woman	State	July 1, 2018-June 30, 2019	$80,000
Lead and Healthy Homes	State	July 1, 2018-June 30, 2019	$161,886
Lead and Healthy Homes	County	March 1, 2018-February 28, 2019	$227,777
Immunizations	State	July 1, 2018-June 30, 2019	$123,327
Tuberculosis	State	July 1, 2018-June 30, 2019	$6,113
HIV	State	July 1, 2018-June 30, 2019	$226,000
Maternal and Child Health	State	July 1, 2018-June 30, 2019	$125,000
Safe and Healthy Communities	State	July 1, 2018-June 30, 2019	
Public Health Emergency Preparedness	State	July 1, 2018-June 30, 2019	$205,858
Highway Safety	State	October 1, 2018-September 30, 2019	$70,000
MFHS	State	July 1, 2018-June 30, 2019	$41,058
Public Health Emergency Preparedness (opioid SAF)	State	July 1, 2018-June 30, 2019	$36,096
Diabetes Prevention	American Lung Association	July 1, 2018-June 30, 2019	$12,000
Public Health Services	County	July 1, 2018-June 30, 2019	$40,000
Public Health Services	County	July 1, 2018-June 30, 2019	$30,000

Introduction

In accordance with the requirements of Act 315 and Title12 legislation for the Commonwealth of Pennsylvania, the 2017 Program Plans for the Bethlehem Health Bureau are written and submitted to the Pennsylvania Department of Health, Bureau of Community Health Systems. The Bethlehem Health Bureau is an independent Municipal Health Department subject to the stipulations set forth in the 3rd Class City Code for the Commonwealth of Pennsylvania. The Bethlehem Health Bureau operates under the joint leadership of the Board of Health and City of Bethlehem Administration and is entering the thirty fourth year of local health operation. The Bethlehem Health Bureau continues to undertake a leadership role in the community by striving to perform high quality public health services that protect and promote optimal health and well-being to assure Bethlehem is a safe and healthy community.

The major divisions within the Bureau that exist are communicable disease, maternal and child health (MCH), chronic disease and public health emergency preparedness, and environmental health. Three program directors provide administrative oversight for the aforementioned divisions. The Administrative division oversees the implementation of the strategic plan, quality improvement plan, community health needs assessment, workforce development and the community health improvement plan. The communicable disease program consists of STDs, HIV/AIDS, partner services, tuberculosis, immunizations, and disease surveillance. The MCH program consists of prenatal home visiting, child abuse prevention, breastfeeding education, and family planning services. The chronic disease and public health emergency preparedness program focuses on cancer prevention, injury prevention, nutrition, physical activity, diabetes, tobacco cessation, highway safety, and public health emergency preparedness activities. Lastly, services provided under the environmental health program include food safety inspections, facility health inspections, Healthy Homes, and investigation and abatement of public health nuisance complaints.

The Bethlehem Health Bureau recognizes its responsibility to the community by actively participating in a number of local and statewide collaboratives aimed at improving the health of the population. Many of the program objectives outlined in this document take into account the *Healthy People 2020* target goals to improve the health status and eliminate the health disparities among City of Bethlehem residents. In addition, the Health Bureau utilizes data collected through a local health needs assessment to assure that services and resource allocations are directed toward the City's most critical needs and health priorities.

PART THREE
PERFORMANCE REVIEWS

Administration and Public Health Planning

2018 Performance Review

Goal: Improve the performance of the Health Bureau.

Objective 1: To work on improving a minimum of three performance indicators that are identified as "not on target" in the performance management system by December 31, 2018.

Achieved:
The Continuous Improvement Team worked on three initiatives: increasing the number of Partners for a Healthy Baby referrals, decreasing overdoses, and increasing revenues. In addition, the team revised the client satisfaction survey.

Goal: To maintain a highly skilled public health workforce.

Objective 2: Staff will participate in a minimum of 6 professional development activities throughout the year.

Achieved:
A total of 7 staff trainings and a team building exercise were held in 2018 for staff. The trainings were based on results from the training needs assessment. A suggestion box was created and placed in the lunch room and staff have been utilizing this as a method to communicate ideas. A survey was developed and disseminated in December asking staff for feedback regarding the staff meetings and upcoming staff trainings.

Goal: Decrease deaths associated with heroin and opioid use.

Objective 3: Reduce the number of heroin and opioid overdoses in Bethlehem by 5% from baseline by December 31, 2018.

Partially Achieved:
Although the overdose rate didn't decline, it remained fairly stable from 2017 to 2018. The Bethlehem Health Bureau continued to analyze overdose data through the City's EMS Bureau as well as EpiCenter. A total of 4 police departments are currently offering the Police Assisting in Recovery program. In 2018, 32 individuals utilized the PAIR program. In addition, 111 home visits were conducted in Bethlehem to follow up with individuals who had previously overdosed. Out of the 111 individuals who received home visits, 21 were referred to CRS and 12 entered treatment.

The Bethlehem Health Bureau provided local first responders with 188 doses of naloxone in 2018 and also participated in the Department of Health's Naloxone Distribution Day in which 76 doses were provided to the public. The Bethlehem Health Bureau was able to secure grants through Northampton County and Two Rivers Health and Wellness Foundation to support the expansion of the Police Assisting in Recovery program. Lastly, the Bethlehem Health Bureau worked with the Center for Humanistic Change, Bethlehem Area School District and Desales University on the creation of short video clips for parents. A total of 4 videos have been produced thus far.

Goal: Increase revenue from grants and billing in order to generate additional funds to address priority health issues and support critical health department operations.

Objective 4: Increase grant and insurance revenue by 10% from baseline by baseline by December 31, 2018.

Achieved:
The health bureau was able to secure additional grant funding through Northampton County to focus public health efforts outside of Bethlehem. A grant was also secured to allow the Police Assisting in Recovery program to continue. In addition, several grants including HIV and Public Health Emergency Preparedness saw an increase in funding.

The quality improvement team looked at ways to increase insurance revenues. Data was analyzed from insurance billing to look at paid and unpaid claims. The team looked at two issues regarding insurance revenues: why are a large percentage of clients uninsured or saying they are uninsured and why are claims being denied. The issues, root causes and potential solutions were discussed. A total of 6 modifications to the process were discussed and implemented in an effort to improve overall insurance revenue.

Grant revenue increased by 42% from 2017 to 2018 and insurance revenue increased by 85%.

Goal: To improve access to care for those with mental health issues in Bethlehem.

Objective 5: Increase depression screens to all clinical services and connect 100% of individuals who screen high risk to mental health services by December 31, 2018.

Partially Achieved:
Depression screens were conducted on STD, FP clinic returning and new clients at least once during the year. Referrals to an external mental health provider/clinic were made for four individuals scoring positive on the depression screenings. The BHB

depression protocol was revised to include one “counseling session/TX referral” by a newly hired staff with a social work background in late 2018 to continue indefinitely.

MCH staff attended community training on vicarious trauma though the Lehigh Valley Trauma Awareness Collaborative (LVTAC). BHB provider and committee attended all 3 LVTAC Meetings and 2 In- person trainings: Trauma 101 & Staff Burnout and 2 on-line trainings on ACE’s. BHB staff had a presentation on the Broughal Middle School Trauma Initiative.

Goal: To become a high-performing, accredited health department that successfully meets core public health standards..

Objective 6: To develop a plan to address 100% of the standards that received a designation of “not demonstrated” or “slightly demonstrated” by December 31, 2018.

Achieved:

The Bethlehem Health Bureau continued to make strides on improving areas that were not demonstrated or slightly demonstrated according to PHAB. Improvements were made in inventory management, policies and protocols, and performance management.

Maternal and Child Health

2018 Performance Review

Program Goal: To promote the physical, social and emotional health status of mothers, infants, children and families; to eliminate maternal complications of pregnancy; to eliminate infant morbidity; and to reduce health inequities in the City of Bethlehem.

Objective 1: Provide health education, screening, and direct services to promote healthy women & healthy pregnancy through a home visiting program for at least 75 women to provide: screening for depression, family planning services, breastfeeding support, and parenting education by December 31, 2018.

Partially Achieved:
The community health nurses (CHN) received 15 new referrals from community agencies and hospitals for the Partners for a Healthy Baby© (PFHB) home visiting program. Only three referrals enrolled in the program in 2018 using the PFHB curriculum from the Florida State University; Center for Prevention and Early Intervention Policy. Referrals coming from agencies were mostly postpartum mothers referred following delivery. Development of an outreach plan for staff was completed with the goal of increasing client referrals and enrollment.

The CHNs stated that mothers are hesitant to commit to a long term program as many families have multiple agencies visiting, different priorities, are working. Nurses successfully screened all pregnant women enrolled in the PFHB program using the Edinburg Depression Screen and 5 P's at least once during the postpartum period and referred appropriately for follow up care.
All families receive Safe to Sleep materials using the Eunice Kennedy Shriver National Institute of Child Health and Human Development resources.

No mothers or their partners were identified as being current smokers and therefore no referrals were made for smoking cessation.

The MCH Director or designee participated in 3 Pennsylvania Perinatal Partnership (PPP) meetings and/or calls to collaborate on maternal child health issues affecting women and families in PA.

PFHB home visitors and clinic staff used One Key Question® (OKQ) from the Oregon Foundation of Reproductive Health for all encounters of 15-35 year old women and provided appropriate education including: preconception healthcare, healthy relationships and contraceptive services. BHB reached 93% (n=210) of clinic clients who were screened and provided reproductive health education. BHB fell slightly short with 95% goal. Folic acid supplementation was given to the uninsured if appropriate.

Staff completed twelve Compass applications, 5 were approved, 3 were denied and 4 were pending at the end of 2018.

All staff attended motivational interviewing and “5 P’s” training required by the PA Department of Health Title V Program.

Objective 2: A total of 100% of families who are breastfeeding or plan to breastfeed will receive a call from the Certified Lactation Counselor (CLC) to offer breastfeeding education and support by December 31, 2018.

Achieved:
All PFHB moms were educated on breastfeeding benefits and if they were breastfeeding they were offered a certified Lactation Counseling visit for support following hospital discharge. One PFHB mom continued breastfeeding past 12 months, two others continued for 1 month or less. Two did not breastfeed at all.

Forty-six referrals were received from St. Luke’s University Health Network (SLUHN) or WIC for support for breastfeeding mothers in 2018. The referrals continue to be sporadic despite discussions with both SLUHN and WIC staff and revisal of the referral form at the request of referring staff.

Nineteen (41%) of the referrals were breastfeeding dyads, eighteen (39%) were reached by phone were currently breastfeeding postpartum. Two home visits were conducted by a Certified Lactation Counselor (CLC) for support to breastfeeding mothers. Five phone consultations were done. Three moms were not interested in support, two moms stopped breastfeeding before we reached them. Six dyads were breastfeeding at 1 month and two at 6 months.

BHB CLC’s started a breastfeeding support clinic at the WIC clinic in Southside Bethlehem held two times a month. Pregnant and breastfeeding mothers were given general breastfeeding education and offered counseling on breastfeeding issues or questions that they or their families had. Days and times were adjusted based on the need of WIC participants.

WIC supervisor evaluated breastfeeding surveys done with pregnant and new mothers to identify needs in the WIC population related to breastfeeding education and support. Forty eight WIC participants were surveyed, 15 were pregnant and of the 15, Nine (60%) were planning on breastfeeding their newborn. Most mothers were aware of the benefits of breastfeeding to their child but less aware of the benefits to themselves. Barriers were similar to what has been identified in many studies. Low milk supply, nipple pain and latching were the top three issues. Forty–one percent reported having been referred for lactation counselor services. Many of the breastfeeding mothers counseled had identified successfully breastfeeding with previous children. Those with

barriers needing support were mothers who never breastfeed or had difficulty breastfeeding previous children and had little support.

Objective 3: Use the Healthy Homes Program Model to provide, preventative health and safety education and supplies to 20 families with children and adolescents in Bethlehem by December 31, 2018.

Partially Achieved:
Five PFHB clients were referred for a Healthy Homes visit. Two visits were completed. The most common issue found is moisture resulting in mold due to structural issues. These are referred to the code enforcement officer if there is a violation. Education is provided to families to improve the wet conditions and eliminate mold. Families with children diagnosed with asthma receive mattress and pillow covers to reduce exposure to dust mites. Common needs were cabinet latches, fire and CO2 alarm installation or replacement. Education is provided for fall safety but stairway gates are no longer provided because we are finding families do not install the gates properly or do not use them. Safe Sleep is reviewed with all PFHB families with ongoing reminders.

Staff conducted Healthy Homes education for 50 families/individuals at William Penn Elementary School for parents and guardians during a family fun night. This school serves a lower income population with higher units of substandard housing.
Twelve Pack and Plays were distributed to families needing a safe sleeping surface. Seven families reported providing a safe sleeping environment for their infants, two reported they were not and were provided additional education and three families were unreachable. The reasons identified by moms for not providing a safe sleeping environment were: falling asleep on the couch or in bed while breastfeeding either at night or during naps.

Objective 4: To provide education about healthy relationships, domestic violence (Intimate Partner Violence) and child abuse prevention to families and the community using research-supported programs by December 31, 2018.

Partially Achieved:
MCH CHN provider attended the newly formed Lehigh Valley Trauma Awareness Collaborative (LVTAC) meetings and trainings and shared information with BHB directors and staff. Staff became the co-chair of the LVTAC website providing updated information for the public. STD and MCH staff attended community training by the LVTA on vicarious trauma. Staff attended the 3 LVTAC and two in–person trainings and 2 online ACE trainings.

MCH CHN developed protocols for Futures Without Violence screening in family/STD clinics, conducted a clinic assessment ,4 trainings for providers and office staff on the Healthy Relationships Screening Program including: Moravian College Health Center, 2 hospital practices and a crises pregnancy center. A total of 67 individuals were reached.

Additionally, two drug court participant trainings were conducted and included components of the Healthy Relationship Program.

No Front Porch Projects were conducted in 2018 due to the difficulty in recruiting participants and a lack of funding.

Objective 5: To collaborate with community agencies and County Drug and Alcohol agencies to promote prevention initiatives related to opioid misuse by December 31, 2018.

Achieved:
Health Director continued to attend the heroin and opioid task force meetings and engage in multiple, ongoing initiatives supporting opioid addiction prevention. Collaboration with local universities and the local school district and non-profits resulted in the development of 4 short videos for parents. (See Administration Objective #2)

Objective 6: To review 100% of child deaths occurring in Northampton County received from the PA Department Health to identify potential prevention initiatives to reduce the incidence of infant and child mortality from birth thru twenty-one years of age in Northampton County and Bethlehem City by December 31, 2018.

MCH staff co-chaired the Northampton County Child Death Review Team and prepared and attended quarterly meeting in 2018. Data was entered into the National CDRT Database. Emphasis was on improving data entry for case reviews.
Fifty three deaths had a review status of complete. Top causes of preventable deaths include: suicide and accidental deaths including motor vehicle accidents and overdoses for the age group 15 years to 24 years. Most infant and young child deaths were natural deaths. Multiple efforts around highway safety and opioid addiction are ongoing in Northampton County with several members of the CDRT in attendance.

Goal: To increase the number of children and parents accessing oral health care and education for families in Bethlehem.

Fifteen dental presentations were done for the Bethlehem Area School District third grade students. Collaboration with the Northampton Community College dental hygiene students resulted in reaching 835 children in the academic year 2017-2018. All children present received a toothbrush, toothpaste, brushing chart and parent education.

Objective 7: To insure infants and children with phenylketonuria (PKU) deficiency are appropriately case managed to maintain appropriate mental and physical health status by December 31, 2018.

No referrals were received for follow up testing.

Objective 8: *To ensure infants in Bethlehem receive appropriate follow up services for failed newborn screenings to maintain appropriate growth and development by December 31, 2018.*

No referrals were received for follow up testing.

Communicable Disease

2018 Performance Review

IMMUNIZATION PROGRAM

Goal: To assure competent, consistent, and convenient immunization services to uninsured and underinsured Bethlehem Area School District (BASD) children and adult city residents.

Objective 1: Bethlehem Health Bureau immunization program will continue work to reduce, eliminate or maintain elimination of cases of vaccine-preventable diseases in accordance with the National Healthy People 2020 Immunization Objectives by December 31, 2018.

Achieved:

During 2018, the Immunization Program investigated 100% of reported cases of vaccine preventable diseases according to guidelines set by the Pennsylvania Department of Health (PADOH) Division of Immunization and Center for Disease Control (CDC). Investigations and follow-up were completed on the following cases: 63 Hepatitis A, 91 Hepatitis B, 22 Pertussis, and 3 shingles/varicella zoster reports.

In addition to cases investigated, health bureau staff administered a total of 1,104 vaccines which included 675 vaccines to children and 429 to adults. A total of 2,241 flu doses were administered to children and adults for a total of 3,345 immunizations administered in 2018.

The Immunization Program enrolled 1 Hepatitis B Surface Antigen positive mother in the Perinatal Hepatitis B Prevention Program. The child is currently being followed to ensure she receives timely and adequate administration of gamma- globulin, immunization of Hepatitis B vaccine and serology testing.

The Immunization Program provided 18 flu clinics for seasonal influenza vaccinations to the public at various community sites. Flu vaccine was given in weekly wellness clinics held at the Health Bureau.

Several different venues promoted flu vaccine and Bethlehem Health Bureau's (BHB) flu clinic schedule. Venues include public transit buses, local newspapers, and the BHB website, Facebook and Twitter.

BHB provided education on food borne/vaccine preventable diseases to Servsafe class participants.

BHB provided education on adult immunizations to matter of class participants.

In August, long-term care facilities were sent information about influenza reporting. Instructions on the reporting requirements to BHB were sent. A copy of a reportable disease form was also included with instructions on how to complete the form. A flu update was sent in December. The update included information on the status of flu in Pennsylvania and a reminder to collect information required for long-term care(LTC) facility reporting.

Objective 2: To promote adult immunizations to at risk populations by December 31, 2018.

Partially Achieved:

8 presentations were provided to matter of balance class participants and Servsafe class attendees. 126 clients were educated on adult immunizations. BHB clinic services and educational materials on adult immunizations were distributed to all participants.

0% of participants scheduled an appointment at a BHB clinic. Unable to determine if any of them received vaccinations at their private provider offices.

Objective 3: To increase by at least 75% the number of children receiving routine Hepatitis A vaccine by December 31, 2018.

Partially Achieved:

A total of 28 children received Hepatitis A vaccine in 2018.

Objective 4: To increase by at least 50% the number of adults receiving routine Tdap vaccination by December 31, 2018.

Not Achieved:

A total of 36 adults received the Tdap vaccination in 2018.

Objective 5: To promote HPV vaccination among local dental providers by encouraging oral health screenings through education by December 31, 2018.

Achieved:

Provided 20 local dentists with education on the connection between HPV and oral cancer, the importance of HPV vaccinations and resources where their patients can receive this vaccination.

Local dentists surveyed to assess HPV education provided to their patients. 5 providers completed the survey. 100% of these providers begin oral cancer screenings under the age of 13 and 80% discuss the connection between HPV and oral cancer and the HPV vaccine.

Objective 6: The Immunization program will partner with the Lehigh Valley Immunization Coalition (LVIC) to plan and participate in at least six health promotion events for specific targeted populations by December 31, 2018.

Achieved:

In celebration of National Infant Immunization Week, bags were distributed to WIC offices, school districts, home visitation programs, OB offices, hospital prenatal classes, health department clinics. Bags included immunization handouts, onesie, bib, sippy cup with immunization messages on all items.

Both Allentown and Bethlehem Health Bureaus partnered with their respective school districts to provide catch-up clinics at the schools and health departments to meet the new requirements. LVIC branded ear buds given to all children vaccinated at these clinics.

NIAM promotion through the Morning Call Newspaper online.

Cervical Health Awareness Month, Teen Health Week, Hepatitis Awareness Month, National Immunization Awareness Month and Influenza Awareness week all promoted through social media posts.

Quarterly meetings are held for LVIC members between Allentown and Bethlehem Health Bureaus. The community health nurse immunization coordinator is co-chairperson of the LVIC. Attendance and minutes are documented.

Due to a decrease in funding through the immunization grant, LVIC was unable to provide immunization education through widespread advertising as done in previous years.

Objective 7: The Immunization Program staff will attend and participate in at least four educational conferences, trainings or web casts by December 31, 2018.

Achieved:

In 2018, the following conferences/meetings were attended by BHB staff members:

-Pennsylvania Immunization Conference(PIC) in Harrisburg

-Lehigh Valley Immunization Coalition Meetings

-BHB bi-monthly staff development trainings

-PA DOH immunization conference calls

-Perinatal Hepatitis B conference calls

-CDC immunization updates including vaccine safety, storage and handling

-Immunization Action Coalition conference calls

COMMUNICABLE DISEASE

Objective 1: To increase the identification and reduce the transmission of communicable diseases by investigating 100% of the Notifiable Disease Reports, National Electronic Disease Surveillance System, and suspect and confirmed communicable disease outbreaks in accordance with the guidelines indicated by the Pennsylvania Department of Health through December 31, 2019.

Achieved:
PA NEDSS is used by all Bethlehem Health Bureau staff to conduct communicable disease investigations. Staff review PA-NEDSS reports twice daily and begin investigations with in the required timeframe per PA DOH. BHB staff investigated 1236 cases, 47% (n=586) of which were confirmed cases. The top eight communicable disease investigations account for 920% (n=539) of CD investigations in Bethlehem. Those investigations include: Chlamydia, Gonorrhea, Hepatitis B, Hepatitis C, Lyme disease, Salmonellosis, Syphilis & Zika with case classifications noted in the chart below.

2018 Bethlehem Communicable Disease Investigations				
Disease	**Reports**	**Investigations**	**2018 Confirmed**	**2017 Confirmed**
Chlamydia	536	406	372	334
Gonorrhea	180	74	67	85
Hepatitis B	200	92	2	1
Hepatitis C	923	175	85	156
Lyme	78	44	9	29
Salmonellosis	43	9	1	6
Syphilis	230	119	3	13
Zika	5	2	0	0

Surveillance and epidemiology databases are monitored regularly to identify potential outbreaks or health threats. There were no reported norovirus outbreaks in 2018; this outbreak was not confirmed by lab test. BHB staff was involved in 7 influenza outbreaks in 2018 all involving long term care facilities.

Objective 2: To increase staff competency in communicable disease investigation, and epidemiological practices, as related to disease incidence in the City of Bethlehem through attendance or viewing of monthly webinars/webex/trainings/conferences throughout 2018.

Achieved:

- Bethlehem Health Bureau health Director attended all the DOH Epidemiology meetings in 2018.
- All staff completed required PA NEDSS confidentiality training on the Learning Management System in 2018.
- Staff completed CDC Epi trainings in 2018.
- Monthly CD/NEDSS meetings with administrative and investigative staff were conducted.
- CHN's attended monthly local health network infectious disease meetings to share local data and events related to infectious diseases
- Staff participated in quarterly PA DOH conference calls and required field staff meetings.

TUBERCULOSIS PROGRAM

Goal: To reduce the transmission of tuberculosis and its associated health consequences through surveillance, report investigation, education and medical treatment.

Objective 1: To reduce the transmission and health consequences of 100% of patients with active tuberculosis by providing case management and medical treatment in accordance with the CDC's recommended therapy regimen by December 31, 2019.

Achieved:

Two patients were identified as having active tuberculosis, both in April 2018. Both patients received case management and medical treatment.

Objective 2: To increase the number of LTBI patients to agree to treatment and adhere to the treatment for the recommended amount of time by December 31, 2018.

Achieved**:**

# of referrals received from local health care organizations (PPD) and IGRAS reported in PA-NEDSS	69
# of clients who agreed to come to a BHB TB Clinic	48
# of clients who showed up at BHB TB clinics (including Lehigh U students)	43
# of clients who never showed up at 1st TB clinic appointment	5
# of clients who opted for Treatment after clinic visit	40
# of clients who declined treatment after clinic visit	3
# clients who dropped out after starting LTBI TX	2
Completed 4 month RIF/ Currently in RIF treatment	7/4
Completed 12 week DOT/ Currently in DOT treatment	14/0
Number of clients who had false positive who no longer needed TX	14
# clients with LTBI in private TX	2
# of Active TB patients completed full treatment	2
# of clients scheduled for 3/2019	3

Objective 3: To reduce the transmission and health impact of tuberculosis by initiating PA-NEDSS investigations for 100% of active or suspected tuberculosis cases within one working day of report or referral as recommended by the PADOH's tuberculosis treatment guidelines throughout 2018.

Achieved: All suspected tuberculosis cases were investigated within one working day of their report or referral.

Objective 4: To reduce the transmission of tuberculosis through contact investigation and tuberculin testing of 100% of close contacts focusing on immunocompromised individuals and children under 5 years of age using the CDC algorithm for TB disease investigation and management to identify the source case of infection throughout 2018.

Achieved:

There were 3 close contacts identified of the active TB case Patient #1. One was a 4 year old child who tested negative on first test, but was prophylactically treated with 12 months of INH. Despite repeated calls and urging, the mother of the child never took the child back for a 2nd test. The other 2 close contacts were adults. Both tested negative on the first TB test and the mother of the patient tested negative on both tests. The adult niece of the patient never went back for her 2nd and final test.

Objective 5: Educate the public and providers about TB and LTBI and specifically the providers about the CDC recommendations regarding TB/LTBI testing, treatment regimens and what BHB does regarding TB testing and treatments by December 31, 2018.

Achieved:

The TB nurse and Pulmonologist Dr. Alia held the annual TB Clinic for Lehigh Students with Lehigh University medical staff. We educated the patients (who are all Lehigh University undergraduate and Graduate students) about TB/LTBI and the implications of LTBI treatment and non-treatment as well as on the 12 week Direct Observation Treatment Therapy (DOT) to be utilized for their treatment.

The TB Nurse participated in the annual Global Tuberculosis Institute Conference in New York and listened to multiple Global Tuberculosis Institute webinars, Southeastern National Tuberculosis Center webinars, participated in PA State TB educational conferences and on line and/or phone seminars, meetings and trainings.

The TB Nurse has developed a good and communicative relationship with the St. Luke's Infection Control Nurses, Infectious Disease Physicians as well as the RN Case Managers and we have communicated and worked together on a regular basis when there are suspect TB cases or confirmed TB cases.

The TB Nurse, the Bethlehem Health Bureau Nurse Supervisor and Health Director worked together with the Bethlehem Police Department, Bethlehem city solicitors, St. Luke's physicians, lawyers and upper management to effectively coordinate and get an active TB involuntarily is a hospital setting to ensure effective treatment of his MTB and prevent the spreading the disease in the community .

HIV/AIDS PROGRAM

Goal: To reduce the spread of HIV and its consequences to health, particularly among at-risk populations, through HIV/STD/HCV prevention counseling/testing, surveillance, education, and partner services.

Objective 1: Increase by 2%, the number of STD and family planning patients who will also be tested for HIV by December 31, 2018.

Partially Achieved:
There were a total of 457 unduplicated clients seen at the STD and Family Planning clinics. There were 407 clients who were tested for CT/GC/Syphilis/HIV; and 50 who were tested for CT/GC only.

A total of 89% of all the people seen at STD/FP were tested for CT/GC and were also tested for HIV.

*Objective 2: By December 31, 2018, refer of minimum of 10 high risk individuals who are referred for HIV Pre-Exposure Prophylaxis (PrEP) counseling and medication***.**

Partially Achieved:
There were 11 clients who expressed an interest in getting PrEP. They were counseled and referred to Novus Clinic, HOPE at St Luke's or their own provider. The referral is documented in the client's medical record in NextGen.

Objective 3: Identify at least 3 newly- identified HIV positives through BHB HIV CTR clinic by December 31, 2018.

Partially Achieved:

Under the current grant agreement, BHB is to provide voluntary opt-out HIV testing instead of targeted testing to high risk population. The performance indicator for routine opt-out HIV testing in healthcare settings is to achieve at least 2 positive cases out of 500 tests. In 2018, BHB identified 2 new HIV positives out of 417 tests performed.

Objective 4: By December 31, 2018, through BHB partner services, there will be a 25% increase in the number of HIV positive individuals who will be interviewed for partner services.

Not Achieved:

There were only 10 HIV positive individuals interviewed for partner services. Even though there were 34 confirmed HIV/AIDS cases reported to BHB as the Local Morbidity Reporting Office through PA NEDSS, only 4 resided in the City of Bethlehem and qualified for partner services; 16 were from Pennsylvania, but not within the BHB jurisdiction and were referred for partner services; and 14 were previously positive moving to Pennsylvania from another state.

Objective 5: BHB will increase by 5% the number of partners, not previously HIV-positive, who are located, notified of HIV exposure and referred for testing by December 31, 2018.

Not Achieved:

There were only 5 partners named out of 10 HIV positives interviewed for partner services; 2 partners were tested negative, 1 was previously positive, and 2 were out of jurisdiction. All activities listed in the program plan were implemented.

Objective 6: By December 31, 2018, reduce the number of open HIV incomplete monthly investigations to 5 by December 31, 2018. .

Achieved:

There were 149 HIV/AIDS investigations reported to BHB as a Local Morbidity Reporting Office, and of those, 115 were closed as not a case. BHB averaged four incomplete investigations monthly. The successful outcome of this objective is due mostly to have been granted permission to have remote access to Lehigh Valley Hospital and St Luke's University Hospital Medical Records.

STD PREVENTION AND MANAGEMENT PROGRAM

Goal: To reduce the transmission of sexually transmitted diseases (STDs) and their respective health consequences through the promotion of responsible sexual behaviors, counseling, testing, education and increased access to quality clinical services.

Objective 1: Decrease by 5%, the number of PA NEDSS investigations without an interview as a value by December 31, 2018.

Not Achieved:
There were 471 PA NEDSS confirmed cases investigated and, of those, 67 were not interviewed, which represents 14%. All investigations had treatment confirmed. The number of PA NEDSS investigations with no interview as a value had a slight increase from the previous year. An increase in positive STDs reported in PA NEDSS from Novus Clinic was experienced, which accounts for most of the patients not being interviewed due to anonymous testing. According to Novus Clinic, partner elicitation is discussed with positive patients. Any contact named is tested and treated by Novus Clinic.

Objective 2: Increase the number of individuals with a positive test result who will return for re-testing of CT/GC/Syphilis/HIV by 3% by December 31, 2018.

Achieved:

A total of 88 patients were tested through BHB STD clinic and had a positive STD result and 30 returned for re-test which represents 34%.

Objective 3: Increase the number of STD clients, 40 years and older, who are also tested for HCV by 6% by December 31, 2018.

Achieved:

A total of 68 patients who were 40 years and older were seen at BHB STD clinics 32% were tested for Hepatitis C.

Objective 4: Increase the percentage of patients diagnosed with CT/GC/Syphilis who will name one or more sex contacts by 3% by December 31, 2018.

Achieved:

A total of 88 patients were tested through BHB STD clinic and had a positive STD test and 79% of those STD positive individuals named at least one contact.

Objective 5: Increase the number of family planning clients who start birth control with BHB clinic by 10% by December 31 2018.

Not Achieved:

A total of 192 childbearing age women were seen at BHB STD Clinic. A total of 10 new referrals were made for family planning and out of those 9 started birth control in 2018.

RABIES SURVEILLANCE PROGRAM

Goal: To reduce the transmission of rabies and its health consequences in the City of Bethlehem through surveillance, education and report investigation.

Objective 1: To prevent the transmission of rabies disease by investigating 100% of reported animal bites in the City of Bethlehem by December 31, 2018.

Achieved:

A total of 100% (147) of animal exposure (bite, scratch, saliva) victim notifications and reports received through telephone calls, faxes or in person were investigated by the Bethlehem Health Bureau. Of the reported animals, 110 were dogs, 34 were cats, 2 bats, 1 squirrel. The report on the squirrel was not investigated. BHB staff spoke with all responsive and known victims regarding wound care, asked about treatment given, and recommended follow up with medical providers when necessary.

Objective 2: To educate 100% of known owners and victims about state and local animal exposure-related laws and ordinances by December 31, 2018.

Partially Achieved:

All animal exposure victims and known owners were mailed an investigation letter, which contained a brochure discussing PA State rabies laws and PA State Dog Law. BHB investigators worked with pet owners to ensure compliance with all applicable state laws and city ordinances, including giving adequate time to have their pet vaccinated against rabies and obtain a current county dog license. Some cases with compliance issues were referred to the Bethlehem Animal Control Officer or Nursing Director for follow up. Citations were issued when appropriate by Bethlehem police animal control.

Objective 3: To reduce the transmission of rabies by providing education to a minimum of 50 people, including animal owners, victims, and medical professionals by December 31, 2018.

Achieved:
BHB staff who investigate animal exposures provided education to all victims and known owners by telephone or mail with the brochure provided with the standard letter that is sent out to animal exposure victims and owners.
Information regarding rabies and reporting requirements for animal-to-human exposures was disseminated to local hospital emergency departments and urgent care centers.
Press releases for identified rabid animals ensure residents are alerted to the need to ensure pets are up to date with rabies vaccination. A list of low cost rabies vaccination clinics is made available to all residents in need.

Public Health Education and Planning Division
2018 Performance Review

SAFE AND HEALTHY COMMUNITIES

Goal: To increase access to healthy foods in Northampton County through the implementation of policy, systems and environmental changes.

Objective 1: To increase access to healthy foods through partnership with one local farm share and farmers market program by December 31, 2019.

Achieved:
A weekly farm share was established with 61 people participating in the farm share program. One of the farm share was SNAP eligible. A total of 4 cooking demonstrations were held at the farm stand and all recipes were shared online. One elementary school offered the farm share program, "Veggie Sales."

Goal: To increase safe physical activity and transportation and pedestrian safety in Northampton County through implementation of policy, systems and environmental changes.

Objective 2: To increase safe transportation and physical activity through adoption of a Complete Streets Policy by December 31, 2019.

Achieved:
A Complete Streets policy was developed and adopted by the City of Bethlehem. The Complete Streets policy was also incorporated into the Vision Zero plan.

Objective 3: To increase safe physical activity and transportation opportunities through expansion of two sites and maintenance of the Bike Share Program by December 31, 2018.

Partially Achieved:
Bike Bethlehem was expanded to one additional rental location in the spring of 2018. The health bureau received a grant from Highmark which allowed for the purchase of additional bikes. A press conference was held to promote the additional location and the bike share was promoted on social media several times throughout the rental season. A total of 93 bikes were rented in 2018.

Objective 4: To deliver the comprehensive falls prevention program, A Matter of Balance, to a minimum of 40 older adults in Northampton County by December 31, 2019.

Achieved:
The Bethlehem Health Bureau maintained 2 master trainers on staff. A total of 3 coaches' trainings were held in which 24 coaches were trained. One coach update meeting was held in 2018. A total of 15 classes were conducted and 150 seniors participated in the program. One booster session was conducted and 2 booster topics were incorporated into the classes. All data was entered and analyzed into Project Enhance.

Objective 5: To distribute and implement the STEADI toolkit to 10 physician practices by December 31, 2018.

Partially Achieved:
Physician practices either have STEADI or are using something similar. We began utilizing the balance assessments from STEADI into our MOB classes.

Objective 6: To increase motor vehicle safety among teenage drivers through delivery of the Teen Impact program in four high schools in Northampton County by December 31, 2018.

Achieved:
The teen driver vehicle death rate has not yet been released. A total f 19 Teen Impact sessions were conducted and one parent forum was held.

Objective 7: To increase motor vehicle safety among adults aged 55 years and older through delivery of four Car-Fit programs by December 31, 2019.

Achieved:
A total of 4 Car-Fit trainings were conducted, 23 technicians were trained and 5 community events were held.

Objective 8: To decrease negative outcomes of traumatic brain injury through implementation of the BrainSTEPS program in one local school by December 31, 2018.

Achieved:
All schools in the Bethlehem Area School District participated on the concussion management team. All schools in Northampton County are using the BrainSTEPS program and two hospital groups are members of the BrainSTEPS team.

Objective 9: To decrease negative outcomes of traumatic brain injury through implementation of 2 ConcussionWise program by December 31, 2018.

Partially Achieved:
The Bethlehem Health Bureau did not provide community sessions but St. Luke's University Health Network and Lehigh Valley Health Network provide education regularly. All coaches go through concussion educational sessions however it is not specifically the ConcussionWise program.

Objective 10: To decrease the prevalence and risk of child sexual abuse through implementation of four Parents in the Know program by December 31, 2018.

Achieved:
Two employees attended the master training for Parents in the Know. A total of 4 Parents in the Know classes were conducted.

EMPLOYEE WELLNESS PROGRAM

Goal: To increase employee wellness program participation rates in order to create a healthier workforce, decrease medical costs to the City, and decrease sick time.

Objective 1: To maintain current participation rate in the Employee Wellness Program by December 31, 2018.

Achieved:
A total of 119 employees participated in the employee wellness program.

Objective 2: To improve employee health status by having 90% of employees receiving reimbursement by December 31, 2018.

Achieved:
A total of 92% of employees enrolled in the program received reimbursement for achievement of pathway criteria.

HEALTHY WOMAN PROGRAM

Goal: To reduce the mortality and morbidity rates of breast and cervical cancer within Northampton County by increasing the number of women who annually receive mammograms and pelvic examinations.

Objective 1: To provide comprehensive breast and cervical screening to one hundred (100) eligible women during 2018.

Partially Achieved:

The Healthy Woman Program provided services to 86 women in 2018, who had at least a screening mammogram, Pap test and self-breast-examination education.

Services provided:

Breast Biopsies (N_{2017}= 15, N_{2018}= 5)

Diagnostic testing of the breast (N_{2017}=40, N_{2018}= 61)

Diagnosed with breast cancer- (N_{2017}=4**,** N_{2018}=6)

Diagnostic testing of the cervix (N_{2017}=14, N_{2018}=12)

Woman diagnosed with a pre-cancerous or cancerous condition were referred to the Breast and Cervical Cancer Program Treatment Program, which is funded by the Department of Public Welfare in collaboration with the Healthy Woman Program to provide further Breast Cancer Treatment to uninsured/underinsured women.

Objective 2: To provide case management to women diagnosed with an abnormal test result with in ninety (90) days of notification.

Achieved:
Case Management was provided to 86 women who were diagnosed with an abnormal clinical breast examination, Pap smear or mammogram. Case management was provided to the women within thirty (30) days of the Bethlehem Health Bureau being notified of the results.

HIGHWAY SAFETY PROGRAM

Goal: To decrease injuries and deaths caused by motor vehicles in Northampton County.

Objective 1: To increase general traffic safety contacts by 10% in Northampton County by September 30, 2018.

Achieved:
Participated in monthly (12) enforcement meetings with the Lehigh Valley Regional DUI and Highway Safety Task Force. Educated police departments on areas with high crash rates.

Objective 2: To increase the number of Northampton County police officers Trained in PENNDOT approved educational programs (Back is Where It's At, Survival 101, Every 16 Minutes) by 5% by September 30, 2018.

Achieved:
Conducted site visits to all police departments within Northampton County to encourage and promote all trainings available through PENNDOT. Attended/assisted with the Back is Where It's At, Every 16 Minutes and Survival 101 training for 8 police officers within Northampton County.

Objective 3: To provide education materials for specific PENNDOT focus areas to 100% of Magisterial District Justices by September 30, 2018.

Achieved:
Provided educational materials (handouts) and statistics regarding aggressive driving, child passenger safety, impaired driving and seatbelts to all magisterial district justices in Northampton County upon request.

Objective 4: To increase by 2% the number of motorists who have special needs who utilize the Yellow Dot program by September 30, 2018.

Achieved:
Participated and provided the Yellow dot program to individuals attending four senior health expos 850+. Provided the Yellow Dot program to individuals participating in the CarFit events.

Objective 5: To increase participation and collaboration of NC police departments to 60% to attend meetings to discuss aggressive driving, impaired driving, seatbelts, heavy truck and motorcycle enforcement activities by September 30, 2018.

Achieved:
Conducted site visits (along with my LEL for Northampton County) to all police departments within Northampton County to encourage and promote all trainings available through PENNDOT. Attended monthly Lehigh Valley DUI Highway Safety Task Force meetings. Local trainings are reviewed and distributed to Lehigh Valley police departments.

Objective 6: To maintain zero fatalities caused by aggressive driving (n=6, 2016; n=0, 2015) in Northampton County by September 30, 2018.

Achieved:
Educated two colleges regarding safe driving practices in Northampton County. Attended the Moravian College Health Safety Day, Educating students on distractive, aggressive and impaired driving. Provided information and assisted with the driving simulators provided by Lehigh Valley Hospital to 150 students and 1 work place. Participated in an interview on safe driving practices with Northampton Community

College communication department. Media promotions done on a monthly basis focusing on different topics and current events. Facebook and twitter total followers are 1242.

Objective 7: To reduce crashes caused by aggressive driving by 10% (n-283, 2016; n=259, 2015) in Northampton County by September 30, 2018.

Achieved:
Educated two college regarding safe driving practices in Northampton County. Attended the Moravian College Health Safety Day, Educating students on distractive, aggressive and impaired driving. Conducted site visits to Northampton County Police Departments and provided information regarding aggressive driving, DUI and seatbelts. Through the Lehigh Valley DUI Highway Safety Task Force, provided 2 media coverage's regarding aggressive driving.

Objective 8: To decrease motorcycle fatalities by 15% (n=8, 2016; n=2, 2015) by September 30, 2018.

Achieved:
Media coverage was provided through the Lehigh Valley DUI/Highway Safety Task Force during Motorcycle Awareness Month. Messages were also posted on social media through Face book and Twitter. The Crime Victims Council Motorcycle Run-Rally through the Valley September 2018 – Lehigh Valley DUI/Highway Safety Task Force sponsors an ad to support this event. Also through the Task Force, attended the Live Free Ride Alive event at the Pocono Raceway. PENNDOT's Motorcycle safety program aimed at reducing the number of motorcycle crashes and fatalities in Pennsylvania through education and interactive program. Also the Safety Press Officer organized a Motorcycle Safety Day at Blackmans Cycle Center in Emmaus, practicing motorcycle skills and techniques, having the new PA motorcycle curriculum available.

Objective 9: To decrease motorcycle crashes by 10% (n=73, 2016; n=80, 2015) by September 30, 2018.

Achieved:
Media coverage was provided through the Lehigh Valley DUI/Highway Safety Task Force during Motorcycle Awareness Month. Messages were also posted on social media through Face book and Twitter. The Crime Victims Council Motorcycle Run-Rally through the Valley September 2018 – Lehigh Valley DUI/Highway Safety Task Force sponsors an ad to support this event.

Objective 10: To decrease crashes caused by older drivers by 5% (n=1175, 2016; n=1089, 2015) by September 30, 2018.

Achieved:
Provided educational programs at 7 senior living facilities educating seniors on safe driving practices. Attended 3 safety fairs educating 1000+ seniors on safe driving. Promoted CarFit at the National Night out in Lehigh Township educating 100 individuals.

Objective 11: To decrease fatalities caused by older drivers by 25% (n=6, 2016; n=24, 2015) in by September 30, 2018.

Achieved:
Organized 3 CarFit trainings in Northampton County. CarFit is an educational program that offers older adults the opportunity to check how well their personal vehicle fits them. Held 5 Car Fit events in Northampton County educating 54 seniors.

Objective 12: To increase proper use of child restraints to a 90% correct use rate by September 30, 2018.

Achieved:
BHB participated in 14 car seat checks in which 76 car seats were inspected and installed correctly. 12 car seats were provided through a rental program for individuals in need. 5 vouchers were provided through Lehigh Valley Health Network for individuals to receive a free convertible car seat and 2 vouchers were provided through St. Luke's Hospital. 42 seats were check and education done on a one on one basis in office by appointment. During Child Passenger Safety Week, participated in 2 car seat checks and inspected seats. Provided 4 educational programs to parents, caregivers and agency staff members regarding child passenger safety. 4 educational presentations were provided to parent groups. BHB staff also answered all calls with questions regarding the proper installation of car seats and PA Laws.

Objective 13: To decrease pedestrian injuries by 15% (n=79, 2016; n=69, 2015) in Northampton County by September 30, 2018.

Achieved:
A total of 5 pedestrian educational programs were conducted within the City of Bethlehem in collaboration with the Bethlehem Police Department, City of Bethlehem Department of Engineering and Lehigh Valley Health Network. The motoring public was educated on the need to be cautious of pedestrians in crosswalks and the need to be aware of your surroundings when commuting. A media event was conducted at the initial kick off.

Objective 14: To decrease pedestrian fatalities in Northampton County by 10% (n=4, 2016; n=6, 2015) on public roads by September 30, 2018.

Achieved:
Program Director chair's the Citizen's Traffic Advisory Committee and held monthly meetings to review and develop solutions to pedestrian problems within the City of

Bethlehem. Data was collected and analyzed to help identify problem areas. Bethlehem Health Bureau collaborated with local pedestrian organizations and assisted with programs. Messages were posted on social media for National Walk to School Day.

Objective 15: To increase seatbelt usage to 90% (n=86%, 2016; n=86%, 2015) in Northampton County by September 30, 2018.

Achieved:
Participated in the Child Passenger Safety Enforcement Mobilization providing education to parents and teens on seatbelt.

Objective 16: To decrease unrestrained crashes by 10% (n=273, 2016; n=254, 2015) in Northampton County by September 30, 2018.

Achieved**:**
Media conducted during Teen Seat Belt Mobilization and Aggressive Driving Week. National Click it or Ticket Mobilization done in Northampton County. Motorist educated during these events.

Objective 17: To decrease unrestrained fatalities by 10% (n=5, 2016, n=8, 2015) in Northampton County by September 30, 2018.

Achieved:
Seat Belt education done during every distractive, impaired and teen driving program with the grant period. Seat belt survey done at high schools with the Lehigh Valley Area. Education provided.

Objective 18: To maintain a zero percent bicycle fatality rate in Northampton County (n=0, 2016; n=0, 2015) by September 30, 2018.

Achieved:
BHB collaborates with local bicycle organization CAT to address problem roadways and ways of improvement in Northampton County through our Citizen's Traffic Advisory Committee. Meetings are held on a monthly basis. Organized a Bicycle Traffic Skilled Training for City Officials and Citizen Traffic Advisory Committee members. Continue to track and monitor bicycle crashes and injuries on the GIS system. Safety messages and events posted to social media (facebook and twitter).

Objective 19: To decrease bicycle crash rate in Northampton County by 10% (n=21, 2016; n=26, 2015) September 30, 2018.

Achieved:
Participated in 3 Safety Town events educating 450 children on bicycle safety. Collaborated with St Luke's Hospital to launch Bike Share Community Program in Bethlehem. Attended the YMCA Healthy Kids Day providing education on bicycle safety. Organized a Bike to Work Event at City Hall in Bethlehem in collaboration with

community partners. Organized a Walk/Bike to school program at Hanover Elementary School educating 236 students.

Objective 20: To reduce by 10% the number of bicyclists committing major violations on public roadways (riding the wrong way, not stopping at traffic signals, riding on sidewalks) in Northampton County by September 30, 2018 (baseline 80%).

Achieved:
Accidents involving bicyclist are tracked through the GIS System. Data is analyzed and problem areas are addressed and evaluated during the CTAC meetings.

Objective 21: To decrease fatalities in crashes caused by teen drivers by 5% (n=0, 2016; n=10, 2015) by September 30, 2018.

Achieved:
Participated and educated 150 high School students with the driving simulator program. Attended the Northampton County SADD Healthy Living Expo educating 600 students on distractive and impaired driving. Provided 7 Impact Teen Driving Programs to students with the Lehigh Valley Area educating 362 students.

Objective 22: To decrease crashes caused by teen drivers by 5% (n=424, 2016; n=403, 2015) by September 30, 2018.

Achieved:
Collaborated with the Lehigh Valley DUI/Highway Safety Task Force to host their annual Youth Conference which was held on April 27st. 200 students attended the conference from the Lehigh Valley. The focus is on youths making positive decisions for better health and safety. Students from each school create a situation based on the topic selected and promote a positive message related to Highway Safety. The Impact Teen Driving Program done at Easton High School.

Objective 23: To reduce impaired driving fatalities by 5% (n=15, 2016; n=17, 2015) in Northampton County by September 30, 2018.

Achieved:
Participated in the Moravian College Students Health Event educating 200 students; Moravian College/Lehigh Valley DUI Task Force Collegiate Event educating 250 students on underage drinking, aggressive driving and seatbelt use. Participated in the National Night Out event at Lehigh Township Police Department and Bethlehem Township Police Department.

Objective 24: To reduce impaired driving crashes by 10% (n=305, 2016; n=306, 2015) in Northampton County by September 30, 2018.

Achieved:
Participated in the Lehigh Valley Health Network 50+ Senior Wellness Expo educating seniors on medication impairment. A total of 300 people attended the event.

PUBLIC HEALTH EMERGENCY PREPAREDNESS

Goal: To improve the public's health by advancing the City of Bethlehem's response to health-related emergencies through the development and implementation of preparedness plans, staff and citizen training, partner agency collaboration, and enhanced communications.

Objective 1: To increase the coordination between state, county, and local entities two times per year to improve the sharing of public health information by December 31, 2018.

Achieved:

1. Participated in state and local conference calls with multiple agencies regarding flu, Zika, and Hepatitis A.
2. Attended and participated in the Southern Zone Healthcare Coalition meetings which is part of the larger Northeast PA Counterterrorism Taskforce's Health, Medical & EMS Committee. Throughout 2018 multiple agencies joined the coalition including nursing homes, VNA's, and dialysis centers.
3. Attended the 2018 NACCHO Preparedness Summit held in Atlanta Georgia.
4. Attended the PA Statewide Advisory Committee Meeting located in Harrisburg PA.
5. Regularly worked with the Allentown Health Bureau, Lehigh County EMA, and American Red Cross to create and/or provide emergency and response-related trainings to MRC, Staff, & CERT volunteers.
6. Worked with the Bethlehem Area School District, local colleges/universities, and Bethlehem Police Department to facilitate a drive through flu vaccine clinic exercise at East Hills Middle School.

Objective 2: To build three new community partnerships to support public health preparedness by December 31, 2018.

Achieved:

1. Worked with various citywide nursing homes to assist in the preparation and evaluation of the required full-scale exercises per CMS guidelines.
2. Worked with Bethlehem Block Watch groups to conduct trainings to better prepare them for emergencies.
3. Through the addition of the Northeast Healthcare Coalition new community partnerships were developed including home health agencies, nursing homes, dialysis centers, etc.

4. Partnerships created with Liberty High School, Freedom High School and Moravian Academy which allows BHB to present various programs which include highway safety/preparedness collaboration.
5. Partnered with Lehigh Valley Center for Independent Living to create program geared towards functional and access needs.
6. Partnered with Lanta Bus, Transbridge Bus, Moravian College Transportation and Lehigh University Transportation to create an MOU for transportation during a large scale incident.
7. Partnered with Eastern PA EMS Council to provide trainings.
8. Working with Novus Adult Care Services to provide Hepatitis A vaccine to identified high risk population.

Objective 3: Increase capacity to handle 100% of public health emergencies through emergency response plan updates, training, and coordination with relevant agencies by December 31, 2018.

Achieved:

1. Made major revisions to USPS BDS plan including response and medical plan.
2. Made changes to ICS structure in response to Points of Dispensing that align better with maintain span of control.
3. BHB staff participated in a total of 25 preparedness specific related trainings, 6 drills, 1 tabletop exercise, and 5 full-scale exercises. These numbers include trainings, drills, and exercises attended by BHB staff for in-house or off-site.
4. Created plan specific to deployment of water bladders and provided to Bethlehem Fire and Emergency Management.
5. Began work on creating a Closed POD plan.

Objective 4: To establish and participate in one information system operations drill or exercise by December 31, 2018.

Achieved:

1. Participated in full-scale Healthcare Coalition Full-Scale exercise in which Bethlehem Health Bureau opened the Emergency Call Center to operate family reunification due to an active shooter incident in Bethlehem. Knowledge Center was utilized for patient tracking during this incident.
2. Utilized Facebook, Twitter, and Instagram to disseminate preparedness tips as well as public health warnings. A preparedness Twitter account was created for specific information and warnings.
3. Conducted two ServPA call down drills throughout the year which involved staff and Medical Reserve Corps.

MEDICAL RESERVE CORPS

Goal: To support and supplement public health services to strengthen community preparedness and assist in the response to emergencies that has an impact on public health, by maintaining a well-trained volunteer unit.

Objective 1: To maintain 100% of all data entry into SERVPA and the National MRC website by December 31, 2018.

Achieved:
A total of 100% of all data entered into SERVPA and National MRC website. A total of 175 individuals were enrolled in SERVPA. A total of 19 meetings were attended and BHB staff participated in 12 conference calls.

Objective 2: To integrate MRC unit member emergency response training and exercises with other local, state, or regional assets such as EMS, hospitals, community health centers, HCC and long-term care facilities in 100% of all planned training and exercises by December 31, 2018.

Achieved:
All MRC exercises include local, state, or regional assets.

Objective 3: To participate in at least 1 MRC volunteer recruitment event by December 31, 2018.

Achieved:
BHB staff participated in an MRC recruitment event at DeSales University to health and science students. Recruitment activities were also conducted via student internship program at BHB and social media. A total of 4 recruitment events were held in 2018.

Objective 4: To develop a training and exercise plan in collaboration with the HCC and other partners by December 31, 2018.

Achieved:
The training and exercise plan completed. A total of 1 orientation session was held, one NIMS training was held for volunteers, and 8 core competency based trainings were conducted. All trainings and agendas were documented in National MRC website.

Objective 5: To complete and submit bi-annual reports detailing all work completed using the work plan template provided by the Department by December 31, 2018.

Achieved:
Bi-annual reports were completed and submitted by required deadlines.

All reports submitted included the following information:

a. MRC membership by occupation category.
b. Number of new MRC members in SERVPA.

c. Total number of MRC unit members in SERVPA.
d. Progress on coordination with state and local partners including new partners, HCC and significant meetings or developments with partners.
e. Progress on training program including planned and completed trainings.
f. Progress on the exercise and rill plan including planned and completed exercise and drills.
g. Results of all volunteer recruitment activities
h. Progress reports from the National MRC website.

SERVPA mission and activity reports as requested by the Department.

Environmental Health Division

2018 Performance Review

FOOD SAFETY PROGRAM

Goal: To decrease incidence of food borne illnesses and assure the quality of food establishments in Bethlehem.

Objective 1: To inspect all food facilities, using a risk based approach, by December 31, 2018, including restaurants, retail, daycares, retail food establishments, mobile and temporary vending, schools, nursing homes, fraternal organizations, and churches.

Achieved:
In 2018, 884 food service inspections were performed (Table 1). All inspections were performed using a risk based approach, with each establishment receiving at a minimum one inspection. Those facilities recognized as being high risk were inspected a minimum of two times.

Table 1
Food Facility Inspection Summary

	2016	2017	2018
Permanent Food Facilities	**497**	**521**	**527**
Routine Inspections	504	581	479
Other Inspections (i.e. complaint, emergency response, follow-up, opening, owner change)	69	66	126
Temporary food stands inspected/licensed	211/509	253/536	278/538
Mobile food unit inspections	4	3	1
Total Food Facility Inspected	**788**	**903**	**884**

Objective 2: Establish a system to detect, collect, investigate and respond to complaints and emergencies that involve foodborne illness, injury, and intentional and unintentional food contamination as outlined in Standard 5 of the Voluntary National Retail Food Regulatory Program Standards. The policy and procedure will be audited

and approved by the FDA Voluntary National Retail Food Regulatory Program by September 30, 2018.

Not Achieved:
Environmental staff continue to develop a written emergency response protocol for food borne illness, injury and intentional and unintentional food contamination. Although progress has been made lack of devoted staff time and funding has prevented this goal from becoming fully achieved and will continue to be a goal for 2019.

INSTITUTION AND FACILITY INSPECTION PROGRAM

Goal: To assure protection against environmental hazards of all the residents in these institutions and to reduce the risk of environmental hazards at those areas.

Objective 1: To inspect the physical facilities of all institutions (i.e. nursing homes, schools and daycares) and all recreation facilities (i.e. parks and swimming pools) at least once a year, including long term care facilities, schools, daycares, and public bathing places.

Partially Achieved:
Due to staffing shortages all nursing home, schools, daycare centers and public bathing places were not inspected in 2018. All food service operations within these facilities (six (6) long term care, fifteen (15) schools, twenty-six (26) daycares) were inspected; however the facility/safety inspections were not completed. Although not all inspections were completed by City of Bethlehem personnel, various other state agencies did inspect the facilities (for example, Pennsylvania Departments of Health and Public Welfare). All public bathing place facilities (n= 15) that were open for the 2018 season were inspected, with no major violations.

WATER QUALITY AND WASTE MONITORING PROGRAM

Goal: To insure quality water for the City of Bethlehem and surrounding areas.

Objective 1: To review all monthly reports sent by the Department of Public Works during current year in order to maintain quality and detect problems.

Achieved:
All reports from the Public Works Department were reviewed and archived. Health Bureau staff assisted with two (2) water distribution issue involving broken water mains in 2018. All complaints regarding water distribution and potential health hazards were referred to the water department and support was provided as needed.

Objective 2: When requested, conduct on-lot sewage inspections and issue necessary permits as required by State regulations throughout 2018.

Achieved:
Four (4) site inspections were conducted resulting in two (2) soil tests, two (2) plan reviews and two (2) permits being issued in 2018. All permits utilized conventional trench systems, no alternative or experimental systems were approved and/or installed in 2018.

Objective 3: To respond and provide assistance to all pollution incidents threatening natural bodies of water located in the City of Bethlehem within two hours of notification throughout 2018.

Achieved:
No pollution incidents were reported in 2018.

SOLID WASTE MANAGEMENT

Goal: To reduce the hazard of solid waste contamination in the City of Bethlehem.

Objective 1: To respond within one working day to all notifications, complaints, health or sanitation related problems involving solid waste at commercial facilities throughout 2018.

Achieved:
Constant monitoring of solid waste haulers occurred throughout the year. No issues concerning solid waste transport or storage at a facility were referred to Department of Environmental Protection in 2018.

RESPONSIVE SERVICES

Goal: To reduce the hazards of environmental pollution in Bethlehem.

Objective 1: To respond within three workdays to 100% of health related public complaints received throughout 2018.

Achieved:
In 2018, 100% (n=1088) of all complaints were responded to within 48 hour working time period (Table 2). The largest responsive service continues to be accumulation of Solid Waste, specifically that cited under Section 1162.04(a), pertaining to maintaining the premises free form solid waste, garbage, rubbish and debris.

Table 2. Summary of Responsive Services in the City of Bethlehem

Response to:	2016	2017	2018
Vector responses (rats or insects)	97	104	70
Weed Overgrowth	321	484	379
Solid Waste	502	673	585
Animal Problems (fecal, increased numbers, illegal animals)	49	75	38
Citizen Unsanitary Living Conditions	14	13	3
Food/ Restaurant Complaints	7	4	4
Sewage	3	2	1
Public Bathing Place Complaint	9	10	2
Other	20	16	6
Total Complaints	1022	1381	1088
Confirmed Foodborne Outbreaks/People Ill	0/7	0/5	0/2

Objective 2: To initiate an investigation of all potential foodborne disease outbreaks in the City, within 1 hour of notification and/or classification of an outbreak (specific for each suspected agent) throughout 2018.

Achieved:
There were no confirmed food illness reported in 2018, however there were five food illness complaints (all unrelated). None of the individuals complaining of illness were willing/able to provide a specimen for testing; therefore the organism could not be identified. All suspect facilities were inspected by the Sanitarian on the same business day.

LEAD BASED PAINT ASSESSMENT PROGRAM

Goal: To identify and eliminate lead hazards in pre-1978 housing.

Objective 1: To conduct a Hazard Risk Assessment within 30-days of Health Bureau's notification by inspecting all dwelling units or other structures occupied or frequented by children between the ages 6 months to 6 years diagnosed with elevated blood lead levels of at least 10 micrograms of lead per deciliter of venous whole blood throughout 2018.

Achieved:
Two (2) child was found to have an elevated lead level in 2018. A complete risk assessment was completed by on one of the homes, and at the end of 2018 that home has been enrolled in our lead hazard control program. The parent of the other home refused entry to the investigation staff, causing staff to consult with the legal department

on ways to gain entry to the home. During the time period of this discussion the lead level of the child dropped to below action level, therefore no risk assessment was conducted at this time. Staff continue to monitor blood lead levels of this child.

Objective 2: To conduct education within 30-days of Health Bureau's notification of a child ages 6 months to 6 years diagnosed with elevated blood lead levels of at least 5 micrograms of lead per deciliter of venous whole blood throughout 2018.

Partially Achieved:
The National Electronic Disease Surveillance System (NEDSS) is checked daily in an effort to find children that have been reported as having elevated levels. When a level above 5 micrograms of lead/deciliter is reported, a letter providing basic education and information about our lead hazard control program is sent to the parent. During 2018, staff reached out to these parents to explain the lead hazard control program and attempt to enroll those individuals into the program, however further effort must be made to contact every child identified.

Objective 3: To perform risk assessments and lead hazard reduction in homes where a child under 6 years of age lives or spends significant amount of time (defined as more than 6 hours per week), within 30 days of participant enrollment in the Lead Hazard Reduction and Healthy Homes grant throughout 2018.

Achieved:
The City of Bethlehem was able to enroll eight (8) units into the lead hazard control grant in 2018. Of the 8 homes enrolled, six (6) had lead hazards remediated, and two (2) are currently in progress, estimated to be completed in the first quarter of 2019.

HEALTHY HOMES PROGRAM

Goal: Prevent diseases and injuries that result from housing related hazards and deficiencies

Objective 1: Reduce the number of housing units that have moderate or severe physical problems by at least 10% during the client's enrollment in the Lead and Healthy Homes program by December 31, 2018.

Achieved :
All homes that were enrolled into the Lead Hazard Control program had all healthy home concerns addressed, either by utilizing the Lead and Healthy Home, or by leveraging funding from CDBG Housing Rehabilitation Program. Corrected hazards included falls between levels, concerns regarding security and water intrusion, and the lack of appropriate fire/ carbon dioxide detectors.

Objective 2: Improve post education knowledge check results by at least 25%, thereby improving the client's knowledge base of how to maintain a healthy living environment by December 31, 2018.

Partially Achieved:
Every client enrolled in the Healthy Homes program was provided with the appropriate education and materials and/or tools needed to gain and maintain a healthy living environment for all residents of the home, from newborn to older adults. Clients were often referred to additional outside agencies in order to assist them in their quest for a healthy home. Such agencies include the various family centers throughout the city, parent groups, WIC, the Hispanic Center, Visiting Nurses Association, Head Start, the Lead Hazard Control Program, the Housing Rehab Program and many of the Health Department's services including Tobacco Cessation, Partners for a Healthy Baby, Cribs for Kids, Insurance Assistance, the Car Seat Rental Program and Immunizations to name a few.

Objective 3: Decrease the effects of allergens in the home for all Healthy Homes clients by eliminating and/or managing at least one identified allergen source during the client's enrollment in the Healthy Homes program by December 31, 2018.

Achieved:
Every client enrolled in the healthy homes program who claimed to have allergies or respiratory issues were given information regarding identifying and managing allergen triggers, and was also given supplies to help reduce/contain/eliminate allergen sources. Allergen sources were identified and suggestions/referrals were made to the client. When necessary, home owners or landlords were instructed to make contact with the proper pest management agency in order to eliminate pests, and in extreme cases code enforcement was called in to assist. Materials given out include but are not limited to: pest traps, Tupperware containers, allergen-free mattress and pillow covers and various cleaning supplies.

EDUCATIONAL SERVICES PROGRAM

Goal: To provide educational support for all environmental problems.

Objective 1: To educate a minimum of 100 food operators, facility staff, contractors, landlords and the general public about environmental safety including: sanitary hazards, lead poisoning, vector caused diseases and proper waste disposal by December 31, 2018.

Achieved:
This is an ongoing process performed during the inspection of the establishments, or via press releases, informational brochures, and general public meetings. The Environmental Staff held two (2) lead abatement contractor courses, certifying twenty-five (25) lead abatement workers. The Lead Hazard Control Program was able to pay

for the licensing of ten (10) of the contractors after they performed work for the lead hazard control program. Finally, education is an integral part of all our food facility inspections and every facility manager and/or operator received education on violations noted as well as the importance of employee personal hygiene (handwashing and employee illness policy).

Objective 2: To assist restaurant owners and workers obtain food employee certification by holding a minimum of two City of Bethlehem sponsored certification course by December 31, 2018 and proctor examinations as requested.

Achieved**:**
Three (3) ServSafe Food Manager's Certification courses were held in August, November and December 2018 to assist food facilities meet the requirements of licensure renewal. A total of sixty four (64) individuals were instructed in Food Safety and sat for the credentialing exam immediately following the course. A total of eleven (11) individuals received private instruction and testing after completing the required on-line course.

PART FOUR
PROGRAM PLANS

Accreditation

Accreditation is a five year voluntary recognition that recognizes health departments who meet a set of core standards. Accreditation promotes high performance and continuous quality improvement; recognizes high performers that meet nationally accepted standards of quality and improvement; illustrates health department accountability to the public and policymakers; increases the visibility and public awareness of governmental public health, leading to greater public trust and increased health department credibility, and ultimately a stronger constituency for public health funding and infrastructure; and clarifies the public's expectations of health departments. The Bethlehem Health Bureau received accreditation status in March 2017.

	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
G Acc To become a high-performing accredited health department that successfully meets core public health standards.				
LO Acc Accreditation Status and Re-accreditation status	2017	1	–	–
O Acc To receive accreditation status.				
E Acc Accreditation status	2017	1	–	–
O Acc To increase the number of performance measures that are performing "at or above target".				
E Acc Number of slightly demonstrated measures.	2018	8	–	↘ 1
E Acc Number of not demonstrated measures.	2018	1	–	↘ 1
E Acc Number of fully demonstrated measures.	2018	34	–	↗ 1
E Acc Number of largely demonstrated measures.	2018	54	–	↗ 1

Mental Health

Mental health is an important part of overall health and well-being. Mental health includes our emotional, psychological, and social well-being. Mental illnesses are among the most common health conditions in the United States. According to the CDC, more than 50% of Americans will be diagnosed with a mnetal illness or disorder at some point in their lifetime.

Several years ago, the Bethlehem Health Bureau instituted screening protocols for all clinic patients and home visit clients for depression using the PHQ-2 and PHQ-9 tools. If a person screens positive, they are referred to care as approriate.

G MH To connect individuals who screen high risk for depression to mental health care.	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
LO MH Poor mental health days	–	–	–	–

O MH Complete depression screens on all clinic patients and home visit clients and connect 100% of individuals who screen high risk to mental health services by December 31, 2019.	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
E MH Number of programs utilizing the screening tool	–	–	–	–
E MH Percent of clients screened who are identified as high risk	–	–	–	–
E MH Percent of clients who screen high risk who are referred to treatment	–	–	–	–
E MH Percent of clients referred to care who receive treatment	–	–	–	–
E MH Number of clinic patients.	–	–	–	–
E MH Number of PFHB clients.	–	–	–	–
E MH Total number of clinic and PFHB clients.	–	–	–	–
E MH Number of clinic patients screened.	–	–	–	–
E MH Number of PFHB clients screened.	–	–	–	–
E MH Total number of clinic patients and PFHB clients screened.	–	–	–	–
E MH Percent of clinic patients and PFHB clients screened.	–	–	–	–
E MH Number of PFBB clients who screen high risk.	–	–	–	–
E MH Number of home visit clients who screen high risk.	–	–	–	–
E MH Total number of clinic patients and PFHB clients who screen high risk.	–	–	–	–
E MH Number of PFHB clients referred to treatment.	–	–	–	–
E MH Number of clinic patients referred to treatment.	–	–	–	–
E MH Total number of clinic patients and PFHB clients referred to treatment.	–	–	–	–
E MH Percentage of clinic patients and PFHB clients who screen high risk and were referred to treatment.	–	–	–	–

Grant and Insurance Revenue

Tracking the revenue we receive through grants and billing insurance companies for services.

			Most Recent Period	Current Actual Value	Current Target Value	Current Trend
G	Revenue	Increase revenues from grants and billing in order to generate additional funds to address priority health issues and support critical health department operations.				
LO	Revenue	Total insurance (billing) revenue	Q4 2018	11,421	–	↗ 1
LO	Revenue	Total grant revenue	Q4 2018	308,678	–	↘ 2
O	Revenue	Increase billing revenue by 10% from baseline.				
E	Revenue	Number of programs and services BHB bills for	2018	4	–	→ 0
E	Revenue	Percent of unpaid claims	Q2 2018	62	–	↗ 1
E	Revenue	Number of new services being billed	2018	0	–	→ 0
O	Revenue	Increase grant revenue by 5% from baseline.				
E		Number of new grant applications submitted.	Q4 2018	1	–	↘ 1
E		Number of new grant applications received.	Q4 2018	1	–	→ 3

Heroin and Opioid Overdoses

Heroin and opioid overdoses are a serious public health threat impacting Northampton County, Pennsylvania and the nation. Northampton County, like many other communities across the country, has seen an increase in heroin and opioid use over the last few years.

To confront the crisis, the Northampton County Heroin and Opioid Task Force was formed to create a multi-faceted approach to reduce overdoses and deaths accoated with heroin and opioid use in Northampton County.

G HO To decrease number of heroin and opioid deaths in Northampton County.	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
LO HO Number of heroin and opioid deaths.	–	–	–	–
LO HO Number of Drug Overdose deaths	2019	291	–	↗ 2
LO HO Drug overdose motatlity rate	2019	32%	–	↗ 2

Performance Accountability

O HO Reduce the number of heroin and opioid overdoses in Northampton County by 5% from baseline.	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
E HO Number of PAIR participants	Q4 2018	23	–	↗ 2
E HO Number of home visits conducted	Q4 2018	32	–	↘ 1
E HO Number of advertising campaigns conducted	Q1 2019	2	–	↗ 2
E HO Number of naloxone kits distributed to public	Q4 2018	76	–	→ 0
E HO Number of individuals entering treatment from PAIR and home visits	2018	12	–	→ 0
E HO Number of heroin and opioid overdoses	Q4 2018	126	–	↘ 2
E Number of naloxone administrations by first responders	Q4 2018	26	–	↘ 1

Community Health Improvement Plan 2017-2019

A community health improvement plan is a long-term, systematic effort to address public health problems based on the results of community health assessment activities and the community health improvement process. BHB's Community Health Improvement Plan focus area's include substance abuse, housing, mental health and healthy lifesyles.

		Most Recent Period	Current Actual Value	Current Target Value	Current Trend
G	HO To decrease number of heroin and opioid deaths in Northampton County.				
LO	HO Number of heroin and opioid deaths.	–	–	–	–
LO	HO Number of Drug Overdose deaths	2019	291	–	↗ 2
LO	HO Drug overdose motatlity rate	2019	32%	–	↗ 2
G	MH To connect individuals who screen high risk for depression to mental health care.	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
LO	MH Poor mental health days	–	–	–	–

Quality Improvement Plan 2017-2019

A Quality Improvement Plan is a detailed work plan intended to enhance an organization's quality in a specific area of need. A Quality Improvement Plan includes essential information about how your organization will design, implement, manage, and assess quality. The purpose of the plan is to increase the efficiency and the effectiveness of the services/programs that the Bethlehem Health Bureau offers through ongoing efforts to improve services, systems or processes. These efforts can seek incremental improvements over time or "breakthrough" improvements all at once. BHB used the Plan, Do, Check Act cycle as part of the QI process in addition to Kaizen, Waste, Lean, Mapping, Root Cause Analysis and Six Sigma.

			Most Recent Period	Current Actual Value	Current Target Value	Current Trend
G	Revenue	Increase revenues from grants and billing in order to generate additional funds to address priority health issues and support critical health department operations.				
LO	Revenue	Total insurance (billing) revenue	Q4 2018	11,421	–	↗ 1
LO	Revenue	Total grant revenue	Q4 2018	308,678	–	↘ 2
G	Acc	To become a high-performing accredited health department that successfully meets core public health standards.				
LO	Acc	Accreditation Status and Re-accreditation status	2017	1	–	–
G	QC	To improve health outcomes among clients receiving BHB clinical services.				
LO	QC	Percentage of clients who rate services as Good	–	–	–	–

Strategic Plan 2017-2019

The Bethlehem Health Bureau is committed to providing high quality public health services that protect and promote the health of the residents we serve. The Bethlehem Health Bureau serves every City of Bethlehem resident and offers preventive care such as vaccines; conducts restaurant food inspections to ensure the safety of the food; provides smoking cessation programs to assist individuals with quitting smoking; conducts investigations in order to stop the spread of communicable diseases; facilitates fall prevention programs with the elderly; and prepares residents for emergency situations, among many other programs.

Healthy Bethlehem was developed to guide the planning, priorities, and decision making for the Bethlehem Health Bureau over the next three years. The Strategic Planning Committee took a comprehensive approach to creating an agency-wide strategic plan aimed at improving health outcomes, creating a more efficient organization, and providing effective public health programming.

Development of this strategic plan was based on the National Association of City and County Health Officers' (NACCHO) planning model for local health departments. Healthy Bethlehem outlines the strategic initiatives along with the objectives, tactics, and measures to achieve those goals. This strategic plan, developed in alignment with data obtained from the community health needs assessment, local health status indicators, local demographic trends, and legislative priorities, will guide the Health Bureau's efforts over the next three years.

The Bethlehem Health Bureau looks forward to working with our community partners, key stakeholders and residents in an effort to fulfill our mission and create a healthier Bethlehem.

		Most Recent Period	Current Actual Value	Current Target Value	Current Trend
G	Revenue Increase revenues from grants and billing in order to generate additional funds to address priority health issues and support critical health department operations.				
LO	Revenue Total insurance (billing) revenue	Q4 2018	11,421	–	↗ 1
LO	Revenue Total grant revenue	Q4 2018	308,678	–	↘ 2
G	HO To decrease number of heroin and opioid deaths in Northampton County.				
LO	HO Number of heroin and opioid deaths.	–	–	–	–
LO	HO Number of Drug Overdose deaths	2019	291	–	↗ 2
LO	HO Drug overdose motatlity rate	2019	32%	–	↗ 2
G	Acc To become a high-performing accredited health department that successfully meets core public health standards.				
LO	Acc Accreditation Status and Re-accreditation status	2017	1	–	–

Workforce Development

The Workforce Development Team assists with identifying gaps in staff knowledge and skills and providing training opportunities to decrease those gaps.

		Most Recent Period	Current Actual Value	Current Target Value	Current Trend
G	WFD Ensure the maintenance of a highly skilled, well-trained, culturally competent BHB workforce				
O	WFD A minimum of 90% of BHB staff will agree or strongly agree that workforce development trainings have increased the knowledge and skills related to the programs and work activities they perform.	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
E	WFD Percent of staff who complete training needs assessment.	–	–	–	–
E	WFD Number of gaps identified	–	–	–	–
E	WFD Number of workforce development team meetings	–	–	–	–
E	WFD Percent of trainings that align with gaps	–	–	–	–
E	WFD Percent increase in knowledge and skills among staff	–	–	–	–
E	WFD Number of staff	–	–	–	–
E	WFD Number of staff who complete training needs assessment.	–	–	–	–
E	Number of workforce development trainings.	–	–	–	–
E	Number of workforce development trainings that align with gaps.	–	–	–	–

Communicable Disease

The Communicable Disease Program protects the public from the spread of communicable diseases. The Communicable Disease Program actively works to contain and prevent diseases by investigating individuals diagnosed with a communicable disease; responding to outbreaks in the community; offering vaccinations; testing individuals for certain communicable diseases to confirm the presence of a disease or virus; educating the public and health care providers; and performing disease surveillance activities.

G CD Reduce the transmission of communicable diseases	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
LO CD Number of confirmed Chlamydia cases	Feb 2019	36	–	↘ 1
LO CD Number of confirmed Gonorrhea cases	Feb 2019	8	–	↗ 1
LO CD Number of confirmed Hepatitis A cases	Feb 2019	0	–	→ 3
LO CD Number of confirmed Hepatitis B cases	Feb 2019	0	–	↘ 1
LO CD Number of confirmed Hepatitis C cases	Feb 2019	1	–	→ 1
LO CD Number of confirmed Legionella cases	Feb 2019	0	–	→ 3
LO CD Number of confirmed Lyme cases	Feb 2019	2	–	↗ 1
LO CD Number of confirmed Salmonellosis cases	Feb 2019	0	–	→ 3
LO CD Number of confirmed Syphilis cases	Feb 2019	1	–	↘ 1
LO CD Number of confirmed Zika cases	Feb 2019	0	–	→ 13
LO CD Number of confirmed Acid Fast Bacillli cases	Mar 2019	0	–	→ 14
LO CD Number of confirmed active TB cases	Feb 2019	0	–	→ 9
LO CD Number of confirmed Amebiasis cases	Feb 2019	0	–	→ 13
LO CD Number of confirmed Campylobacteriosis cases	Feb 2019	0	–	→ 12
LO CD Number of confirmed Chikungunya cases	Feb 2019	0	–	→ 13
LO CD Number of confirmed Cryptosporidosis cases	Feb 2019	0	–	→ 5
LO CD Number of confirmed Dengue Fever cases	Feb 2019	0	–	→ 13
LO CD Number of confirmed Ehrlichiosis or Anaplasmosis cases	Feb 2019	0	–	→ 13
LO CD Number of confirmed Encephalitis cases	Feb 2019	0	–	→ 8
LO CD Number of confirmed E Coli Cases	Feb 2019	0	–	→ 6
LO CD Number of confirmed Giardiasis cases	Feb 2019	0	–	→ 5
LO CD Number of confirmed Guillian Barre cases	Feb 2019	0	–	→ 2
LO CD Number of confirmed HIB cases	Feb 2019	0	–	→ 12
LO CD Number of confirmed Herpes Zoster cases	Feb 2019	1	–	↗ 1
LO CD Number of confirmed Histoplasmosis cases	Feb 2019	0	–	→ 13
LO CD Number of confirmed Listeriosis cases	Feb 2019	0	–	→ 13
LO CD Number of confirmed Measles cases	Feb 2019	0	–	→ 13

LO CD Number of confirmed Meningitis cases (asepetic)	Feb 2019	0	–	→	6
LO CD Number of confirmed Mumps cases	Feb 2019	0	–	→	13
LO CD Number of confirmed Norovirus cases	Feb 2019	0	–	→	13
LO CD Number of confirmed Pertussis cases	Feb 2019	0	–	→	13
LO CD Number of confirmed Shigella cases	Feb 2019	0	–	→	4
LO CD Number of confirmed Streptococcal A cases	Feb 2019	1	–	→	1
LO CD Number of confirmed Streptococcal Pneumoniae cases	Feb 2019	0	–	→	7
LO CD Number of confirmed Toxoplasmosis cases	Feb 2019	0	–	→	13
LO CD Number of confirmed Typhus/Rickettsial cases	Feb 2019	0	–	→	13
LO CD Number of confirmed Varicella Zoster cases	Feb 2019	0	–	→	13
LO CD Number of confirmed West Nile cases	Feb 2019	0	–	→	13
O CD To increase the identification and reduce the transmission of communicable diseases by investigating 100% of Notifiable Disease Reports, National Electronic Data Surveillance System (NEDSS) reports, suspect and confirmed communicable disease outbreaks in accordance with the guidelines.	Time Period	Current Actual Value	Current Target Value	Current Trend	
E CD Number of Chlamydia reports	Feb 2019	46	–	↗	1
E CD Number of Chlamydia investigations	–	–	–	–	
E CD Number of Gonorrhea reports	Feb 2019	16	–	↗	1
E CD Number of Gonorrhea investigations	–	–	–	–	
E CD Number of Hepatitis A reports	Feb 2019	6	–	↘	2
E CD Number of Hepatitis A investigations	–	–	–	–	
E CD Number of Hepatitis B reports	Feb 2019	17	–	↘	1
E CD Number of Hepatitis B investigations	–	–	–	–	
E CD Number of Hepatitis C reports	Feb 2019	79	–	↘	1
E CD Number of Hepatitis C investigations	–	–	–	–	
E CD Number of Legionella disease reports	Feb 2019	0	–	→	3
E CD Number of Legionella investigations	–	–	–	–	
E CD Number of Lyme disease reports	Feb 2019	2	–	↘	1
E CD Number of Lyme disease investigations	–	–	–	–	
E CD Number of Salmonellosis reports	Feb 2019	1	–	→	1
E CD Number of Salmonellosis investigations	–	–	–	–	
E CD Number of Syphilis reports	Feb 2019	13	–	↘	1
E CD Number of Syphilis investigations	–	–	–	–	
E CD Number of Zika reports	Feb 2019	0	–	→	1

E CD Number of Zika investigations	–	–	–	–
E CD Percentage of Chlamydia reports investigated	–	–	–	–
E CD Percentage of Gonorrhea reports investigated	–	–	–	–
E CD Percentage of Hepatitis A reports investigated	–	–	–	–
E CD Percentage of Hepatitis B reports investigated	–	–	–	–
E CD Percentage of Hepatitis C reports investigated	–	–	–	–
E CD Percentage of Lyme reports investigated	–	–	–	–
E CD Percentage of Salmonellosis reports investigated	–	–	–	–
E CD Percentage of Legionella reports investigated	–	–	–	–
E CD Percentage of Syphilis reports investigated	–	–	–	–
E CD Percentage of Zika reports investigated	–	–	–	–
E CD Number of Acid Fast Bacilli reports	Feb 2019	3	–	↗ 1
E CD Number of Acid Fast Bacilli investigations	–	–	–	–
E CD Percentage of Acid Fast Bacilli reports investigated	–	–	–	–
E CD Number of Active TB reports	Feb 2019	0	–	→ 9
E CD Number of Active TB investigations	–	–	–	–
E CD Percentage of Active TB reports investigated	–	–	–	–
E CD Number of Amebiasis reports	Feb 2019	0	–	→ 5
E CD Number of Amebiasis investigations	–	–	–	–
E CD Percentage of Amebiasis reports investigated	–	–	–	–
E CD Number of Campylobacteriosis reports	Feb 2019	0	–	↘ 1
E CD Number of Campylobacteriosis investigations	–	–	–	–
E CD Percentage of Campylobacteriosis reports investigated	–	–	–	–
E CD Number of Chikungunya reports	Feb 2019	0	–	→ 9
E CD Number of Chikungunya investigations	–	–	–	–
E CD Percentage of Chikungunya reports investigated	–	–	–	–
E CD Number of Cryptosporidosis reports	Feb 2019	0	–	→ 5
E CD Number of Cryptosporidosis investigations	–	–	–	–
E CD Percentage of Cryptosporidosis reports investigated	–	–	–	–
E CD Number of Dengue Fever reports	Feb 2019	0	–	→ 9
E CD Number of Dengue Fever investigations	–	–	–	–
E CD Percentage of Dengue Fever reports investigated	–	–	–	–

E CD Number of Ehrlichiosis or Anaplasmosis reports	Feb 2019	0	–	→	13
E CD Number of Ehrlichiosis or Anaplasmosis investigations	–	–	–	–	
E CD Percentage of Ehrlichiosis or Anaplasmosis reports investigated	–	–	–	–	
E CD Number of Encephalitis reports	Feb 2019	0	–	→	8
E CD Number of Encephalitis investigations	–	–	–	–	
E CD Percentage of Encephalitis reports investigated	–	–	–	–	
E CD Number of E Coli reports	Feb 2019	1	–	→	1
E CD Number of E Coli investigations	–	–	–	–	
E CD Percentage of E Coli reports investigated	–	–	–	–	
E CD Number of Giardiasis reports	Feb 2019	0	–	→	5
E CD Number of Giardiasis investigations	–	–	–	–	
E CD Percentage of Giardiasis reports investigated	–	–	–	–	
E CD Number of Guillian Barre reports	Feb 2019	0	–	→	2
E CD Number of Guillian Barre investigations	–	–	–	–	
E CD Percentage of Guillian Barre reports investigated	–	–	–	–	
E CD Number of HIB reports	Feb 2019	0	–	→	12
E CD Number of HIB investigations	–	–	–	–	
E CD Percentage of HIB reports investigated	–	–	–	–	
E CD Number of Herpes Zoster reports	Feb 2019	1	–	↗	1
E CD Number of Herpes Zoster investigations	–	–	–	–	
E CD Percentage of Herpes Zoster reports investigated	–	–	–	–	
E CD Number of Histoplasmosis reports	Feb 2019	0	–	→	13
E CD Number of Histoplasmosis investigations	–	–	–	–	
E CD Percentage of Histoplasmosis reports investigated	–	–	–	–	
E CD Number of Listeriosis reports	Feb 2019	0	–	→	13
E CD Number of Listeriosis investigations	–	–	–	–	
E CD Percentage of Listeriosis reports investigated	–	–	–	–	
E CD Number of Measles reports	Feb 2019	0	–	→	13
E CD Number of Measles reports investigated	–	–	–	–	
E CD Percentage of Measles reports investigated	–	–	–	–	
E CD Number of Meningitis (aseptic) reports	Feb 2019	1	–	↗	1
E CD Number of Meningitis (aseptic) investigations	–	–	–	–	

E CD Percentage of Meningitis reports investigated	–	–	–	–
E CD Number of Mumps reports	Feb 2019	0	–	→ 5
E CD Number of Mumps investigations	–	–	–	–
E CD Percentage of Mumps reports investigated	–	–	–	–
E CD Number of Norovirus reports	Feb 2019	0	–	→ 13
E CD Number of Norovirus investigations	–	–	–	–
E CD Percentage of Norovirus reports investigated	–	–	–	–
E CD Number of Pertussis reports	Feb 2019	0	–	→ 1
E CD Number of Pertussis investigations	–	–	–	–
E CD Percentage of Pertussis reports investigated	–	–	–	–
E CD Number of Influenza A reports	Feb 2019	114	–	↘ 1
E CD Number of Influenza B reports	Feb 2019	1	–	→ 1
E CD Number of Influenza, other unspecified, reports	Feb 2019	1	–	↗ 1
E CD Number of RSV reports	Feb 2019	22	–	↘ 2
E CD Number of Shigella reports	Feb 2019	1	–	↘ 1
E CD Number of Shigella investigations	–	–	–	–
E CD Percentage of Shigella reports investigated	–	–	–	–
E CD Number of Streptococcal A reports	–	–	–	–
E CD Number of Streptococcal A investigations	–	–	–	–
E CD Percentage of Streptococcal A reports investigated	Feb 2019	1	–	↘ 1
E CD Number of Streptococcal Pneumoniae reports	Feb 2019	0	–	→ 6
E CD Number of Streptococcal Pneumoniae investigations	–	–	–	–
E CD Percentage of Streptococcal Pneumoniae reports investigated	–	–	–	–
E CD Number of Toxoplasmosis reports	Feb 2019	1	–	↗ 1
E CD Number of Toxoplasmosis investigations	–	–	–	–
E CD Percentage of Toxoplasmosis reports investigated	–	–	–	–
E CD Number of Typhus/Rickettsial reports	Feb 2019	0	–	→ 13
E CD Number of Typhus/Rickettsial investigations	–	–	–	–
E CD Percentage of Typhus/Rickettsial reports investigated	–	–	–	–
E CD Number of Varicella Zoster reports	Feb 2019	0	–	→ 4
E CD Number of Varicella Zoster investigations	–	–	–	–
E CD Percentage of Varicella Zoster reports investigated	–	–	–	–

E CD Number of West Nile Virus reports	Feb 2019	0	–	→ 2
E CD Number of West Nile Virus investigations	–	–	–	–
E CD Percentage of West Nile Virus reports investigated	–	–	–	–

HIV/AIDS

The Bethlehem Health Bureau (BHB) provides voluntary opt-out, routine HIV testing in its public health clinics in conjunction with Sexually Transmitted Disease (STD) (e.g., syphilis, gonorrhea, Chlamydial infection), Hepatitis C Virus (HCV), and Tuberculosis (TB) testing, including referral and linkage to appropriate services, where feasible and appropriate in accordance with CDC's 2006 "Revised Recommendations for HIV Testing of Adults, Adolescents, and Pregnant Women in Health-Care Settings". BHB also conducts partner services and surveillance activities in an effort to decrease the incidence of HIV in the City of Bethlehem.

Population Accountability

		Most Recent Period	Current Actual Value	Current Target Value	Current Trend
G HIV	To reduce the spread of HIV and its consequences to health within the City of Bethlehem.				
LO HIV	Number of new HIV cases	–	–	–	–

Performance Accountability

		Most Recent Period	Current Actual Value	Current Target Value	Current Trend
O HIV	A minimum of 80% of BHB clients tested for Chlamydia and Gonorrhea will receive an HIV test				
E HIV	Number of clients tested for Chlamydia and Gonorrhea.	–	–	–	–
E HIV	Number of clients who came in for CT/GC and also received an HIV test.	–	–	–	–
E HIV	Percentage of clients who came in for CT/GC and also received an HIV test.	–	–	–	–
E HIV	Total number of condoms distributed.	–	–	–	–
E HIV	Number of clients reporting using condoms.	–	–	–	–
E HIV	Percent of clients reporting use of condoms.	–	–	–	–
O HIV	Interview a minimum of 85% of HIV positive clients who are eligible for partner services				
E HIV	Number of HIV positive individuals interviewed for partner services.	Q1 2019	5	–	→ 0
E HIV	Number of HIV positive individuals eligible to be interviewed for partner services.	–	–	–	–
E HIV	Percent of HIV positive individuals interviewed for partner services.	–	–	–	–
E HIV	Number of contacts named and located	–	–	–	–
E HIV	Number of contacts named and located tested who were tested.	–	–	–	–
E HIV	Percentage of named contacts who were tested.	–	–	–	–
E HIV	Total number of STD Other non-reportable investigations opened.	–	–	–	–
E HIV	Percentage of partners referred to HIV navigational services, PrEP, STD testing and other support services.	–	–	–	–
E HIV	Number of partners referred to HIV navigational services, PrEP, STD testing and other support services.	Feb 2019	2	–	→ 0
O HIV	All investigations missing Pa Central Office required fields will be completed for 90% of confirmed new cases reported through PA NEDSS				
E HIV	Number of new HIV investigations reported through Pa NEDSS with in two weeks.	–	–	–	–
E HIV	Number of new HIV investigations reported through Pa NEDSS.	–	–	–	–
E HIV	Percent of all new HIV investigations reported through Pa NEDSS within two weeks of receipt .	–	–	–	–
E HIV	Number of CDC required fields that are totally completed for confirmed new diagnoses.	–	–	–	–
E HIV	Percentage of CDC required fields that are totally completed for confirmed new diagnoses.	–	–	–	–

			Most Recent Period	Current Actual Value	Current Target Value	Current Trend
O	HIV	Achieve a .004% HIV positivity rate of newly identified HIV positives tested through BHB				
E	HIV	Total number of HIV positive clients receiving their results.	–	–	–	–
E	HIV	Total number of HIV positive test results.	–	–	–	–
E	HIV	Percent of clients testing HIV positive and getting their test result.	–	–	–	–
E	HIV	Number of HIV positive clients referred and are linked to medical care and attend their first appointment within three months of diagnosis.	–	–	–	–
E	HIV	Percentage of clients receiving a HIV positive test result and are linked to medical care and attend their first appointment within three months of diagnosis.	–	–	–	–
E	HIV	Number of HIV positive clients who are referred and linked to Partner Services in six months.	–	–	–	–
E	HIV	Percentage of clients testing HIV positive who are referred and linked to Partner Services in six months.	–	–	–	–
E	HIV	Total number of individuals tested for HIV.	–	–	–	–
E	HIV	Percent of clients who test positive for HIV.	–	–	–	–
O	HIV	A minimum of 80% of PLWH/A lost to care and referred to D2C will be linked to care and support services	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
E	HIV	Total numbers of providers making referrals of PLWH/A who were lost to care.	–	–	–	–
E	HIV	Total number of clients linked to care	–	–	–	–
E	HIV	Percent of PLWH/A lost to care and referred to D2C will be linked to care and support services	–	–	–	–
O	HIV	A minimum of 20% individuals who are referred to PrEP actually receive PrEP.	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
E	HIV	Number of individuals referred for PrEP through the Department of Health.	–	–	–	–
E	HIV	Number of high risk individuals will be referred to PrEP through BHB.	–	–	–	–
E	HIV	Total number of individuals who are referred to PrEP.	–	–	–	–
E	HIV	Number of individuals who are referred to PrEP who actually receive PrEP.	–	–	–	–
E	HIV	Percentage of individuals who are referred to PrEP who actually receive PrEP.	–	–	–	–

Quality Care

The Bethlehem Health Bureau is committed to providing quality public health services to all clients. In an effort to fulfill this goal, various clinical services are monitored to ensure that appropriate screenings and referrals are completed.

	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
G QC To improve health outcomes among clients receiving BHB clinical services.				
LO QC Percentage of clients who rate services as Good	–	–	–	–
O QC To connect a minimum of 10 STD clients to family planning services.				
E QC Percentage of female STD patients attending family planning clinic.	–	–	–	–
O QC Screen and educate 95% of clinic and program female patients about intimate partner violence (IPV) and healthy relationships.				
E QC Percentage of patients screened for IPV and provided a healthy relationships care.	–	–	–	–
O QC A total of 100% of female clinic and program patients will have One Key Question (OKQ) reproductive life plan assessment, with appropriate education and interventions.				
E QC Percent of family planning clients completing OKQ.	–	–	–	–
O QC A minimum of 5 clients will join the patient portal.				
E QC Number of clients joining patient portal.	–	–	–	–
O QC To connect 100% of internally referred clients to other BHB services.				
E QC Number of internal referrals	–	–	–	–
E QC Total number of people connected to other BHB services	–	–	–	–
E QC Percentage of individuals connected to other BHB services	–	–	–	–

STD

The Bethlehem Health Bureau is an organization dedicated to providing both preventative and curative care for sexually transmitted diseases (STDs) within the City of Bethlehem and surrounding areas. The investigation and surveillance of STD reportable infections in the City through the PA-National Electronic Disease Surveillance System (NEDSS) is a required component of Act 315 activities. The state funded Sexually Transmitted Disease Clinic follows the rules and regulations as set forth by the Pennsylvania Department of Health in all prevention and treatment activities. The mission of the STD program at the Bethlehem Health Bureau is to help reduce the spread of STDs and their consequences on the health of our community. This is accomplished through the accessibility of STD clinic services, testing/treatment, partner elicitation/notification, surveillance and investigation of reported STDs, and education of clients. Collaboration with other healthcare providers to assure that the most current recommended CDC treatment guidelines is promoted.

		Most Recent Period	Current Actual Value	Current Target Value	Current Trend
G STD	To reduce the transmission of sexually transmitted diseases, and their respective health consequences in Bethlehem.				
LO STD	Number of Gonorrhea cases in Bethlehem	–	–	–	–
LO STD	Number of Chlamydia cases in Bethlehem.	–	–	–	–
LO STD	Number of Syphilis cases in Bethlehem.	–	–	–	–
LO STD	Number of congenital Syphilis cases in Bethlehem.	–	–	–	–
O STD	A minimum of 95% of STD patients who are treated for Chlamydia, Gonorrhea, and/or Syphilis will not re-infected.				
E STD	Number of individuals who test positive for Chlamydia, Gonorrhea and/or Syphilis.	–	–	–	–
E STD	Number of individuals who test positive for an STD who receive adequate treatment.	–	–	–	–
E STD	Percentage of STD positive patients who receive adequate treatment.	–	–	–	–
E STD	Number of STD positive patients who are interviewed.	–	–	–	–
E STD	Percentage of STD positive patients who are interviewed.	–	–	–	–
E STD	Number of STD positive patients who name at least one partner.	–	–	–	–
E STD	Percentage of STD positive patients who name at least one partner.	–	–	–	–
E STD	Number of STD positive patients' partners who receive expedited therapy.	–	–	–	–
E STD	Number of STD positive patients who receive treatment and return for a test of cure at 3 months.	–	–	–	–
E STD	Percentage of STD positive patients who return for a test of cure at 3 months.	–	–	–	–
E STD	Number of STD positive patients' partners who receive an STD test	–	–	–	–
E STD	Number of partners named	–	–	–	–
E STD	Percentage of partners who receive an STD test	–	–	–	–
E STD	Number of partners who receive a positive STD result	–	–	–	–
E STD	Number of partners who test positive who receive treatment.	–	–	–	–
E STD	Percentage of partners who test positive who received treatment.	–	–	–	–
E STD	Number of STD positive patients who get re-infected.	–	–	–	–
O STD	A minimum of 40% of STD clients who are aged 40 years and older will be tested for Hepatitis C.				
E STD	Number of STD clients over 40 who are tested for Hepatitis C	–	–	–	–
E STD	Number of newly identified chronic Hepatitis C cases.	–	–	–	–

E STD Number of Hepatitis C patients who name a partner	–	–	–	–
E STD Percentage of Hepatitis C patients who name a partner.	–	–	–	–
E STD Number of Hepatitis C patients who are linked to care.	–	–	–	–
E STD Percentage of Hepatitis C patients who are linked to care.	–	–	–	–
E STD Number of named partners who receive a Hepatitis C test.	–	–	–	–
E STD Percentage of partners tested for Hepatitis C.	–	–	–	–
E STD Number of STD clients over 40 years of age.	–	–	–	–
E STD Percentage of STD clients over 40 years of age tested for Hepatitis C.	–	–	–	–
O STD A minimum of 75% of MSM clients attending STD clinic will be tested for pharyngeal and/or rectal Chlamydia and Gonorrhea.	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
E STD Number of MSM clients attending STD clinic.	–	–	–	–
E STD Number of MSM clients tested for throat and rectal Chlamydia and Gonorrhea.	–	–	–	–
E STD Percentage of MSM clients receiving throat and rectal Chlamydia and Gonorrhea tests.	–	–	–	–
E STD Number of MSM clients referred to PrEP	–	–	–	–
E STD Percentage of MSM clients referred to PrEP	–	–	–	–

TB

The World Health Organization reported that Tuberculosis (TB) is the ninth leading cause of death worldwide and the leading cause from a single infectious agent, ranking above HIV/AIDS. In 2016, there were an estimated 1.3 million TB deaths among HIV-negative people (down from 1.7 million in 2000) and an additional 374 000 deaths among HIV-positive people. An estimated 10.4 million people fell ill with TB in 2016.

Eliminating tuberculosis (TB) will require interrupting TB transmission as well as major efforts to address latent TB infection. In 2016, a total of 9,272 TB cases were reported in the United States. This represents a 2.9% decrease from 2015. However, epidemiologic modeling demonstrates that if similar slow rates of decline continue, the goal of U.S. TB elimination will not be reached during this century. Although current programs to identify and treat active TB disease must be maintained and strengthened, increased measures to identify and treat latent TB infection (LTBI) among populations at high risk are also needed to accelerate progress toward TB elimination. TB was reported in all 50 states. Nine states, the District of Columbia (DC), and New York City reported incidence rates above the national average. TB case counts were highest in California, Texas, New York (including New York City), and Florida. These four states accounted for just over half of the total cases in the United States.

In 2015, the United States reported 9,563 cases of TB. During that same year, Pennsylvania had 200 cases. The number of tuberculosis cases in Pennsylvania decreased from 208 in 2014 to 200 in 2015, which represents a 3.8 percent decrease.

Over the past five years, the number of TB cases in Pennsylvania has decreased by a total of 23 percent - from 260 in 2011 to 234 in 2012, 214 in 2013, 208 in 2014 and now 200 in 2015.

In 2016, the most common form of primary resistance was isoniazid (INH) mono-resistance or INH only resistance. INH only resistance occurred in 577 cases (8.7% of cases with drug susceptibility results).Multidrug-resistant TB (MDR TB) is resistant to both isoniazid (INH) and rifampin (RIF). There were 96 MDR TB cases (1.4% of cases with drug susceptibility results) in 2016.Extensively drug-resistant TB (XDR TB) is resistant to INH and RIF, any fluoroquinolone, and at least one of three of the injectable second-line anti-TB drugs. There was 1 case of XDR TB in 2016.

Although the rate of extensively drug-resistant (XDR) TB doubled between 2012 and 2013, the rate was cut in half between 2013 and 2014 from 4 cases to 2 cases nationwide. In 2014, Pennsylvania had one cases of multi-drug resistant TB as well as 3.2% of cases resistant to at least one primary drug in 2013. Although the rates of MDR as well as XDR cases are declining, it is important that the Bethlehem Health Bureau continue its TB control strategies including; education about TB and its communicability, ensuring the use of Directly Observed Therapy (DOT) procedures for active cases, and confirming completion of treatment with latent TB infected patients to prevent increased drug resistance. In accordance with the Tuberculosis Control Program policy the Bethlehem Health Bureau will continue mandatory DOT for 100% of active TB clients and DOPT (Directly Observed Preventative Therapy) for those latent TB clients at high risk for non-adherence to prescribed TB medications especially young children.

Without intervention, it is estimated that 10% of infected individuals will develop TB disease at some point in their lifetime. This number increases greatly when co-infections such as HIV or diabetes are present. Research has found that approximately 50% of patients taking TNF Alpha antagonist medicines and medications causing immunocompromised health can develop TB in a short period of time. With the increased use of Interferon Gamma Release Assay (IGRA) tests for screening of TB infection, reporting by rheumatologists has increased. It is critical that persons positive for TB infection with co-morbidities be managed by the TB clinic to determine adequate treatment is completed. Targeted interventions for populations at high risk and strong local TB intervention programs are critical to TB elimination. Throughout 2017, the Bethlehem Health Bureau will continue to follow CDC and PA DOH public health policies to control and prevent the spread of TB.

G TB Reduce the number of active TB cases in Bethlehem	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
LO TB Number of active TB cases	—	—	—	—
O TB Ensure that 98% of people diagnosed with LTBI receive and complete appropriate LTBI treatment	**Most Recent Period**	**Current Actual Value**	**Current Target Value**	**Current Trend**
E TB Number of TB patients completing treatment who attended the clinic.	—	—	—	—
E TB Number of TB patients referred to BHB.	—	—	—	—
E TB Percentage of TB patients completing treatment.	—	—	—	—
E TB Number of TB patients attending clinic	—	—	—	—
O TB To increase TB provider knowledge by 90%.	**Most Recent Period**	**Current Actual Value**	**Current Target Value**	**Current Trend**
E TB Number of community health providers receiving TB education packets.	—	—	—	—
E TB Number of TB education sessions provided.	—	—	—	—
E TB Percent increase in TB provider knowledge.	—	—	—	—

Immunizations

Although the incidence of Vaccine Preventable Diseases continues to decrease in the United States, a risk of occurrence remains for some diseases. Due to this risk, the goal of the Immunization Program remains to decrease and/or eliminate the indigenous cases of vaccine preventable diseases by increasing immunization education and awareness in the adults and children residing in the City of Bethlehem.

Population Accountability

		Most Recent Period	Current Actual Value	Current Target Value	Current Trend
G IMM	To reduce vaccine preventable diseases in Bethlehem.				
LO IMM	Number of Flu cases in Bethlehem.	Q4 2018	0	–	→ 2
LO IMM	Number of Rubella cases in Bethlehem.	–	–	–	–
LO IMM	Number of Pertussis cases in Bethlehem.	Q4 2018	0	–	→ 3
LO IMM	Number of Meningitis cases in Bethlehem.	Q4 2018	0	–	↘ 1
LO IMM	Number of Hepatitis A cases in Bethlehem.	Q4 2018	1	–	↗ 1
LO IMM	Number of Hepatitis B cases in Bethlehem.	Q4 2018	0	–	→ 1
LO IMM	Number of Varicella cases in Bethlehem.	Q4 2018	0	–	→ 7
LO IMM	Number of Shingles cases in Bethlehem.	Q4 2018	0	–	↘ 1
LO IMM	Number of Measles cases in Bethlehem..	Q4 2018	0	–	→ 7
LO IMM	Number of Mumps cases in Bethlehem.	–	–	–	–

Performance Accountability

		Most Recent Period	Current Actual Value	Current Target Value	Current Trend
O IMM	To increase vaccination rates among our clients by 50% for all vaccine preventable diseases in Bethlehem. .				
E IMM	Number of infants enrolled in perinatal Hepatitis B prevention program.	–	–	–	–
E IMM	Number of clinics.	–	–	–	–
E IMM	Number of mass immunization clinics.	–	–	–	–
E IMM	Number of flu vaccines given.	–	–	–	–
E IMM	Number of Hepatitis A vaccines given.	–	–	–	–
E IMM	Number of Hepatitis B vaccines given.	–	–	–	–
E IMM	Number of Pneumonia vaccines given.	–	–	–	–
E IMM	Number of shingles vaccines given.	–	–	–	–
E IMM	Number of Tdap vaccines given.	–	–	–	–
E IMM	Number of HPV vaccines given.	–	–	–	–
E IMM	Number of conferences, training's and webcasts attended.	–	–	–	–
E IMM	Number of individuals who received full series of vaccinations.	–	–	–	–
E IMM	Number of Hepatitis B negative infants born to Hepatitis B surface antigen positive mothers.	–	–	–	–
O IMM	To reduce the transmission of vaccine preventable diseases among our clients by investigating 100% of reportable diseases using PA-NEDSS.	Most Recent Period	Current Actual Value	Current Target Value	Current Trend

E	IMM	Number of PA HAN alerts distributed during a communicable disease outbreak or bioterrorist incidence or threat.	–	–	–	–
E	IMM	Total number of vaccine preventable disease investigations completed.	–	–	–	–
E	IMM	Total number of vaccine preventable confirmed cases.	–	–	–	–
E	IMM	Percent vaccine preventable disease investigations completed.	–	–	–	–

MCH

The Bethlehem Health Bureau will focus efforts on access to care, infant and child mortality, child abuse, family planning and preconception care, maternal depression, breastfeeding support, healthy and safe environments, and oral health education all of which significantly impact maternal and child health in the City of Bethlehem.

Social determinants of health factor greatly into the health status of individuals especially children. Protective factors also determine the outcome of a child's well-being. Socioeconomic status, education, family stability, and cultural traditions need to be considered and evaluated in order to determine their impact on disparities in maternal child health. Outreach including follow-up and referral plus culturally applicable education programs targeting at-risk populations is essential for understanding and reducing risk factors.

Bethlehem Health Bureau has transitioned to the use of primarily evidence based programming (EVB) as the movement from funders to use extensive science based research is overwhelming to produce positive outcomes. EVP Programming is expensive and detailed in order to assure positive outcomes. BHB continues to use the Healthy Homes Model and the Partners For a Healthy Baby (PFHB) curriculum. Both programs incorporate family safety education and home environmental assessments to assure that families have a safe environment. PFHB incorporates a home visiting model focusing on prenatal care and parenting. The program reinforces early childhood development and family relationships both thought to improve the social determinants of health.

BHB continues to work collaboratively with the local Health Care Council (HCC) to identify barriers and increase resources. BHB is also taking an active role in the Lehigh Valley Trauma Awareness Collaborative, whose goals include creating networks of service providers that promote a trauma-informed approach to care in order to build a healthier, more resilient community. New projects focusing on data collection and analysis have been developed to ensure efforts are directed at the appropriate MCH concerns in Bethlehem.

G MCH To decrease maternal, infant, child and adolescent morbidity and mortality in Bethlehem.	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
LO MCH Percentage of mothers who breastfeed	–	–	–	–
LO MCH Percent pre-term birth rates	–	–	–	–
LO MCH Percent low birth weight	–	–	–	–
LO MCH Infant death rate	–	–	–	–
LO MCH Percent of women who receive prenatal care in first trimester	–	–	–	–
LO MCH Percent of births to mothers under 18	–	–	–	–
O MCH To provide family planning services to a minimum of 75 individuals.	**Time Period**	**Current Actual Value**	**Current Target Value**	**Current Trend**
E MCH Number of family planning patients.	–	–	–	–
E MCH Number of female STD patients.	–	–	–	–
E MCH Number of female STD patients attending family planning clinic.	–	–	–	–
E MCH Percentage of female STD patients attending family planning clinic.	–	–	–	–
E MCH Number of STD patients attending the family planning clinic who started birth control.	–	–	–	–
E MCH Percentage of STD patients attending the family planning clinic who started birth control.	–	–	–	–
O MCH Increase the number of participants enrolled in Partners for a Healthy Baby (PFHB) by 15 clients.	**Most Recent Period**	**Current Actual Value**	**Current Target Value**	**Current Trend**
E MCH Number of referrals received for PFHB	–	–	–	–
E MCH Number of clients enrolled in PFHB	–	–	–	–
E MCH Number of depression screens completed	–	–	–	–
E MCH Percentage of depression screens completed.	–	–	–	–
E MCH Number of cribs distributed.	–	–	–	–
E MCH Number of breastfeeding clinics held.	–	–	–	–
E MCH Number of CLCs trained.	–	–	–	–
E MCH Number of referrals to CLCs	–	–	–	–

E	MCH	Number of women enrolled in PFHB who are breastfeeding.	–	–	–	–
E	MCH	Percentage of PFHB clients who breastfeed.	–	–	–	–
E	MCH	Number of safe sleep practices documented.	–	–	–	–
E	MCH	Percentage of clients who receive a crib that demonstrate safe sleep practices.	–	–	–	–
O	MCH	Screen and educate 95% of clinic and program female patients about intimate partner violence (IPV) and healthy relationships.	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
E	MCH	Number of patients screened for IPV and provided a healthy relationships safety card.	–	–	–	–
E	MCH	Number of community agencies that receive staff training and IPV tools.	–	–	–	–
E	MCH	Number of clients who screen positive for IPV.	–	–	–	–
E	MCH	Percentage of clients who screen positive for IPV.	–	–	–	–
E	MCH	Percentage of patients screened for IPV and provided a healthy relationship safety card.	–	–	–	–
O	MCH	A total of 100% of female clinic and program patients will have One Key Question (OKQ) reproductive life plan assessment, with appropriate education and interventions.	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
E	MCH	Number of female patients given OKQ/reproductive life plan counseling.	–	–	–	–
E	MCH	Number of multi vitamins distributed.	–	–	–	–
E	MCH	Number of family planning clients.	–	–	–	–
E	MCH	Number of clients who are planning a pregnancy with documented preconception counseling and folic acid supplements.	–	–	–	–
E	MCH	Percent of family planning clients completing OKQ.	–	–	–	–
E	MCH	Number of patients who do not desire a pregnancy who receive birth control options counseling and education.	–	–	–	–
E	MCH	Number of clinic patients with a planned pregnancy.	–	–	–	–

Community Paramedicine

BHB's Community Paramedicine program goal is to improve health outcomes among medically vulnerable populations; and to save healthcare dollars by preventing unnecessary ambulance transports, emergency department visits, and hospital readmissions. The Community Paramedicine program provides optimal social/prevention services for our residents, regardless of ability to pay. This includes care that is timely, high quality, and patient-centered through: improved collaboration, communication, coordination of services, and continuity of care by supporting efficient, real-time communication of patient information among those caring for the patient; and by fostering patient engagement of vulnerable patients, thereby producing better health outcomes and reducing the number of ambulance transports, visits to the emergency department, and hospital readmissions. The on site EMT/Paramedic identifies the patients Quality of Life needs: to include but not limited to the following: falls, uncontrolled diabetes, at risk for homelessness, drug abuse, mental health, hoarders, and home care gap and refers them to BHB for case management/services intervention. Patient is referred to appropriate services and followed up with to determine effectiveness of service and assess vulenerability status.

Population Accountability

G To reduce EMS no transport calls.	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
LO CP Number of EMS no transport calls.	2017	1,040	–	→ 0

Performance Accountability

O CP To decrease no transport calls by 10%.	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
E CP Number of referrals from NREMS.	–	–	–	–
E CP Number of Community Paramedicine home visits.	–	–	–	–
E CP Number of care plans created.	–	–	–	–
E CP Number of clients with referrals.	–	–	–	–
E CP Number of Community Paramedicine follow ups conducted	–	–	–	–
E CP Number of community paramedicine clients connected to services.	–	–	–	–
E CP Number of EMS calls from clients in community paramedicine program .	–	–	–	–
E CP Total number of falls calls.	2017	468	–	→ 0
E CP Total number of fall patients refused care calls.	2017	46	–	→ 0
E CP Total number of fall patients treated with no transport.	2017	12	–	→ 0
E CP Total number of fall patients cancelled on scene.	2017	11	–	→ 0
E CP Total of fall patient lift assists.	2017	68	–	→ 0
E CP Total fall patient refused care for lift assist.	2017	30	–	→ 0
E CP Total fall patient cancelled on scene for lift assist.	2017	11	–	→ 0
E CP Total calls uncontrolled diabetes .	2017	85	–	→ 0
E CP Total uncontrolled diabetes patient refused care.	2017	13	–	→ 0
E CP Total uncontrolled diabetes patient treated no transport.	2017	8	–	→ 0
E CP Total calls drug abuse.	2017	95	–	→ 0
E CP Total drug abuse patient refused care.	2017	1	–	→ 0
E CP Total drug abuse patient treated no transport.	2017	1	–	→ 0

E CP	Total at Psychiatric problems.	2017	324	–	→ 0
E CP	Total Psychiatric problems refused care.	2017	15	–	→ 0
E CP	Total Psychiatric problems patient treated no transport.	2017	2	–	→ 0
E CP	Total Psychiatric problems cancelled on scene.	2017	5	–	→ 0
E CP	Total number of no transport calls.	2017	1,040	–	→ 0

Diabetes Prevention Program

Almost 10% of the US population has diabetes and more than 1 in 3 Americans has pre-diabetes. Pre-diabetes is a serious condition that can lead to type 2 diabetes and other significant health problems, such as heart disease and stroke.

The National Diabetes Prevention Program (DPP) was created to address the increasing burden of pre-diabetes and type 2 diabetes in the United States.

Population Accountability

G DP To decrease the prevalence of diabetes.	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
LO DP Prevalence rate of diabetes in Northampton County.	2018	12%	–	↗ 1
LO DP Prevalence rate of diabetes in Carbon County.	2018	11%	–	→ 2
LO DP Prevalence rate of diabetes in Monroe County.	2018	12%	–	↗ 1

Performance Accountability

O DP To have 10% of participants decrease blood sugar to within normal limits.	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
E DP Number of lifestyle coaches training's attended.	–	–	–	–
E DP Number of Diabetes prevention programs conducted.	–	–	–	–
E DP Number of participants in Northampton county class.	Q1 2019	5	–	→ 0
E DP Average weight loss for Northampton county class.	–	–	–	–
E DP Average 6 month weight loss for Northampton county class.	–	–	–	–
E DP Number of participants who decreased blood sugar in Northampton County class.	Q1 2019	3	–	→ 0
E DP Number of participants in Lehigh county class.	Q1 2019	10	–	→ 0
E DP Average weight loss for Lehigh county class.	–	–	–	–
E DP Average 6 month weigh loss for Lehigh county class.	–	–	–	–
E DP Number of participants who decreased blood sugar in Lehigh County class.	Q1 2019	6	–	→ 0
E DP Total number of participants who decrease blood sugar.	Q1 2019	9	–	→ 0
E DP Total number of class participants.	Q1 2019	15	–	→ 0
E DP Percent of participants who decreased blood sugar.	Q1 2019	60%	–	→ 0

Employee Wellness

Worksite wellness programs encourage employees to improve their health status for themselves and their families. Healthy employees have better productivity, better morale and lower health care costs. Data shows that poor employee health results in unnecessary healthcare costs and the research clearly demonstrates that by encouraging healthier choices among their current employees, they are reaping long term savings in terms of sick time, disability and health care costs. Further return on investment analysis demonstrates that these measurables are only a portion of the cost savings. In reality, in an effectively developed wellness culture, an organization can also experience cost savings in reference to retention, recruitment, reputation and employee engagement.

The Employee Wellness Program categorized employees into one of five different pathways. Based on Biometric screenings, employees were asked to follow the criteria in the Maintenance pathway, Diabetes pathway, High Blood Pressure pathway, Heart Disease pathway and Obesity pathway. In 2016, the employee wellness program had 58 participants out of 606 (9% participation rate) total employees. 50% of participants were in the Maintenance category, 12% in the Blood pressure pathway, 21% in the heart disease pathway, 3% in the diabetes pathway and 14% in the obesity pathway.

Population Accountability

		Most Recent Period	Current Actual Value	Current Target Value	Current Trend
G EW	Create a healthy worksite culture.				
LO EW	Number of covered lives diagnosed with Diabetes	–	–	–	–
LO EW	Number of covered lives diagnosed with Heart Disease	–	–	–	–
LO EW	Number of covered lives diagnosed with Stroke	–	–	–	–
LO EW	Number of covered lives diagnosed with Cancer	–	–	–	–
LO EW	Number of covered lives diagnosed with Chronic Lower Respiratory Disease	–	–	–	–
LO EW	Number of covered lives diagnosed with Obesity	–	–	–	–

Performance Accountability

		Most Recent Period	Current Actual Value	Current Target Value	Current Trend
O EW	Reduce modifiable risk factors for: Diabetes, Heart Disease, Stroke, Cancer, Chronic Lower Respiratory Disease and Obesity by 10%.				
E EW	Number of employees and spouses who completed the Healthy Rewards program activation.	2018	116	150	↗ 1
E EW	Total of eligible employees and spouses for Employee Wellness program	2017	1,163	–	→ 0
E EW	Percent of employees and spouses who participant in Employees Wellness program.	2017	10%	–	→ 0
E EW	Number of employees and families who completed health assessment	2018	59	30	↘ 1
E EW	Number of employees who completed the biometric screening.	2017	49	150	→ 0
E EW	Number of employees who completed monthly challenges	2018	227	150	↗ 1
E EW	Number of employees who received flu shots	2018	200	150	↗ 1
E EW	Number of employees wellness programs offered	2018	9	8	↗ 1
E EW	Percent of employees with Blood Pressure Within Normal Limits	2017	37%	–	→ 0
E EW	Percent of employees with Blood Pressure in the At-Risk category (120/89-139/89)	2017	45%	–	→ 0
E EW	Percent of employees with Blood Pressure in the High-Risk category (greater than 140/90)	2017	18%	–	→ 0
E EW	Percent of employees with a Blood Sugar in the Diabetic range (greater than 126 mg/dl)	2017	0%	–	→ 0
E EW	Percent of employees with a Blood Sugar in the Pre-Diabetic range (100-125 mg/dl)	2017	14%	–	→ 0
E EW	Percent of employees with a Blood Sugar Within Normal Limits (70-99 mg/dl)	2017	86%	–	→ 0
E EW	Percent of employees with a Body Mass Index greater than 30	2017	33%	–	→ 0
E EW	Percent of employees with a Body Mass Index Within Normal Limits	2017	67%	–	→ 0

E EW	Percent of employees with LDL's in the At-Risk category (100-160 mg/dl)	2017	57%	–	→ 0
E EW	Percent of employees with LDL's in the High Risk category (greater than 160 mg/dl)	2017	2%	–	→ 0
E EW	Percent of employees with LDL's Within Normal Limits (less than 100 mg/dl)	2017	41%	–	→ 0
E EW	Percent of Employees who are in 0 risk categories	2017	51%	–	→ 0
E EW	Percent of Employees who are in 1 high risk category	2017	33%	–	→ 0
E EW	Percent of Employees who are in 2 high risk categories	2017	14%	–	→ 0
E EW	Percent of Employees who are in 3 high risk categories	2017	2%	–	→ 0

Healthy Lifestyles

Chronic diseases include conditions such as heart disease, stroke, cancer, diabetes and respiratory conditions. Chronic diseases has long been the leading causes of death and disability. In the United States more than 87% of deaths are due to chronic diseases. One in two American have a chronic disease. Chronic diseases directly affect overall health care budgets, employee productivity, and economies. Chronic diseases can be reduced and/or eliminated with changes in lifestyle and diet, reducing overweight/obese status, eliminate smoking and increaseing fruit and vegetable intake and physicial activity.

			Most Recent Period	Current Actual Value	Current Target Value	Current Trend
G	CHIP	To decrease the burden of chronic diseases among Bethlehem residents.				
LO	CHIP	Physical activity in children rate.	–	–	–	–
LO	CHIP	Chronic Lower Respiratory Disease rate	2016	50	–	→ 0
LO	SHC	Adult obesity rate.	2018	29%	–	→ 2
LO	SHC	Adult physical inactivity rate.	2018	26%	–	↗ 1
LO	SHC	Heart Disease rate	2016	7	–	→ 0
LO	CHIP	Lung Cancer rate	–	–	–	–
LO	CHIP	Stroke rate	2016	31	–	→ 0
LO	CHIP	Diabetes rate	2016	22	–	→ 0
LO	CHIP	Percent residents with High Blood Pressure	2016	30%	–	→ 0
LO	CHIP	Percent residents with High Cholesterol	2016	17%	–	→ 0
LO	CHIP	Percent residents who are physically Active at least 5 days per week	2016	15%	–	→ 0
LO	CHIP	Percent residents who eat 5 or more servings of fruit/vegetables daily	2016	11%	–	→ 0
O	CHIP	To increase knowledge, attitudes and behavior change to improve health.				
E	CHIP	Number of educational programs conducted in the community.	2018	8	2	→ 1
E	DP	Number of Diabetes prevention programs conducted.	–	–	–	–
E	DP	Total number of class participants.	Q1 2019	15	–	→ 0
O	CHIP	To conduct Veggie Sales fundraiser in a minimum of one school.				
E	CHIP	Number of Veggie Sales implemented.	2018	1	–	→ 1
E	CHIP	Number of Veggie Sales participants	2018	20	–	↘ 1
E	CHIP	Number of Bags sold.	2018	85	–	↗ 1
O	CHIP	To facilitate three infrastructure changes to promote opportunities for Healthy Living.				
E	CHIP	Number of infrastructure changes.	2018	12	3	→ 1
O	CHIP	To promote physical activity and literacy in the City of Bethlehem.				
E	CHIP	Number of storywalks.	2018	5	–	→ 1
E	CHIP	Number of storywalk participants who completed all 5 stories.	2018	18	–	↘ 1
E	CHIP	Number of storywalks loaned out.	–	–	–	–

Healthy Woman Project

Breast and cervical cancers are diseases that are preventable and treatable with preventive methods and early detection; however, women of Latino and African American origin do not get screened as regularly. The same can be said for women who are of low-income and are uninsured and/or underinsured. As a result, rates for preventable and treatable types of cancer are higher among these women.

According to the Cancer Facts and Figures Report (2017), an estimated seventy seven thousand, seven hundred ten (77,710) new cancer cases will be diagnosed in Pennsylvania. Among the fifty (50) states, in 2017 Pennsylvania is the fifth (5) highest with estimated eleven thousand three hundred (11,300) new cases of female breast cancer. Even though the prevalence of cervical Cancer in Pennsylvania is considerably lower than the prevalence of breast cancer, Pennsylvania ranked fifth (5) for the number of new cases of Cervical Cancer reported (Cancer Facts and Figures Report, 2017).

Population Accountability

		Most Recent Period	Current Actual Value	Current Target Value	Current Trend
G HW	To reduce morbidity rates of breast and cervical cancer within Northampton County.				
LO HW	Number of women who had a diagnosis of cervical cancer.	Q4 2018	0	0	→ 1
LO HW	Number of breast cancer diagnoses.	Q4 2018	0	0	→ 5
G HW	To reduce mortality rate of breast and cervical cancer within Northampton County.				
LO HW	Number of breast cancer fatalities.	–	–	–	–
LO HW	Number of cervical cancer fatalities.	–	–	–	–

Performance Accountability

		Most Recent Period	Current Actual Value	Current Target Value	Current Trend
O HW	To provide services to 30 women for comprehensive breast and cervical screening between the ages of 40 to 49 and 50 women between the ages of 50 to 64.				
E HW	Number of women who completed screening pap tests.	Q4 2018	9	7	↗ 1
E HW	Number of women who completed screening mammograms.	Q4 2018	10	10	↘ 1
E HW	Number of women who completed surgical pathology.	Q4 2018	1	1	→ 2
E HW	Number of women who completed colposcopies.	Q4 2018	1	1	↗ 1
E HW	Number of women who completed mammogram biopsies	Q4 2018	0	1	↘ 1
O HW	To provide case management to women diagnosed with an abnormal test result with in ninety (90) days of notification.				
E HW	Number of clients who were referred for case management.	Q4 2018	2	–	→ 1
E HW	Number of women who are diagnosed with breast cancer and applied for BCCPT.	Q4 2018	1	–	↘ 2
E HW	Number of women who were eligible for case management	Q4 2018	2	–	→ 1
E HW	Percent women referred to case management	Q4 2018	100%	–	→ 7

Highway Safety

Motor vehicle crashes (MVC) are the leading cause of death and injury for those between the age of 5-24 and second leading cause of death and injury for those between 1-4 and 25-65+, respectively in the USA according to the CDC. MVC's account for approximately half the number of deaths from unintentional injuries. In 2016, the reportable traffic crashes in PA were at their lowest number since 1950, making a good argument to support that the collaboration between law enforcement and education was working to reduce crashes. In Northampton County (NC), according to PENNDOT's 2016 data, the top five motor vehicle-related fatal crashes are: aggressive driving, drinking driving/ impaired driving, crashes involving teen (16-17), distracted driver crashes and older driver 65+ crashes. Heavy truck, motorcycle and pedestrian also are key areas of concern in Northampton County. Older driver 65+ is the first leading cause of fatalities and crashes. Enforcement and education are imperative to reduce injuries and fatalities caused by older drivers. Impaired driving is the second leading cause of fatalities and is becoming more serious as law enforcement is being trained as drug recognition experts.

The Surgeon General's report states that over half of all highway safety deaths are rooted in lifestyle behavior or environmental factors that are amendable to change. In order to assist in the downward trend of these traffic deaths, Department of Health and Human Services developed guidelines for the nation to follow and meet national goals called Healthy People 2020.This states that injuries are not accidents or uncontrollable acts of fate because most injuries are predictable and preventable. Therefore, society must put the responsibly on them to prevent the accidents from occurring.

Population Accountability

		Most Recent Period	Current Actual Value	Current Target Value	Current Trend
G HWS	Decrease motor vehicle fatalities in Northampton County.				
LO HWS	Number of motor vehicle fatalities in Northampton County.	2017	26	–	↘ 1
LO HWS	Number of motor vehicle crashes in Northampton County.	2017	3,092	–	↘ 1

Performance Accountability

		Most Recent Period	Current Actual Value	Current Target Value	Current Trend
O HWS	To reduce crashes caused by aggressive driving by 10%. in Northampton County.				
E HWS	Number of aggressive driving fatalities.	2017	4	–	↘ 1
E HWS	Number of aggressive driving crashes.	2017	222	–	↘ 1
E HWS3	Number of aggressive driving posts for social media.	Q4 2018	2	–	→ 0
E HWS3	Number of aggressive driving likes, shares and re-tweets (contacts).	Q4 2018	3,908	–	→ 0
E HWS3	Aggressive Driving and Speeding Elementary School Outreach Activities	Q4 2018	3	–	→ 0
E HWS3	Aggressive Driving and Speeding Elementary School Outreach officers trained	Q4 2018	24	–	→ 0
E HWS3	Number of Sit Back its Elementary trainings	Q4 2018	1	–	→ 0
E HWS3	Number of Survivor 101 trainings	Q4 2018	1	–	→ 0
E HWS3	Number of Every 16 Minutes trainings	Q4 2018	1	–	→ 0
E HWS3	Number of Sit Back its Elementary officers trained	Q4 2018	8	–	→ 0
E HWS3	Number of Survivor 101 officers trained	Q4 2018	8	–	→ 0
E HWS3	Number of Every 16 Minutes officers trained	Q4 2018	8	–	→ 0
E HWS3	Aggressive Driving and Speeding Post-Secondary Educational Outreach Activities	Q4 2018	2	–	→ 0
E HWS3	Aggressive Driving and Speeding Post -Secondary Educational Outreach participants	Q4 2018	400	–	→ 0
E HWS3	Number of aggressive driving college programs	Q4 2018	2	–	→ 0
E HWS3	Number of aggressive driving college program participants	Q4 2018	400	–	→ 0
E HWS3	Number of aggressive driving admin and planning Activities (CTAC)	Q4 2018	1	–	→ 0
E HWS3	Number of aggressive driving admin and planning contacts (CTAC)	Q4 2018	10	–	→ 0

		Most Recent Period	Current Actual Value	Current Target Value	Current Trend
O HWS	To maintain zero bike crashes in Northampton County.				
E HWS	Number of bicycle crashes.	2017	18	–	↘ 1
E HWS	Number of bicycle fatalities.	2017	1	–	↗ 1
E HWS3	Bicycle Coalition Development Activity (Number of roadways identified and improvements made).	Q4 2018	0	–	→ 0
E HWS3	Bicycle Coalition Development Activities (# of roadways with Share the Road).	Q4 2018	10	–	→ 0
E HWS	Number of bike educational programs.	Q4 2018	0	–	→ 0
E HWS	Number of bike educational program participants.	Q4 2018	0	–	→ 0
E HWS	Number of bicycles who are referred to a bike education diversion program.	Q4 2018	0	–	→ 0
E HWS	Number of Magisterial District Judges who accept the Bicycle Diversion program.	Q4 2018	1	–	→ 0
E HWS3	Bicycle Coalition Development Contacts (# of bicycle crashes on roadways with share the road signs	Q4 2018	0	–	→ 0
E HWS3	Bicycle Community Outreach Activities	Q4 2018	1	–	→ 0
E HWS3	Number of Walk/Bike to School day events	Q4 2018	1	–	→ 0
E HWS3	Number of Walk/Bike to School day participants	Q4 2018	200	–	→ 0
E HWS3	Number of Bike to work week events	Q4 2018	0	–	→ 0
E HWS3	Number of bike to work week participants	Q4 2018	0	–	→ 0
E HWS3	Bicycle Community Outreach Contact	Q4 2018	200	–	→ 0
E HWS3	Bicycle Earned Media Activities	Q4 2018	0	–	→ 0
E HWS3	Bicycle Earned Media Contacts	Q4 2018	0	–	→ 0
E HWS3	Bicycle Enforcement Outreach Activities	Q4 2018	0	–	→ 0
E HWS3	Bicycle Enforcement Outreach Contacts	Q4 2018	0	–	→ 0
E HWS3	Bicycle Judicial Outreach Activities	Q4 2018	1	–	→ 0
E HWS3	Bicycle Judicial Outreach Contacts	Q4 2018	0	–	→ 0
E HWS3	Bicycle Social Media Outreach Activites (# of posts)	Q4 2018	0	–	→ 0
E HWS3	Bicycle Social Media Outreach Contacts (# reached)	Q4 2018	0	–	→ 0
E HWS3	Bicycle Admin Activities (# of CTAC's created)	Q4 2018	1	–	→ 0
E HWS3	Bicycle Admin Contacts (# of members)	Q4 2018	10	–	→ 0
O HWS	To increase proper use of child restraints to a 90% correct use rate in Northampton County .	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
E HWS	Number of attendee's at the Safe Kids Car Seat Check	Q4 2018	0	–	→ 0
E HWS	Number of Car Seat Check Events	Q4 2018	1	–	→ 0
E HWS	Number of CSS checked.	Q4 2018	5	–	→ 0
E HWS	Number of Safe-Kids events.	Q4 2018	0	–	→ 0

E	HWS	Number of Safe Kids Meetings.	Q4 2018	0	–	→ 0
E	HWS	CPS Coordinate and conduct trainings (# of CPS trainings)	Q4 2018	0	–	→ 0
E	HWS	CPS Coordinate and conduct trainings (# of CPS participants in the training).	Q4 2018	0	–	→ 0
E	HWS	CPS Earned Media (Car Seat Checks). (Line 28)	Q4 2018	0	–	→ 0
E	HWS	CPS Earned Media Activities (Operation Safe Stop) (Line 30)	Q4 2018	0	–	→ 0
E	HWS	CPS Earned Media Activities (# efforts Safety Press Officer) (Line 29).	Q4 2018	0	–	→ 0
E	HWS	CPS Earned Media Contacts (# SPO likes, shares, re-tweets) (Line 29)	Q4 2018	0	–	→ 0
E	HWS	CPS Elementary School Outreach Activities (# of school districts participating in Operation Safe Stop.) (Line 31)	Q4 2018	1	–	→ 0
E	HWS	CPS Elementary School Outreach Contacts (# of violations) (Line 31)	Q4 2018	0	–	→ 0
E	HWS	Elementary School Outreach Activities (Sit Back It's Elementary Programs). (Line 32)	Q4 2018	0	–	→ 0
E	HWS	Elementary School Outreach Contacts (# participants Sit Back Program). (Line 32)	Q4 2018	0	–	→ 0
E	HWS	Number of Sit Back IT's Elementary participants.	Q4 2018	1	–	→ 0
E	HWS	CPS Programming/Curriculum Development Activities (child restraint usage). (Line 34)	Q4 2018	0	–	→ 0
E	HWS	CPS Programming/Curriculum Development Contacts (# participants child restraint usage). (Line 34)	Q4 2018	0	–	→ 0
E	HWS	CPS Programming/Curriculum Development Contacts (# seats rented out). (Line 36)	Q4 2018	4	–	→ 0
E	HWS3	CPS Car Seat Check Events Activities (Line 24)	Q4 2018	0	–	→ 0
E	HWS3	CPS CPS Car Seat Check Events Contacts (Line 24)	Q4 2018	0	–	→ 0
E	HWS3	Number of Safe Kids Car Seat Checks	Q4 2018	0	–	→ 0
E	HWS3	CPS Car Seat Check Events Activities (Line 25)	Q4 2018	1	–	→ 0
E	HWS3	CPS CPS Car Seat Check Events Contacts (Line 25)	Q4 2018	5	–	→ 0
E	HWS3	Number of rental seat installed	Q4 2018	0	–	→ 0
E	HWS3	CPS Coalition Development Activities	Q4 2018	0	–	→ 0
E	HWS3	CPS Coalition Development Contacts	Q4 2018	0	–	→ 0
E	HWS3	Number of Safe Kids meeting participants	Q4 2018	0	–	→ 0
E	HWS3	Number of Safe Kids event participants	Q4 2018	0	–	→ 0
E	HWS3	CPS Earned Media Contacts (Operation Safe Stop) (Line 30)	Q4 2018	0	–	→ 0
E	HWS3	CPS Earned Media Contacts (Car Seat Checks) (Line 28)	Q4 2018	0	–	→ 0
E	HWS3	CPS Programming/Curriculum Development Activities (educational programs) (Line 35)	Q4 2018	0	–	→ 0
E	HWS3	CPS Programming/Curriculum Development Contacts (educational programs (Line 35)	Q4 2018	0	–	→ 0
E	HWS3	CPS Admin Activities (CTAC)	Q4 2018	1	–	→ 0
E	HWS3	CPS Admin Contacts (CTAC)	Q4 2018	10	–	→ 0

			Most Recent Period	Current Actual Value	Current Target Value	Current Trend
O	HWS	To decrease older driver crashes by 15% in Northampton County.				

E HWS Number of programs conducted for mature drivers.	–	–	–	–
E HWS Number of older driver program participants.	–	–	–	–
E HWS Number of Car Fit programs.	–	–	–	–
E HWS Number of Car Fit participants.	–	–	–	–
E HWS Number of resource guides distributed to older drivers.	–	–	–	–
E HWS Number of earned media efforts for older driver safety week..	–	–	–	–
E HWS Number of older adult crashes.	2017	551	–	↘ 1
E HWS Number of older adult fatalities.	2017	10	–	↗ 1
O HWS To decrease motorcycle crashes by 15% in Northampton County .	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
E HWS MC Enforcement Outreach Activities (# earned media)	Q4 2018	0	–	→ 0
E HWS MC Enforcement Outreach Contacts (# earned media)	Q4 2018	0	–	→ 0
E HWS Number of programs MC Programming/Curriculum Development Activities	Q4 2018	0	–	→ 0
E HWS Number of contacts MC Programming/Curriculum Development Contacts	Q4 2018	0	–	→ 0
E HWS Number of Social Media Posts. (Social Media Activities)	Q4 2018	0	–	→ 0
E HWS Number of motorcycle crashes.	2017	95	–	↗ 1
E HWS Number of motorcycle fatalities.	2017	6	–	↘ 1
E HWS Number of Social Media likes shares and retweets (Social Media contacts)	Q4 2018	0	–	→ 0
O HWS To decrease pedestrian crashes by 15% in Northampton County .	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
E HWS Number of CTAC meetings.	–	–	–	–
E HWS Number of CTAC attendees at the meetings.	–	–	–	–
E HWS Number of police departments interested in conducting pedestrian enforcement programs.	–	–	–	–
E HWS Number of pedestrian interventions developed by reviewing data.	–	–	–	–
E HWS Number of pedestrian earned media efforts.	–	–	–	–
E HWS Number of pedestrian social media likes, shares and re-tweets	–	–	–	–
E HWS Number of pedestrian programs conducted.	–	–	–	–
E HWS Number of pedestrian citations issued.	–	–	–	–
E HWS Number of other citations issued as a result of the pedestrian operation.	–	–	–	–
E HWS Number of schools participating in Walk To School Day.	–	–	–	–
E HWS Number of Walk to School day likes, shares and re-tweets.	–	–	–	–
E HWS Number of Pedestrian crashes in Northampton County.	2017	81	–	↗ 1
E HWS Number of pedestrian fatalities in Northampton County.	2017	4	–	↘ 1

		Most Recent Period	Current Actual Value	Current Target Value	Current Trend
O HWS	To coordinate and support general traffic safety rules, violations and educational programs.				
E HWS	Number of programs in the community to educate and answer direct inquirers from the public concerning Pennsylvania s traffic	–	–	–	–
E HWS	Number of attendees at the community meetings.	–	–	–	–
E HWS	Number of participants attending the training's/meetings.	Q4 2018	8	–	→ 0
E HWS	Number of enforcement meetings.	–	–	–	–
E HWS	Number of training's conducted in (Back is Where It's At, Survival 101, Every 16 Minutes)	Q4 2018	1	–	→ 0
E HWS	Number of police officers trained during the DUI Meeting.	–	–	–	–
E HWS	Number of police departments trained in the Yellow Dot Program.	–	–	–	–
E HWS	Number of social media likes, shares, etc. Winter driving, National Work Zone etc....	–	–	–	–
E HWS	Number of Yellow Dot Programs completed.	–	–	–	–
E HWS	Number of participants who attended the Yellow Dot program.	–	–	–	–
E HWS	Number of Yellow Dot cards completed.	–	–	–	–
O HWS	To increase seatbelt usage to 90% in NC.	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
E HWS2	Number of seatbelt earned media efforts.	Q4 2018	0	–	→ 0
E HWS2	Number of seatbelt earned media contacts	Q4 2018	0	–	→ 0
E HWS2	Number of seatbelt campaigns participated in.	Q4 2018	0	–	→ 0
E HWS2	Number of unrestrained crashes	2017	229	–	↘ 1
E HWS2	Number of unrestrained fatalities	2017	5	–	→ 1
E HWS2	Seatbelt use rate for Northampton County.	2017	86%	–	↗ 1
E HWS3	SB Enforcement Outreach Activities	Q4 2018	0	–	→ 0
E HWS3	SB Enforcement Outreach Contacts	Q4 2018	0	–	→ 0
E HWS3	Number of participants reached through seatbelt campaign	Q4 2018	0	–	→ 0
E HWS3	# of SB programs SB Community Outreach Activities	Q4 2018	10	–	→ 0
E HWS3	# of SB program participants SB Community Outreach Contacts	Q4 2018	465	–	→ 0
O HWS	To decrease crashes caused by teen drivers by 5% in Northampton County.	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
E HWS	Number of Teen Impact programs.	–	–	–	–
E HWS	Number of students participated in Teen Impact programs.	–	–	–	–
E HWS	Number of school with links to education information for parents of young drivers.	–	–	–	–
E HWS	Number of teen driver public information and education materials distributed.	–	–	–	–

E HWS	Number of participants at the Youth Conference.	–	–	–	–
E HWS	Number of schools attending the Youth Conference.	–	–	–	–
E HWS	Number of teen driver crashes.	2017	210	–	↘ 1
E HWS	Number of teen driver fatalities.	2017	1	–	↗ 1
O HWS	To reduce crashes caused by impaired driving by 10%. in Northampton County.	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
E HWS	Number of impaired driving crashes.	2017	295	–	↘ 1
E HWS	Number of impaired driving fatalities.	2017	4	–	↘ 1
E HWS3	Impaired Driving Coalition Development Activities (Schools) Line 19	Q4 2018	2	–	→ 0
E HWS3	Impaired Driving Coalition Development Contacts (Schools) Line 19	Q4 2018	600	–	→ 0
E HWS3	Impaired Driving Coalition Development Activities (Community) (Line 20)	Q4 2018	0	–	→ 0
E HWS3	Impaired Driving Coalition Development Contacts (Community) (Line 20)	Q4 2018	0	–	→ 0
E HWS3	Impaired Driving Earned Media Activities	Q4 2018	2	–	→ 0
E HWS3	Impaired Driving Earned Media Contacts	Q4 2018	1,954	–	→ 0
E HWS3	Impaired Driving Enforcement Outreach Activities	Q4 2018	0	–	→ 0
E HWS3	Impaired Driving Enforcement Outreach Contacts	Q4 2018	0	–	→ 0
E HWS3	Impaired Driving Social Media Activities (NHTSA's Calendar) (Line 23)	Q4 2018	2	–	→ 0
E HWS3	Impaired Driving Social Media Contacts (NHTSA's Calendar) (Line 23)	Q4 2018	3,908	–	→ 0
E HWS3	Impaired Driving Social Media Activities Thanksgiving Eve (Line 50)	Q4 2018	2	–	→ 0
E HWS3	Impaired Driving Social Media Contacts Thanksgiving Eve (Line 50)	Q4 2018	5,000	–	→ 0

Matter of Balance

The goal of A Matter of Balance is to reduce fear of falling, stop the fear of falling cycle, and increase activity levels among community-dwelling older adults. A Matter of Balance is an 8-week structured group intervention that emphasizes practical strategies to reduce fear of falling and increase activity levels. Participants learn to view fall and fear of falling as controllable, set realistic goals to increase activity, change their environment to reduce fall risk factors, and exercise to increase strength and balance. Studies indicate that up to half of the community who reside in their own home experience fear of falling and that many stop doing social activities because of this fear. A majority of falls occur during routine activities. Falls are usually caused by multiple factors in and outside the home or with the individual's perception of falling. A large portion of falls are preventable. Being inactive results in loss of muscle strength and balance. It can also compromise social interaction and increase the risk for isolation, depression, and anxiety. Fear of falling can actually contribute to falling. MOB acknowledges the risk of falling but emphasizes practical coping strategies to reduce this concern. Participants learn to view falls and fear of falling as controllable and set realistic goals for increasing activity. Participants also find ways to change the environment to reduce fall risk factors and learn simple exercises to increase strength and balance. The group format provides an opportunity for people with a common problem to learn from each other and to help each other deal with the shared problem of fear of falling.

Population Accountability

		Most Recent Period	Current Actual Value	Current Target Value	Current Trend
G MOB	To reduce falls among seniors 65 years of age and above in Northampton County.				
LO MOB	Number of falls in Northampton County age 65 years and above.	–	–	–	–
LO MOB	Number of falls in Carbon County age 65 years and above .	–	–	–	–
LO MOB	Number of falls in Monroe County age 65 years and above .	–	–	–	–

Performance Accountability

		Most Recent Period	Current Actual Value	Current Target Value	Current Trend
O MOB	To hold a minimum of 6 Matter of Balance (MOB) classes in Northampton, Monroe and Carbon Counties.				
E MOB	Number of master trainers in Northampton County.	–	–	–	–
E MOB	Number of master trainers in Monroe County.	–	–	–	–
E MOB	Number of master trainers in Carbon County.	–	–	–	–
E MOB	Number of coach training's in Northampton County.	–	–	–	–
E MOB	Number of coach training's in Monroe County.	–	–	–	–
E MOB	Number of coach training's in Carbon County.	–	–	–	–
E MOB	Number of MOB programs in Northampton County.	–	–	–	–
E MOB	Number of MOB programs in Monroe County.	–	–	–	–
E MOB	Number of MOB programs in Carbon County.	–	–	–	–
E MOB	Number of participants who improved their STEADI balance assessment scores in Northampton County.	–	–	–	–
E MOB	Number of MOB class participants in Northampton County.	–	–	–	–
E MOB	Percent of participants who improves their STEADI balance assessment in Northampton County.	–	–	–	–
E MOB	Number of participants who improved their STEADI balance assessment scores in Carbon County.	–	–	–	–
E MOB	Number of MOB class participants in Carbon County.	–	–	–	–
E MOB	Percent of participants who improves their STEADI balance assessment in Carbon County.	–	–	–	–
E MOB	Number of participants who improved their STEADI balance assessment scores in Monroe County.	–	–	–	–
E MOB	Number of MOB class participants in Monroe County.	–	–	–	–
E MOB	Percent of participants who improves their STEADI balance assessment in Monroe County.	–	–	–	–

Medical Reserve Corps

The Bethlehem Medical Reserve Corps (MRC) comprises of medical and non-medical volunteers to help supplement public health capabilities in emergencies and disasters. The unit is part of the Public Health Preparedness Division of the Bethlehem Health Bureau. Volunteers have the opportunity to participate in trainings, drills and exercises that enhance their skills and may choose to work with the Bethlehem Health Bureau to provide public health emergency education to the community.

Population Accountability

		Most Recent Period	Current Actual Value	Current Target Value	Current Trend
G MRC	To support and supplement public health services to strengthen community preparedness and assist in the response to emergencies that has an impact on public health, by maintaining a well-trained volunteer unit.				
LO MRC	Increased level of trained volunteers.	–	–	–	–

Performance Accountability

		Most Recent Period	Current Actual Value	Current Target Value	Current Trend
O MRC	To improve volunteer preparedness for disasters and public health emergencies by completing a minimum of 1 training for MRC volunteers.				
E MRC	Number of volunteers who participated in personal and family preparedness training's	–	–	–	–
E MRC	Number of volunteers who participated in the personal safety trainings.	–	–	–	–
O MRC	To increase volunteer response through participation in at least 1 training, drill, or exercise with a minimum of a 20% participation rate per drill.				
E MRC	Volunteer participation rate in call down drill.	–	–	–	–
E MRC	Volunteer participation rate in operational drill.	–	–	–	–
E MRC	Number of volunteers who participated in NIMS/ICS training.	–	–	–	–
E MRC	Overall response rate of volunteer MRC unit.	–	–	–	–
E MRC	Total number of MRC Volunteers.	**Feb 2019**	**177**	–	→ **15**
E MRC	Total number of volunteers who responded "available" to the call down drill.	–	–	–	–
E MRC	Total number of volunteers who responded "available" in the operational drill.	–	–	–	–
E MRC	Volunteer participation rate in the NIMS/ICS training.	–	–	–	–
E MRC	Total volunteer "availability" response rate.	–	–	–	–
E MRC	Total number of volunteers who responded "not available" to the call down drill.	–	–	–	–
E MRC	Total number of volunteers who responded "not available" in the operational drill.	–	–	–	–
E MRC	Total volunteer "not available"response rate.	–	–	–	–
E MRC	Call down drill "Available" participation rate.	–	–	–	–
E MRC	Operational drill "Available" participation rate.	–	–	–	–
O MRC	To increase volunteer leadership and volunteer support for community resiliency competency through participation in 1 training.				
E MRC	Number of volunteer leadership training's offered to volunteers.	–	–	–	–
E MRC	Volunteer participation rate at volunteer leadership training's.	–	–	–	–
E MRC	Number of community resiliency training's offered to volunteers.	**Jan 2018**	**1**	–	↗ **1**
E MRC	Volunteer participation rate at community resiliency training's.	**Jan 2018**	**3%**	–	↗ **1**

E MRC Number of community resiliency events.	Oct 2017	2	–	↗ 1
E MRC Number of volunteers who participate in community resiliency events.	Jan 2018	5	–	↗ 1
E MRC Number of volunteers who participate in leadership trainings	–	–	–	–
O MRC To increase the number of volunteers in the MRC unit by 1% .	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
E MRC Number of volunteer recruitment events held.	–	–	–	–
E MRC Number of volunteers recruited via social media.	–	–	–	–
E MRC Number of new volunteers recruited.	Feb 2019	5	–	→ 0
E MRC Total number volunteers plus new recruits	Feb 2019	182	–	↗ 1
E MRC Percent new recruits.	Feb 2019	3%	–	→ 0

Public Health Emergency Preparedness

The Public Health Preparedness Division of the Bethlehem Health Bureau is committed to improving the public's health and safety through the City of Bethlehem's response to health-related emergencies. This is achieved through partnerships with local and state agencies, the creation and implementation of preparedness, recovery and mitigation plans, creating capable staff through regular trainings, the surveillance of diseases, enhanced communications, and community education. This division actively educates the public on how to prepare themselves for a variety of disasters and emergencies that commonly occur in our area and partners with local agencies to strengthen community assets.

Population Accountability

		Most Recent Period	Current Actual Value	Current Target Value	Current Trend
G PHEP	Improve community and agency readiness status for chemical, biological, radiological, nuclear and environmental hazard events.				
LO PHEP	Community readiness status	–	–	–	–
LO PHEP	Agency readiness status.	–	–	–	–

Performance Accountability

		Most Recent Period	Current Actual Value	Current Target Value	Current Trend
O PHEP	To increase community members who are trained in community resilience by 3%.				
E PHEP	Number of community members who attended community preparedness training's	–	–	–	–
E PHEP	Number of community members who attended community recovery training's	–	–	–	–
E PHEP	Number of community preparedness training's.	–	–	–	–
E PHEP	Number of preparedness community recovery training's.	–	–	–	–
O PHEP	To have 100% coordination for all events that require Incident Management.				
E PHEP	Number of public health events which required emergency operations coordination.	–	–	–	–
E PHEP	Number of public health events where emergency operations occurred.	–	–	–	–
E PHEP	Percent of event where emergency operations coordination occurred.	–	–	–	–
E PHEP	Number of times Incident command structure is followed for public health events.	–	–	–	–
E PHEP	Percent use of Incident Command Structure.	–	–	–	–
O PHEP	To share warning information with the community for 100% of emergency events.				
E PHEP	Number of public health hazardous events that required a warning to be shared to the community.	–	–	–	–
E PHEP	Number of warnings disseminated to the public.	–	–	–	–
E PHEP	Percentage rate of warnings disseminated to the public.	–	–	–	–
E PHEP	Number of community members reached for emergency preparedness warnings.	Q4 2018	8,136	–	→ 3
E PHEP	Number of times public health information was shared with the public.	–	–	–	–
E PHEP	Number of community members reached with public health information.	–	–	–	–
O PHEP	To have a minimum of a 20% availability rate of the MRC Unit for any event that has exceeded BHB's surge capacity.				
E PHEP	Total MRC volunteers who participated in training's.	Jan 2018	1	–	↗ 1
E MRC	Total number of MRC Volunteers.	Feb 2019	177	–	→ 15
E PHEP	Number of events that exceeded BHB"s surge capacity.	–	–	–	–

			Most Recent Period	Current Actual Value	Current Target Value	Current Trend
E	MRC	Total volunteer "availability" response rate.	–	–	–	–
O	PHEP	To train a minimum of 100 staff and volunteers who will respond to public health emergency events which require countermeasure and mitigation response.				
E	PHEP	Number of open POD exercises.	–	–	–	–
E	PHEP	Number of non pharmaceutical intervention training's.	–	–	–	–
E	PHEP	Number of fully functional closed PODS.	–	–	–	–
E	PHEP	Number of Fit tests performed.	–	–	–	–
E	PHEP	Number of participants who attended non pharmaceutical intervention training's.	–	–	–	–
E	PHEP	Number of participants who trained in closed PODS.	–	–	–	–
E	PHEP	Number of participants in open POD exercises.	–	–	–	–
E	PHEP	Total number of staff and volunteers trained.	–	–	–	–

Safe and Healthy Communities

The program is devoted to increasing the quality, availability and effectiveness of educational and community-based programs designed to prevent disease and improve health and quality of life. The Bethlehem Health Bureau provides population based primary prevention services by using policy, environmental and systems change strategies to improve the overall health and safety of our community.

Population Accountability

		Most Recent Period	Current Actual Value	Current Target Value	Current Trend
G SHC	To improve health status.				
LO SHC	Adult obesity rate.	2018	29%	–	→ 2
LO SHC	Adult smoking rate.	2018	15%	–	↘ 1
LO SHC	Adult physical inactivity rate.	2018	26%	–	↗ 1
LO SHC	Poor or fair health status.	2018	13%	–	↘ 1
LO SHC	Heart Disease rate	2016	7	–	→ 0

Performance Accountability

		Most Recent Period	Current Actual Value	Current Target Value	Current Trend
O SHC	To increase access to healthy foods through partnership with one local farm share and farmers market program.				
E SHC	Number of weekly farm share programs established.	–	–	–	–
E SHC	Total number of farm shares sold	–	–	–	–
E SHC	Percent of Farm shares who are SNAP eligible	–	–	–	–
E SHC	Number of recipes shared.	–	–	–	–
E SHC	Number of schools partnered with to sell farm shares.	–	–	–	–
E SHC	Number of local farm stands established.	2018	1	1	→ 1
E SHC	Number of cooking demonstrations provided.	–	–	–	–
E SHC	Number of families participating in school farm share program overall	–	–	–	–
E SHC	Total # of bags sold	–	–	–	–
E SHC	Total number of families in school	–	–	–	–
E SHC	Percent of families participating in Veggies Sales	–	–	–	–
E SHC	Number of cooking demonstration participants	–	–	–	–
E SHC	Farm Stand customer count.	–	–	–	–
E SHC	Farm stand revenue.	–	–	–	–
O SHC	To increase utilization of the Bike Share Program by 2%.				
E SHC	Number of times bike share is promoted.	–	–	–	–
E SHC	Number of bikes rented.	–	–	–	–
E SHC	Number of local businesses contributing bikes.	–	–	–	–
E SHC	Number of local businesses that are rental locations for the bike share program.	–	–	–	–

			Most Recent Period	Current Actual Value	Current Target Value	Current Trend
O	SHC	To reduce the fear of falling and increase activity levels in a minimum of 40 older adults completing the Matter of Balance Program.				
E	MOB	Number of coach training's in Northampton County.	–	–	–	–
E	MOB	Number of master trainers in Northampton County.	–	–	–	–
E	MOB	Number of MOB programs in Northampton County.	–	–	–	–
E	MOB	Number of participants who improved their STEADI balance assessment scores in Northampton County.	–	–	–	–
O	SHC	To reduce teen driver motor vehicle deaths by 10%.	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
E	HWS	Number of students participated in Teen Impact programs.	–	–	–	–
E	HWS	Number of Teen Impact programs.	–	–	–	–
O	SHC	To increase motor vehicle safety among older adults through delivery of a minimum of 4 CarFit programs.	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
E	HWS	Number of Car Fit participants.	–	–	–	–
E	HWS	Number of Car Fit programs.	–	–	–	–
O	SHC	To implement 2 Concussion Wise programs.	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
E	SHC	Number of Concussion Wise programs to community sessions.	–	–	–	–
E	SHC	Number of staff trained in Concussion Wise.	–	–	–	–
O	SHC	To conduct a minimum of 4 Parents in the Know Programs.	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
E	SHC	Number of employees trained to facilitate Parents in the Know Program.	–	–	–	–
E	SHC	Number of Parents in the Know programs implemented	–	–	–	–

Facility and Pool Inspections

The Environmental Health Division of the City of Bethlehem Health Bureau is charged with routine inspections of all daycare centers, nursing homes, schools, recreational facilities, and swimming pools within the City limits.

Facility Inspections:

- Nursing Homes
- Schools
- Day Cares
- Recreational Facilities
- Swimming Pools

		Most Recent Period	Current Actual Value	Current Target Value	Current Trend
G FPI	To protect the environmental health of individuals visiting and/or residing in institutional setting and/or public bathing places within the City of Bethlehem.				
LO FPI	Number of outbreaks in facilities and institutions	–	–	–	–
LO FPI	Number of water-borne illness reported that had City of Bethlehem public bathing places implicated.	–	–	–	–
O FPI	To ensure the physical facilities of all institutions (ie nursing homes, schools, daycares) met minimum applicable standards listed in PA Code Chapter 17	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
E FPI	Number of City of Bethlehem recreational facilities	–	–	–	–
E FPI	Number of City of Bethlehem recreational facility inspections conducted	–	–	–	–
E FPI	Percentage of City of Bethlehem recreational facilities inspected	–	–	–	–
E FPI	Number of daycare facilities	–	–	–	–
E FPI	Number of daycare inspections conducted	–	–	–	–
E FPI	Perecentage of daycare facilities inspected	–	–	–	–
E FPI	Number of minor daycare violations	–	–	–	–
E FPI	Number of minor recreational facility violations	–	–	–	–
E FPI	Number of long term care facilities	–	–	–	–
E FPI	Number of long term care inspections conducted	–	–	–	–
E FPI	Percentage of long term care facilities inspected	–	–	–	–
E FPI	Number of minor long term facility violations	–	–	–	–
E FPI	Number of major long term care violations	–	–	–	–
E FPI	Number of major day care violations	–	–	–	–
E FPI	Number of major recreational facility violations	–	–	–	–
E FPI	Number of confirmed illness or reported injury associated with day care facilities	–	–	–	–
E FPI	Number of confirmed illness or reported injury associated with long-term care facilities	–	–	–	–
E FPI	Number of confirmed illness or reported injury associated with recreational facilities.	–	–	–	–
O	To decrease the incidence of water-borne illness associated with public bathing places located within the City of Bethlehem.	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
E FPI	Number of City of Bethlehem public bathing places.	–	–	–	–

E	FPI	Number of public bathing place inspections conducted.	–	–	–	–
E	FPI	Percentage of public bathing places inspected.	–	–	–	–
E	FPI	Number of failing laboratory reported	–	–	–	–
E	FPI	Number of corrective actions implemented (ie, closure, shocking)	–	–	–	–

Food Safety

The Environmental Health Division of the City of Bethlehem Health Bureau is charged with regulating, licensing, and approving plans for all public eating and drinking establishments within the City limits. These duties entail the basic monitoring/ inspection of construction, setup and operation of any site in which food is offered to the public (regardless of if the food is offered free of cost). This includes, but is not limited to, restaurants, grocery stores, hotels, hospitals, churches, bars, daycares, nursing homes, and concession stands. The Department of Agriculture also assists with facilities that manufacture and transport food items to be offered or sold outside the City of Bethlehem limits.

	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
G FS To decrease incidence of foodborne illnesses and assure the quality of food establishments in Bethlehem				
LO Number of confirmed outbreaks associated with City of Bethlehem food facility	–	–	–	–
O FS To inspect all retail food establishments, using a risk based approach, by December 31, 2019, including restaurants, retail, daycares, retail food establishments, mobile and temporary vending, schools, nursing homes, fraternal organizations and churches.	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
E FS Number of licensed retail food establishments.	–	–	–	–
E FS Number of permitted temporary food establishments	–	–	–	–
E FS Number of permanent food facility inspections completed	–	–	–	–
E FS Number of temporary food facility inspections completed	–	–	–	–
E FS Number of facilities deemed Out of Compliance at time of inspection.	–	–	–	–
E FS Number of re-inspections completed.	–	–	–	–
E FS Percentage of facilities In Compliance after re-inspection	–	–	–	–
E FS Total number of retail food establishments with risk factor violations.	–	–	–	–
E FS Total number of retail food establishments with retail violations.	–	–	–	–
E FS Percentage of facilities inspected as per Risk Analysis	–	–	–	–
O FS To ensure all retail food establishments employ at least one ANSI-accredited Certified Food Safety Manager (CFSM) by December 31, 2019.	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
E FS Number of food employees trained by COB certification courses.	–	–	–	–
E FS Number of food employees certified through proctored examinations by COB staff.	–	–	–	–
E FS Percentage of food employees trained that successfully completed Food Employee Manager Certification.	–	–	–	–
E FS Number of Facilities with at least one Certified Food Safety Manager	–	–	–	–
E FS Percentage of Facilities with at least one Certified Food Safety Manager.	–	–	–	–
O FS Establish a system to detect, collect, investigate and respond to complaints and emergencies that involve foodborne illness, injury, and intentional and unintentional food contamination as outlined in Standard 5 of the Voluntary National Retail Food Regulatory Program Standards by December 31, 2019.	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
E FS Number of Voluntary Food Standards Completed	–	–	–	–
E FS Number of Voluntary Food Standards in Progress	–	–	–	–
E FS Number of Voluntary Food Standards under Verification Audit	–	–	–	–
E FS 1. Number of Food Outbreaks requiring response by City of Bethlehem Staff.	–	–	–	–
E FS 2. Number of Food Outbreaks requiring response by City of Bethlehem Staff in which Standard 5 Protocol was implemented.	–	–	–	–

E	FS	Percentage of outbreaks where Standard 5 Protocol was utilized/followed.	–	–	–	–

Lead and Healthy Homes

The LHCP is a lead abatement program intended to protect the residents of the City of Bethlehem from the harms of lead poisoning. Income-qualifying residents with children in the home under the age of six years are eligible to enroll in the LHCP to have their homes tested for lead and, if needed, abated for lead.

The City of Bethlehem's Healthy Homes program consists of a thorough, customized home visiting program. We conduct a walk-through of the home and provide education and materials to help residents create and maintain a healthy and safe environment in which to live.

G HH To identify and eliminate lead hazards in pre-1978 housing.	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
LO HH Number of children <6 years of age whose housing was made lead-safe.	–	–	–	–
LO HH Percentage of individual previously identified as having an EBL that have decreased to less than 10 µg/dL.	–	–	–	–
LO HH Percentage of previously identified EBL children with lead levels below 5 µg/dL.	–	–	–	–
LO HH Percentage of residents who live in substandard housing.	–	–	–	–
O To conduct a Hazard Risk Assessment within 10-business days of Health Bureau's notification that a child occupying, or spending significant amount of time in, a target home has an elevated lead level (EBL-10 micrograms of lead per deciliter of venous whole blood).	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
E HH Number of individuals trained and certified in lead activities	–	–	–	–
E HH Number of staff who obtain access to PA NEDSS	–	–	–	–
E HH Number of EBL children identified	–	–	–	–
E HH Number of EBL triggered risk assessments conducted	–	–	–	–
E HH Number of EBL triggered assessed homes identified as having a Lead Hazard	–	–	–	–
E HH Number of referrals to the Lead Hazard Control Program	–	–	–	–
E HH Number of enforcement actions due to EBL residency	–	–	–	–
E HH Percentage of EBL triggered risk assessments conducted within 10 day period.	–	–	–	–
E HH triggered homes with approved Lead Hazard Remediation Plan.	–	–	–	–
E HH Number of EBL triggered assessed homes with remediation activity completed and cleared.	–	–	–	–
O To utilize Pennsylvania Housing Affordability and Rehabilitation Enhancement Fund (PHARE), and Lead Hazard Control Program (LHCP) Funding to remediate lead hazards in 55 units throughout Northampton County.	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
E HH Number of LHCP risk assessments conducted	–	–	–	–
E HH Number of units enrolled in LHCP Program	–	–	–	–
E HH Number of EBL child units enrolled (county-wide)	–	–	–	–
E HH Percentage of Risk Assessment conducted resulting in unit enrollment	–	–	–	–
E HH Number of Lead Abatement Activities (Remediation) professionals trained.	–	–	–	–
E HH Number of outreach events conducted	–	–	–	–
E HH Percentage of contractors trained that complete licensing and has performed and/or contracted to perform LHCP work.	–	–	–	–
E HH Number of homes remediated or under contract	–	–	–	–

O	To utilize Pennsylvania Housing Affordability and Rehabilitation Enhancement Fund (PHARE), and Healthy Homes Funding to remediate safety/health issues in 20 homes throughout Northampton County.	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
E	HH Number of homes receiving Healthy Homes Assessment	–	–	–	–
E	HH Number of homes receiving Healthy Homes Education	–	–	–	–
E	HH Number of homes receiving grant funded Healthy Home Modifications	–	–	–	–
E	HH Number of homes receiving Healthy Home Supplies	–	–	–	–
E	HH Number of homes identified as having Hazard One: Damp and Mold Growth	–	–	–	–
E	HH Number of homes identified above that had Damp/Mold Growth remediated through grant funding.	–	–	–	–
E	HH Number of homes identified above that had Excess Cold remediated through grant funding	–	–	–	–
E	HH Number of homes identified as having Hazard 3: Excess Heat	–	–	–	–
E	HH Number of homes identified above that had Excess Heat remediated through grant funding.	–	–	–	–
E	HH Number of homes identified as having Hazard 6: Carbon monoxide and fuel combustion products.	–	–	–	–
E	HH Number of homes identified above that had Carbon monoxide and fuel combustion products remediated through grant funding.	–	–	–	–
E	HH Number of homes identified as having Hazard 12: Entry by Intruders	–	–	–	–
E	HH Number of homes identified above that had Entry by Intruders remediated through grant funding.	–	–	–	–
E	HH Number of homes identified as having Hazard 13: Lighting	–	–	–	–
E	HH Number of homes identified above that had Lighting remediated through grant funding.	–	–	–	–
E	HH Number of homes identified as having Hazard 15: Domestic Hygiene, Pests and Refuse.	–	–	–	–
E	HH Number of homes identified above that has Domestic Hygiene, Pest and Refuse remediated through grant funding.	–	–	–	–
E	HH Number of homes identified as having Hazard 19: Falls associated with Baths.	–	–	–	–
E	HH Number of homes identified above that had fall associated wit baths that were remediated through grant funding.	–	–	–	–
E	HH Number of homes identified as having Hazard 20: Falling on Level Surfaces.	–	–	–	–
E	HH Number of homes identified above that had falling levels of surfaces remediated.	–	–	–	–
E	HH Number of homes identified as having Hazard 21: Falling on Stairs.	–	–	–	–
E	HH Number of homes identified above that has falling on stairs remediated through grant funding.	–	–	–	–
E	HH Number of homes identified as having Hazard 22: Falling Between Levels.	–	–	–	–
E	HH Number of homes identified above that had falling between levels remediated through grant funding.	–	–	–	–
E	HH Number of homes identified as having Hazard 23: Electrical Hazards.	–	–	–	–
E	HH Number of homes identified above that had electrical hazards remediated through grant funding.	–	–	–	–
E	HH Number of homes identified as having Hazard 24: Fire.	–	–	–	–
E	HH Number of homes identified above that had Fire remediated through grant funding.	–	–	–	–
E	HH Number of homes identified as having Other Hazards.	–	–	–	–

E	HH	Number of homes identified as having Hazard 2: Excess Cold	–	–	–	–

Responsive Services

The Bethlehem Health Bureau's Environmental Department responds to all complaints that are harmful to the public's health. These complaints include high grass/weeds, garbage, animal related, vectors, unsanitary living and food related.

G RS To reduce the hazards associated with Environmental surrounding with the City of Bethlehem	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
LO RS Number of public health nuisance violations	–	–	–	–
LO RS Number of repeat properties in violation	–	–	–	–
LO RS Number of Confirmed Food Outbreaks where implicated facility is within the City of Bethlehem	–	–	–	–
O RS To respond within three workdays to 100% of health related public complaints received throughout 2019.	**Most Recent Period**	**Current Actual Value**	**Current Target Value**	**Current Trend**
E RS Number of Solid Waste Related Complaints	–	–	–	–
E RS Number of Solid Waste Related Violations Reported	–	–	–	–
E RS Number of High Grass/Weed Complaints	–	–	–	–
E RS Number of High Grass/Weed Violations Reported	–	–	–	–
E RS Number of Animal Related Complaints	–	–	–	–
E RS Number of Animal Related Violations Reported	–	–	–	–
E RS Number of Vector Related Complaints	–	–	–	–
E RS Number of Vector Violations Reported	–	–	–	–
E RS Number of Unsanitary Living Condition Complaints	–	–	–	–
E RS Number of Unsanitary Living Condition Violations Reported.	–	–	–	–
E RS Number of Other Complaints	–	–	–	–
E RS Number of Other Violations Reported	–	–	–	–
E RS Number of Properties with more than 3 violations per year.	–	–	–	–
E RS Number of Property Owners with more than 4 violations per year.	–	–	–	–
O RS To initiate an investigation of all potential foodborne disease outbreaks in the City, within 1 hour of notification and/or classification of an outbreak (specific for each suspected agent) throughout 2019	**Most Recent Period**	**Current Actual Value**	**Current Target Value**	**Current Trend**
E Number of Food Related Complaints Received	–	–	–	–
E Number of people with confirmed food-related illness	–	–	–	–
E 3 Number of facilities implicated in food related complaint where implicated facility is within the City of Bethlehem	–	–	–	–
E Number of City of Bethlehem facilities with 2 or more unrelated food complaints in a given year.	–	–	–	–

Water Quality

Monitoring water quality is a mandated service that the Environmental Program is responsible for overseeing.

		Most Recent Period	Current Actual Value	Current Target Value	Current Trend
G WQ	To ensure quality water for the City of Bethlehem and surrounding areas.				
LO WQ	Number of City of Bethlehem residents with confirmed illness associated with City of Bethlehem water supply.	–	–	–	–
LO WQ	Number of water pollution events associated with City of Bethlehem on-site sewage system.	–	–	–	–
LO WQ	Number of environmental mitigations initiated from water pollution event.	–	–	–	–
LO WQ	Number of people ill from water pollution event.	–	–	–	–
O WQ	To review all monthly reports sent by the Department of Public Works during current year in order to maintain quality and detect problems.	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
E	Number of events involving water supply where Health Bureau assistance was requested.	–	–	–	–
E	Number of events involving water supply where Health Bureau assistance was provided.	–	–	–	–
E	Percentage of events where Health Bureau assistance was requested and provided.	–	–	–	–
O	When requested, conduct on-lot sewage inspections and issue necessary permits as required by State regulations throughout 2018.	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
E WQ	Number of on-site sewage applications received (new and/or repair).	–	–	–	–
E WQ	Number of site inspections/ soil probes conducted	–	–	–	–
E WQ	Number of percolation tests completed	–	–	–	–
E WQ	Number of on-site sewage plans reviewed.	–	–	–	–
E WQ	Number of on-site sewage permits issued.	–	–	–	–
E WQ	Number of on-site sewage systems inspected and approved.	–	–	–	–
E WQ	Percentage of applications for new/repaired on-site sewage system that resulted in approved system.	–	–	–	–
O WQ	To respond and provide assistance to all pollution incidents threatening natural bodies of water located in the City of Bethlehem within two hours of notification throughout 2019.	Most Recent Period	Current Actual Value	Current Target Value	Current Trend
E WQ	Number of requests for assistance associated with water pollution events.	–	–	–	–
E WQ	Number of water pollution events where Health Bureau staff provided assistance.	–	–	–	–
E WQ	Percentage of water pollutions events requested and responded to	–	–	–	–