St. Joseph County Department of Health Strategic Plan 2020 – 2024

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

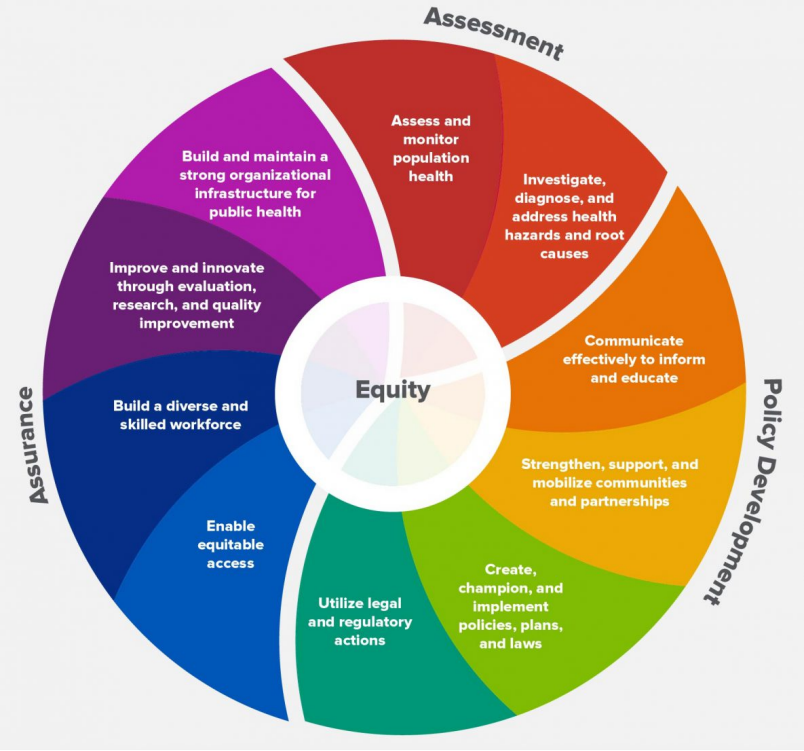
Healthy people in a healthy St. Joseph County.

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)

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)

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)

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)

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)

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)

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)

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)

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)

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)

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)

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)

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

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)

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)

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)

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)

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

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)

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)

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)

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

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

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
- Contact community partners for scheduled events that could benefit from onsite access to birth certificates (little leagues, kindergarten round-up, etc.)
- Secure mobile equipment and IT standards to make these efforts obtainable

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

- Continue/complete digitizing and indexing of vital records
- Communicate with ISDH and up to three other counties to see if we could benefit from any of their programing or procedures

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

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)

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.
- Increase surveillance and mitigation of mosquitoes (ULV spraying, larvicide, and public education).
- Purchase a ramp reader and cartridges specific to West Nile Virus.
- Map mosquito breeding sites and trapping locations in GIS.
- Increase tick surveillance.

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
- Review and update website information, and create an area for Frequently Asked Questions
- 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.
- Expand on-line permit renewals to include annual permits
- Add evening/weekend service hours during January renewal.

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
- 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)

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.
- Update database to allow for the input of all available data, past and present.
- Develop auto-generated correspondence for delinquent accounts.

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
- Develop a permit timeliness tracking system

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.

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.

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)

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)

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)

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

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