MINUTES AND MEMORANDA
ST. JOSEPH COUNTY BOARD OF HEALTH

January 20, 2021
Regular Meeting
ALL-VIRTUAL MEETING

Present at the Meeting:

St. Joseph County Board of Health Members:

Heidi Beidinger-Burnett, PhD., M.P.H.	President
Jason Marker, M.D.	Vice President
Jamie Shoemaker, Jr. M.D.	Member
Ilana Kirsch, M.D., FACOG	Member
John Linn	Member
Michelle Migliore, D.O.	Member
Emily Dean	Member

Also Present at the Meeting:

Robert M. Einterz, M.D.	Health Officer
Mark Fox, M.D., PhD., M.P.H.	Deputy Health Officer
Amy Ruppe	Administrator
Jennifer S. Parcell	Executive Administrative Asst.
Mark Espich	Environmental Health Director
Brett Davis	Environmental Health Asst. Director
Cassy White	Health Equity, Epidemiology, and Data (HEED) Director
Carolyn Smith	Food Services, Director
Robin Vida	Health Outreach, Promotion & Education (HOPE) Director

I. CALL TO ORDER

Board President, Dr. Beidinger-Burnett, called the January 20, 2021 regular Board of Health meeting to order at 4:30 p.m. All board members, members of the public, and press, participated via audio/visual Zoom.

II. ADOPTION OF THE AGENDA

On motion made by Michelle Migliore, seconded by Jason Marker, and unanimously approved, the agenda for the January 20, 2021 regular meeting of the Board of Health was adopted with the change of taking the Unit Spotlight of Vital Records off and putting the SJCDoH Strategic Plan updated on the agenda.

It was noted that committee appointments are usually done in the January meeting but that the Board was not prepared to do this at this meeting and the committee appointments would be made in the February meeting. This was unanimously consented to by the Board.

III. APPROVAL OF THE MINUTES

On motion made by Emily Dean, seconded by John Linn, and unanimously approved as presented, the minutes of the December 16, 2020 regular meeting of the Board of Health were approved. Amy Drake's Letter will be attached to the minutes.

IV. BOARD PRESIDENT ANNOUNCEMENTS

1. Dr. Beidinger-Burnett shared her thoughts and positive reflections on the work of the Department of Health and the day's Presidential inauguration.

V. HEALTH OFFICER PRESENTATION AND REPORT

21-01 Discussion and Vote on December 2020 Health Officer's Report

Dr. Einterz referenced the submission of his December 2020 Health Officer's Report of Unit Activities and welcomed any questions or comments with regard to this report. He noted that there was nothing particularly outstanding in the Report; COVID-19 remains the most pressing item for the Department of Health's activities.

One exception that did stand out from the December 2020 Financial Report is the offset of salaries because of COVID-19. Federal money has offset some of the Department of Health salaries: ~$141,000 in nursing and salary support for other individuals totaling close to $250,000.00.

Dr. Marker noted that influenza and other respiratory illnesses are down due to proper mask wearing. Dr. Marker also addressed tick surveillance and tick-related illness. Brett Davis has been working with the State of Indiana on tick surveillance in St. Joseph County.

Dr. Kirsch had concerns over the pop-up clinic at IvyTech. Dr. Einterz said the State controls vaccination rollout. Dr. Einterz said he was unsure if IvyTech was listed as a site. We are not an immunization coop with IvyTech and do not receive information from them.

Dr. Shoemaker was curious if lists of people on the standby list for COVID vaccination were coordinated with us. Dr. Einterz stated that each site keeps its own list. The list is established equitably, and no vaccine is wasted. The Department of Health is trying to keep a list of people that are not signed up now but are in the potential next list of eligible people for vaccinations. Dr. Fox stated that obtaining a vaccine is not a matter of who you know but of eligibility.

VI. DEPUTY HEALTH OFFICER PRESENTATION

21-02 COVID-19 Update

Dr. Fox stated the Department of Health is focusing on standard aspects of the COVID-19 response. Testing is still a concern. The Department of Health is working with K-12 schools. The Department of Health is expecting a bump in new cases from Christmas and New Year's; however, currently hospitalizations are the lowest since October 2020.

The 7-day rolling average of new cases in St. Joseph County is 114 per day, which is the lowest since Halloween.

Dr. Fox stated that the COVID-19 variants may be more communicable among school age children, so we need to keep staying alert on that basis.

Dr. Beidinger-Burnett asked about community transmission of COVID-19 at the University of Notre Dame as students return to campus. Cases did increase in the fall but became normalized after three weeks. Now, Notre Dame has a better testing capacity and can do 1300 tests a day with every undergraduate tested once per week. They can also do targeted testing with discrete subgroups. Faculty coming to campus will be tested every 2 weeks. Also, Notre Dame is doing testing on arrival on campus for everyone. There is also an enhanced understanding of student expectations. Limiting gatherings in indoor settings will be very important.

VII. NEW BUSINESS

21-03 Introduction of New Board of Health Member

Dr. Shoemaker is an emergency physician who lives in Granger with two (2) children and wife. He wanted to do something here locally to give back to the community. He has done substantial work nationally and serves on a national board.

21-04 COVID-19 Vaccination Clinic

The Department of Health is vaccinating 300 people per day at Hedwig Memorial Center. Supply and eligibility are dictated by the State of Indiana. It has been running very smoothly. No serious events or reactions have occurred. Staff are still on guard with EpiPen's, and SJC emergency personnel are aware of the vaccination clinic at Hedwig Memorial Center. Most everybody has an adverse reaction of some minor type. Reactions seem to occur more in the younger population. It will still be a few weeks before the most vulnerable populations are fully vaccinated. It will still be a few months until all eligible individuals who want to be vaccinated are. We will be having more volunteers come on board in the next few weeks as vaccination continues, and quantity of vaccines allocated to SJC increases.

Dr. Beidinger-Burnett discussed communities of color and issues relating to vaccine trust. Dr. Einterz said he has been in contact with leaders in the Black and Latino communities and intends to hire Black and Latino employees.

Dr. Kirsch asked how to volunteer as a vaccinator and where are they needed. The number of volunteers needed will be based on the number of vaccinations per day. The Department of Health can cover 200. Three Hundred is more challenging. With 600 vaccinations they will need more volunteers. The Department of Health will look at volunteers and see if they could volunteer ½ day for a few months. There will be a greater need for volunteers in the future; however, there are lots of moving parts and things are very fluid right now.

21-05 Strategic Plan Review

Dr. Einterz stated that bullet points have been added to demonstrate progress made in achieving objectives. Dr. Einterz reviewed the 4-year strategic plan. An electronic copy of the strategic plan inclusive of the added bullet points was distributed to all board members and is attached to these minutes.

VIII. OLD BUSINESS

None was presented.

IX. BOARD NOTIFICATIONS

1. Hirings: Giovanni Alvarez, Environmental Health Specialist, 01/04/21

Still need one Social Worker and one Food Safety Inspection Officer.

2. Resignations: None

3. Retirements: None

4. Terminations: None

X. PUBLIC COMMENT

Amy Drake: Ms. Drake discussed adverse reactions to the COVID-19 vaccine and asked if VAERS information is available. She also discussed tainted vaccine in California

Dr. Einterz responded and said they are concerned about adverse reactions and have VAERS information. The California Mod was from a different lot than ours after review.

There was no further public comment.

XI. TIME AND PLACE OF NEXT REGULAR MEETING

The next regular meeting of the St. Joseph County Board of Health is scheduled for Wednesday, February 17, 2021 at 4:30 p.m., at the St. Joseph County Department of Health, 8th Floor Board Room. (Zoom only).

XII. ADJOURNMENT

The meeting was adjourned at 5:57 p.m.

ATTEST:

Robert M. Einterz, M.D.
St. Joseph County Health Officer

Respectfully submitted,

Jamie C. Woods
St. Joseph County Attorney

St. Joseph County Department of Health Strategic Plan 2020 – 2024
Progress to Date, 19 January 2021

Mission

The current mission statement of St. Joseph County Department of Health SJCDoH states: "To promote physical and mental health and facilitate the prevention of disease, injury and disability for all St. Joseph County residents." This strategic plan will affirm the elements of that mission statement. The strategic plan will also include delivery of health care services, enabling access to curative or palliative services, and attentiveness to social well-being.

Vision

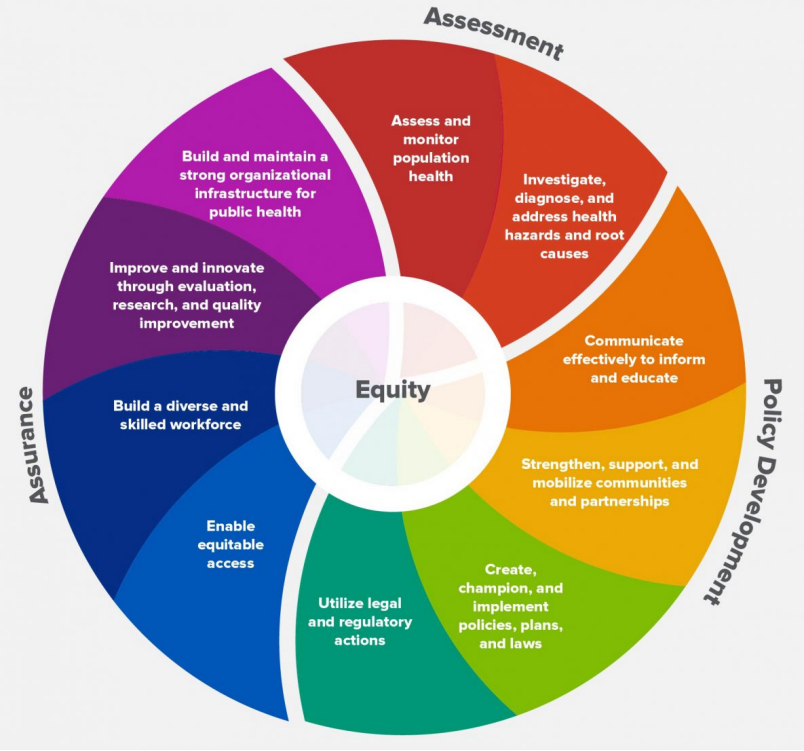
Healthy people in a healthy St. Joseph County.

Values

The strategic plan will align with the following aspirational values: Effectiveness, Efficiency, Equity, Evidence-based Decisions, Excellence, Humility, Integrity, Resiliency, Respect, and Service.

Introduction

This plan uses the definition of health as defined in the Declaration of Alma Ata: Health is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity. According to the US Department of Health and Human Services and the Centers for Disease Control and Prevention, the SJCDoH should perform the following ten essential public health services:



Ten Essential Public Health Services

1. Monitor Health
2. Diagnose and Investigate
3. Inform, Educate, Empower
4. Mobilize Community Partnership
5. Develop Policies
6. Enforce Laws
7. Link to/Provide Care
8. Assure a Competent Workforce
9. Evaluate
10. Research

There is no systematic reporting and assessment in St. Joseph County of the health conditions and associated risk factors, disparities, and inequities. However, based on reports from a number of reliable sources including Robert Wood Johnson County Health Profile; IHME burden of disease report; community assessments done by local hospital systems; interviews with local business, health and medical leaders; reports from ISDH; the documentation and experience of the SJCDoH; and personal experiences, one can ascertain a reasonably accurate list of the most important and/or prevalent health conditions, associated risk factors, disparities, and inequities.

The health conditions that cause the most disability (as measured in DALYs) and death are:

- Ischemic Heart Disease
- COPD
- Drug use disorders
- Lung Cancer
- Low back pain
- Diabetes
- Stroke
- Alzheimer's disease
- Depression/Anxiety disorders
- Headache disorders

Additional conditions that merit inclusion in the above list based on their perceived importance locally coupled with magnitude of disparity are COVID 19; neonatal, infant, and child mortality; maternal mortality; interpersonal violence; sexual health; and, lead poisoning. Furthermore, though a number of conditions such as vaccine preventable diseases; other infectious diseases; and water, food, and vector-borne illnesses are not on the above list, they are not there because the public health department has done a stellar—though often unrecognized—job of controlling and preventing those conditions. The commitment to continuing the activities that control those conditions must remain steadfast.

The risk factors that drive the most disparities, death and/or disability are:

- Adverse childhood experiences
- Poverty
- Racism
- Poor housing
- Tobacco
- High body mass index
- High fasting glucose
- High blood pressure
- Drug use
- High LDL
- Alcohol use
- Impaired kidney function
- Air pollution
- Occupational risks

The long-term aim of the SJCDoH is to minimize the morbidity and mortality associated with each of the above-mentioned health conditions and risk factors. To achieve this aim, SJCDoH will prioritize the following goals and objectives. These goals and objectives were chosen after considering local health conditions and risk factors, and the magnitude of local disparities.

The unit of the Department of Health with responsibility for achieving each objective is designated at the end of each listed objective using the following abbreviations: Environmental Health (EH); Emergency Preparedness (EP); Epidemiology and Health Equity (EQ); Finance/Administration (FA); Food Safety (FS); Health Officer (HO); Health Outreach, Promotion and Education (HOPE); Immunization (IZ); Public Health Nursing (PHN); and Vital Records (VR). The Board of Health is abbreviated BoH.

Goal 1: St. Joseph County Department of Health will be data-driven: We will identify the metrics that matter, have robust information systems and analytics, and aspire to be effective and efficient.

Objective 1.1: Fund, recruit and hire an information system director/team with expertise in information systems, programming, and data sciences. The information system director will be responsible for developing an information system that serves relevant units of the Department of Health, exchanges health and demographic information electronically among the medical and health providers, and integrates seamlessly with ISDH systems. (HO, BoH)

- Partnered with enFocus using CARES Act funding to analyze and improve DoH workflow. Recommendations:

Recommendation	SJCDoH	enFocus
1a - Build Organizational Strength	• Create and hire data strategist position • Purchase data tools through SAS and R	• Draft Data Strategist job description • Fill the job role vacancy until the hire can be made (with SJCDoH approval) • Determine the implementation plan for SAS/R
1b - Implement EMR	• Pursue the purchase of athenahealth	• Determine the implementation plan for athenahealth • Work backwards from April 1, 2021 go-live date
2 - Implement Permitting software	• Collaborate with SJC IPG Dept to pursue the purchase of Energov and DHD	• Determine the implementation plan for Energov/DHD • Work backwards from January 1, 2022 go-live date

- Awarded $70K grant from an anonymous source to fund a data strategist for one year.
- Purchased SAS

Objective 1.2: Compile a list of resources available electronically that report measures of health burden (morbidity, mortality, DALYs), health outcomes, quality of life, health behaviors (smoking, obesity, physical activity, alcohol and drug use, sexually transmitted infections, teen births); clinical care (uninsured, cancer screening, immunizations, chronic diseases, etc); social and economic factors (unemployment, children in poverty, income inequality, violent crime, injuries, etc); and/or physical environment (air pollution, drinking water violations, housing) for the county and in selected geographic and racial/ethnic subsets of the county. (EQ, HOPE)

- Developed partnership with Notre Dame
- Embedded three Masters-trained ND graduates
- Ongoing projects on health disparities, lead prevention and control, and ACEs
- Developing an ACEs dashboard in collaboration with various service providers
- Developing a SJC equity scorecard and report
- Burden of disease report completed and under review

Objective 1.3: Develop a socio-behavioral team (SBT) in partnership with the University of Notre Dame charged with helping the DoH create a learning environment to enable continuous quality improvement of the DoH's activities and programs. (HO, FA, EQ)

- Three faculty members from ND, each with PhD, serve as mentors for the ND/HEED team
- Various faculty from ND participate on an as needed basis to support the above listed projects

Output: Personnel within DoH with expertise in Information Systems; a socio-behavioral team embedded within the DoH; a better, evidence-based understanding of unmet health care needs in SJC.

Outcome: The capacity to investigate and analyze social, behavioral, and economic barriers to achieving stated goals and objectives; a learning environment within SJC;

Impact: Continuous improvement in DoH activities leading to greater reduction in morbidity and mortality in SJC; a system that will enable SJC leadership to monitor and evaluate interventions and guide decision making and policy development

Goal 2: St. Joseph County Department of Health will be equity-focused: Using data, we will identify disparities and we will be leaders in mobilizing resources (personnel, policies, and partnerships) to address them.

Objective 2.1: Develop a Health Equity, Epidemiology and Data Unit and an analytical framework to conduct an equity-focused health impact assessment; define baseline data regarding health disparities and equity in SJC; identify factors contributing to health disparities; and, examine and implement best practices to minimize health disparities; and develop metrics to monitor progress. (EQ, HOPE)

- HEED unit established, directed by Cassandra White
- Equity report and scorecard are being developed
- Burden of disease report provides baseline data

Objective 2.2: Train two DoH staff members to serve as peer navigators to assist uninsured individuals in applying for and receiving health insurance. Include on the website of SJCDoH information that directs individuals seeking health insurance to the appropriate resource and/or navigator. (HOPE, PHN)

- Two CHWs have been hired
- CHWs have been reaching out to individuals who self-identify as uninsured at COVID testing sites; and CHWs have f/u with individuals who request insurance assistance through a social needs assessment that was implemented in the immunization clinic

Objective 2.3: Convene a quarterly meeting of representatives from Healthlinc, Indiana Health Center, Beacon Health System, St. Joseph Health System, and South Bend Clinic to identify and review barriers to care for the uninsured and underinsured, and to determine mechanisms to lower those barriers. (HO, EQ, HOPE)

- SJC HO and deputy HO meet three times/week with VPs of Beacon and St Joe, representative of South Bend Clinic, and a representative of business community/elected officials to plan and implement strategies and activities to control and prevent COVID 19

Objective 2.4: Develop a primary care clinic to serve selected individuals that have difficulty establishing a relationship with a primary care provider. The nature of the services provided by the clinic will be determined, in part, by the findings of the health impact assessment. Possible services will include medical assessment of newly arrived refugees, contraception, diagnosis and treatment of sexually transmitted infections, tuberculosis diagnosis and treatment, follow up of selected individuals who test positive for COVID 19, lead draws, and well-baby visits. Explore collaborating with the student clinic at the School of Medicine. (HO, EQ, PHN)

- Ongoing discussions with Beacon Family Medicine residency at E. Blair Warner regarding starting a refugee clinic
- Ongoing discussions with leaders of a potential refugee resettlement program in SJC

Objective 2.5: Participate in Fetal, Infant and Child Mortality Review Committees; compete successfully for renewal of the FIMR program; continue to employ SJC's FIMR coordinator (HOPE, EQ)

- Sally Dixon continues to lead this effort, hold regular FIMR meetings with multiple collaborators

Objective 2.6: Determine which local organizations overlap with the mission and goals of DoH, prioritize them, and network with them on a priority basis. (HOPE)

- Work in progress led by Robin Vida

Objective 2.7: Identify all children served by DoH in SJC who need immunizations (IZ)

1. List all children who are behind on immunizations, and reduce the number of children behind on immunizations by 20% by 2022.
    - Make reminder recalls
    - Send reminder postcards
    - Offer appointments
2. Expand the number of opportunities for children to receive immunizations.
    - Mobile Clinics—we will offer 10 in the next year specifically geared at the schools.

- Fire House Blitz -back to school vaccines—one in 2020.
- Saturday Clinic--offer 4 per year.
- Additional clinic hours in late afternoon/early evening—2 per month

3. Cross train 2 additional RNs trained from the registration process to the RN process in the next 12 months.

Objective 2.8: Increase immunizations in under resourced populations by focusing on where the disparities and unmet needs are within the community. (IZ and EQ)

Objective 2.9: Compile and review best public health practices to reduce the incidence of ASCVD, COPD, Diabetes, and Lung Cancer; determine if those best practices are being in implemented in SJC; and of those practices that are not being implemented, assess the feasibility of implementing them next year. (HOPE, EQ)

Objective 2.10: Assess access to and availability of reproductive health services in SJC, identify any gaps, and develop a strategy to fill those gaps. (HO, EQ, PHN)

Output: Heightened awareness among the public about local health disparities and inequities; capacity to link uninsured individuals and their families to health insurance; regular meetings to address barriers to care among institutions that deliver medical care; identification of some barriers to receiving immunizations and some new activities to reduce those barriers; improved access and availability of contraception; participation on key committees pertaining to fetal, infant, child, and maternal mortality.

Outcome: A roadmap toward more equitable health care in SJC; more responsiveness on the part of DoH and SJC to barriers to care; increased immunization rates; reduction in uninsured rates in SJC; improved access to contraception; improved policies and procedures to reduce fetal, infant, child and maternal mortality.

Impact: Greater access to and availability of care; reduced incidence of unintended and mistimed pregnancies; a more equitable health system; a reduction in morbidity and mortality; reduction in fetal, infant, child and maternal mortality.

Goal 3. St. Joseph County Department of Health will address the social factors impacting health, most notably poverty, racism, and trauma. We will do this through enhanced community engagement and education, and expanded personnel and services (CHWs, navigators, and social workers).

Objective 3.1: Assess public understanding of Adverse Childhood Experiences and their short and long-term health consequences including their impact on racial disparities, chronic diseases, anatomic and physiological changes in the brain, etc. Develop a strategy to respond to the gaps in the public's understanding of ACEs. (HOPE, EQ)

- Ongoing project led by Frank Spesia working with HEED unit, ND collaborators

Objective 3.2: Create the capacity to monitor the incidence of child hood trauma in SJC including personal trauma (physical abuse, verbal abuse, sexual abuse, physical neglect, and emotional neglect)

and family trauma (parents with alcohol use disorder, domestic violence in the home, family member in jail, family member with mental illness, and loss of parent through divorce, death or abandonment); and, develop an accrual ACE scorecard. (EQ)

- Developing the ACE scorecard is an ongoing project, currently under evaluation by ND, Oaklawn, United Way and Beacon

Objective 3.3: Identify evidence-based best practices for the primary prevention of ACEs; identify and list the organizations/agencies that have already implemented programs to raise awareness of ACEs; and, describe any interventions that they have implemented for primary or secondary prevention of ACEs (that is, interventions that reduce the incidence of ACEs or improve resiliency of individuals, families and communities that suffer trauma). (EQ, HOPE)

- Best practices were identified by the HEED unit and Mr. Spesia; the HEED unit submitted one grant to NACCHO requesting funding to implement best practices

Objective 3.4: Engage parents and other community members in dialogue about racism and black infant mortality. (EQ, HOPE)

- BoH declared racism a public health crisis; BoH members and DoH leadership have participated in multiple community wide for in follow up of that declaration

Objective 3.5: Recruit, hire, and deploy community health workers with "lived experience" to build relationships between SJCDoH and the communities it serves and to work in partnership with the community to reduce health disparities including lead poisoning, infant mortality, and selected other conditions; enhance access to and utilization of lead testing, case management, and remediation; develop a strategy to form peer groups to address lead and other health conditions; leverage social media to facilitate interaction among CHWs and groups. The DoH will hire a couple of mothers and/or grandmothers whose children/grandchildren had lead poisoning and whose home subsequently participated in a lead abatement program. The CHWs will be recruited from low income, Black and Latinx neighborhoods. We will explore forming a social media support group (e.g. using WhatsApp) consisting of mothers in the community with children who are diagnosed with high lead levels. We will also explore replicating in SJC the We Care program that has successfully reduced Black infant mortality rate in Marion County. (HO, HOPE, EQ, EH)

- The HEED unit hired one LatinX male and one Black woman to serve as CHWs; they have been working on a number of issues including lead poisoning, health insurance, and COVID related matters.
- Exploration of the WeCare program done in context of writing and submitting the Safety Pin proposal with Beacon Health System

Objective 3.6: Convene a meeting every four months of high-level representatives from IU School of Medicine, Beacon and St. Joseph Health Systems, South Bend Clinic, Healthlinc, IHC, South Bend Regional Chamber of Commerce, and the Health Officer to review and respond to priority health issues. (HO)

- Unified Command meets three times weekly

Objective 3.7: Convene a meeting every four months of the Mayors of Mishawaka and South Bend, the President of the County Commissioners, the Health Officer and Deputy Health Officer to review and respond to priority health issues. (HO)

- Deputy HO, President of Commissioners, and Mayor of SB meeting every other week in a press conference focused on COVID 19

Objective 3.8: Explore with law enforcement, emergency response units, hospital systems, behavioral health systems, and other local and state partners the feasibility of creating, funding, implementing, monitoring and evaluating a pilot program of crisis intervention consisting of crisis interventionists employed by the Department of Health or health systems to provide mobile crisis intervention in response to non-criminal situations including substance abuse, mental/emotional crisis, disorientation, and dispute facilitation - providing assessment, intervention, and transport to services as needed. (HO, EQ, HOPE)

- The Health Officer and the director of HOPE have had multiple meetings regarding this matter with SBPD, SJCPD, Oaklawn, Epworth, 911 Dispatch, BLM leadership, elected leaders, and others. A collaborative group is writing a proposal in response to a block grant opportunity.

Objective 3.9: Recruit and hire one master's trained, licensed clinical social worker. (HO, EQ)

- A social worker was hired but did not work out well. We continue to pursue other options.

Objective 3.10: Increase the visibility and utilization of the SJC Reducing Obesity Coalition

Objective 3.11: Improve the SJC Food Access Council infrastructures and direction by creating operating principles and structure based on best practices for food access sustainability; and, by developing a draft food action plan.

Objective 3.12: Develop and implement a strategy for needle exchange and other evidence-based harm reduction strategies. (HO, HOPE, EQ)

- Collect and disseminate the evidence supporting needle exchange as a best practice
- Liaise with partners in the community to develop a specific policy for needle exchange, a strategy for adopting it, and a procedure for implementing and monitoring it
- Review, update, and continue ongoing efforts to distribute harm reduction packets inclusive of naloxone.

Output: Meetings that produce a more collaborative, coordinated, and community based approach to lead prevention, remediation, abatement; infant mortality; ACEs; obesity; food security; and crisis intervention; a set of indicators that will serve as a "report card" on the health of SJC, including adverse childhood experiences; a strategy to inform the public about ACEs; a list of best public health practices that SJC should consider implementing to prevent the most prevalent chronic diseases; implementation of novel programs to reduce infant mortality and respond to crisis situations; a pilot program to reduce interpersonal violence and trauma; augmentation of DoH with addition of a licensed clinical social worker; a needle exchange policy and procedure

Outcome: Increased lead testing, reduction in lead poisoning, IMR, incidence of ACEs, obesity, food insecurity, and incarceration rates, a pilot program of crisis intervention that holds the promise of scale-

up in the future; reduction in the incidence of HIV, hepatitis B and C, cellulitis due to injecting drug use, infective endocarditis.

Impact: A healthier and safer community; reduction in racial tension; reduction in the long-term morbidity and mortality of numerous chronic diseases, reduced morbidity and mortality from injecting drug use; huge cost savings to the public

Goal 4: The St. Joseph County Department of Health will strengthen its infrastructure to meet all statutory requirements.

Objective 4.1: Identify the steps of national certification of the DoH. (FA)

- In progress

Objective 4.2: Create a culture of professional development for Department of Health by identifying professional development needs and developing and implementing professional development programming. Likely components of such programming will include a list of continuing public health education opportunities for all staff; documentation and reporting of the continuing public health education activities of each member of the DoH; a department-wide health communications strategy & plan with a focus on wellness, inclusive of a department-wide listserv and newsletter. (HOPE, FA)

- In progress; $12K budgeted for professional development in 2021; Implicit bias training completed

Objective 4.3: Develop more robust capacity to bill third-party payors for clinical services provided by SJCDoH, either contractually or by creating capacity within DoH. (PHN, FA)

- In progress

Objective 4.4: Develop and implement a customer satisfaction survey for Vital Records, Environmental, Immunizations, and Food Services units. (HOPE)

- The instrument has been developed but not yet implemented

Objective 4.5: Continue to provide immunization clinic and vital records services at the CCB and in Mishawaka. (IZ, VR)

- Ongoing

Objective 4.6: Provide on-site birth certificate service within the community corresponding with other community-based outreach initiatives. (VR)

- Monthly meeting among HOPE and Vital Records team to coordinate better on outreach initiatives—In progress.
- Contact community partners for scheduled events that could benefit from onsite access to birth certificates (little leagues, kindergarten round-up, etc.) In progress.
- Secure mobile equipment and IT standards to make these efforts obtainable—in progress.

Objective 4.7: Expand online services for customers seeking Vital Records (VR)

- Continue/complete digitizing and indexing of vital records—done!

- Communicate with ISDH and up to three other counties to see if we could benefit from any of their programing or procedures—in progress

Objective 4.8: Train vital records staff to use and implement ISDH's Database Registration of Indiana's Vital Events (VR)

- In progress

Objective 4.9: Retain public health nursing, pandemic/disaster preparedness, environmental, and food safety teams; re-assess their reporting relationships and scopes of work to promote greater efficiency; respond expeditiously and effectively to complaints received from the community; meet statutory obligations. (HO, all units, BoH)

- In progress; salaries for multiple unit directors and pandemic preparedness staff are far below market and need to be boosted

Objective 4.10: Establish a vector program to educate and protect the public from vector borne diseases, particularly Eastern Equine Encephalitis and West Nile Virus. (EH)

- Secure a minimum of $25K funding. Done, grant funded by an anonymous donor.
- Increase surveillance and mitigation of mosquitoes (ULV spraying, larvicide, and public education). Done
- Purchase a ramp reader and cartridges specific to West Nile Virus. Done
- Map mosquito breeding sites and trapping locations in GIS.
- Increase tick surveillance. Done

Objective 4.11: Improve internal and public transparency of the Food Service Unit through clear, intentional, and effective communication. (FS)

- Establish/verify working email contact list for all permitted establishments—Done.
- Review and update website information, and create an area for Frequently Asked Questions—In progress.
- Establish web access of inspection/complaint investigation results.

Objective 4.12 Review and revise the Food Service permit renewal process (FS)

- Identify steps to simplify or modify procedures—In progress.
- Expand on-line permit renewals to include annual permits—In progress.
- Add evening/weekend service hours during January renewal—no longer pursuing.

Objective 4.13: Revise routine Food Service inspection process to include a scheduled procedure consult. (FS)

- Survey target establishments to determine interest and relevant topic areas
- Develop consultation format—Done.
- Create a method to assess consultation's impact.

Objective 4.14: Improve indoor air quality, specifically addressing radon, in under resourced populations by partnering with school systems to distribute radon test kits to improve the current dataset and increase awareness. (EQ, EH and HOPE)—In progress.

Objective 4.15: Improve tracking and management of septic cluster systems. (EH)

- Create a program or develop Filemaker to allow for centralized tracking of maintenance reports and escrow payments. In progress.
- Update database to allow for the input of all available data, past and present. In progress.
- Develop auto-generated correspondence for delinquent accounts. Not started.

Objective 4.16: Improve the timeliness of the septic permitting process (EH)

- Work with EnFocus to review, analyze and map the current septic permitting process—Done.
- Develop a permit timeliness tracking system—In progress.

Output: Listing of steps toward national certification; educational opportunities for staff; capacity to bill third party payors; results of a customer satisfaction survey; retention of DoH workforce; and an expanded vector control program

Outcome: First steps toward national certification; more informed and competent staff; improved capacity to generate revenue; communicable diseases are quantified, reported and controlled; capacity to investigate environmental health and food safety complaints; data to make strategic decisions regarding COVID; reduced incidences of West Nile Virus and EEE; improved tracking of septic cluster systems and a review of the septic permitting process; more efficient and effective septic tracking and permitting

Impact: Higher quality services provided by DoH; greater efficiency, sustainability and responsiveness of the DoH; improved customer service; greater protection of the environment; statutory obligations are fulfilled; prevention of morbidity and mortality from communicable diseases and food and water borne illnesses

Goal 5: St. Joseph County Department of Health will control the spread of respiratory viral illnesses including SARS-CoV-2 and influenza.

Objective 5.1: Continue to convene and participate on St. Joseph County Unified Command, consisting of representatives of St. Joseph County Department of Health, Beacon Health System, St. Joseph Health System, the South Bend Clinic, and the COVID-19 Response Coordinator, serving as a liaison to the elected officials and the business community in the South Bend region.

- On going 3X/week

Objective 5.2: Plan and prepare for mass SARS-CoV-2 immunization of SJC residents.
With the certain development of a COVID-19 vaccine, planning for mass immunization of county residents is essential. Planning strategy should start soon to ensure locations, staffing, and outside partners are prepared to take on this task, though some strategies may change based on ISDH guidance. (EP, IZ)

- Evaluate health department training needs pertaining to dispensing operations.
- Identify and procure needed POD PPE and resources.

- EP, IZ and HOPE to meet and identify alternate/drive thru dispensing sites.
- Assign staff POD positions and train accordingly.
- Based on ISDH guidance, identify needed community partners for vaccine distribution.
- Formulate temporary MOU's with identified partners.
- Train partners in POD organization and operation.
- Identify vendors capable of meeting our needs.
- Establish outside partners willing to allow us to piggyback off their suppliers, like how we partnered with ND to access supplies during the early COVID pandemic.

All the above have been done as of Jan 2021

Objective 5.3: Using CARES funding, establish two SARS-Co-V testing sites welcoming of all people but accessible to uninsured and underinsured populations in Black and Latinx neighborhoods. The sites will have capacity to do diagnostic and serological testing for SARS CoV 2, and to respond to testing needs in selected congregate living centers serving persons experiencing homelessness. (HO, PHN, HOPE, EQ)

- Done contractually through South Bend Clinic through end of 2020 @ St. Adalbert, and for a lesser time period at WUBS
- COVID serological testing done for selected homeless population

Objective 5.4: Plan and prepare for the upcoming influenza season in tandem with a surge in COVID 19 (EP, HOPE, EQ)

- Review usage of PPE during the first half of 2020 and project the quantity and cost of needed PPE for stockpiling in SJC in the event of a viral pandemic in the future.
- Establish outside partners willing to allow us to piggyback off their suppliers, similar to how DoH collaborated with University of Notre Dame to order PPE during the early COVID epidemic.
- Review best practices for promoting influenza vaccine and implement them (IZ, HOPE, EP)

Done; of note, the incidence of influenza to date has been negligible in SJC and across much of the world

Objective 5.5: Create the capacity to isolate and quarantine persons experiencing homelessness who are infected with SARS-CoV-2 or under investigation for infection with SARS-CoV-2. (HO, EQ, PHN)

- Done at Motel 6 in 2020

Output: Immunization campaign for SARS CoV 2 ready to begin as soon as a vaccine is available; knowledge and awareness of the PPE levels and resources that will be needed for future pandemics or emergency situations; functional isolation and quarantine to protect the public from COVID 19 and to protect the health of persons experiencing homelessness

- Ongoing at Hedwig Memorial Center

Outcome: Quantification of the degree of immunity to SARS-CoV-2 in select populations; herd immunity within SJC against SARS-CoV-2; political commitment to stockpile needed PPE and related commodities; reduced transmission of SARS-Co-V-2 and influenza

Impact: Reduced morbidity and mortality from COVID 19 and influenza