BRANCH-HILLSDALE-ST. JOSEPH COMMUNITY HEALTH AGENCY | YOUR LOCAL HEALTH DEPARTMENT
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BOARD OF HEALTH
Agenda for April 25, 2019 at 9:00 AM

1. Call to Order
   a. Opening ceremonies – Pledge Allegiance to the Flag of the United States of America
   b. Roll Call
   c. Approval of the Agenda*
   d. Approval of the Minutes*

2. Public Comment

3. Health Officer's Report

4. Medical Director's Report

5. Committee Reports
   a. Finance Committee – Did not meet
   b. Program, Policies, and Appeals – Did not meet

6. Financial Reports
   a. Approve Payments*
   b. Review Financials

7. Unfinished Business
   a.

8. New Business
   a. Personnel Policy Changes*
   b.
   c.

9. Departmental Reports
   a. Environmental Health
   b. Area Agency on Aging
   c. Personal Health & Disease Prevention

10. Adjournment - Next meeting: May 23, 2019 at the Coldwater office

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March 28, 2019 – Board of Health Meeting Minutes

The Branch-Hillsdale-St. Joseph Community Health Agency Board of Health meeting was called to order at 9:02 a.m. by Chairman, Don Vrablic, with the Pledge of Allegiance to the Flag of the United States and roll call as follows: Don Vrablic, Bruce Caswell, Terri Norris, Al Balog, and Mark Wiley.

Also present from BHSJ: Rebecca Burns, Dr. Vogel, Theresa Fisher, Yvonne Atwood, Joe Frazier, and Laura Sutter.

Ms. Norris moved to approve the agenda with support from Mr. Wiley. The motion carried.

Ms. Norris moved to approve the minutes from the previous meeting with support from Mr. Wiley. The motion carried.

Public comment:

- None

Rebecca Burns, Health Officer, reviewed her monthly report. Items discussed: Annual Audit Year End Close, Hometown Hero Award, LARA's Legal Division of the Bureau of Medical Marihuana Regulation, AAA3c, Personnel Policy Manual, New Software Updates, Legionella, Health Promotion & Education Updates, Staff Vacancies, Agency Attorney, Annual All Staff Meeting, Comprehensive Compensation Study, Legislative Updates, and the Hepatitis A Outbreak.

Dr. Vogel, Medical Director, reviewed the Medical Director's monthly report. This month's reports covered Colorectal Cancer Screening.

Committee Reports:

- Finance Committee – Did not meet.
- Program, Policy, and Appeals Committee – Did not meet.

Financial Reports/Expenditures

- Ms. Norris moved to approve the expenditures as reported with support from Mr. Wiley. The motion carried.

Unfinished Business

- There was no unfinished business to discuss.

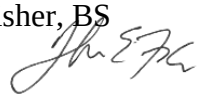
New Business:

a. Ms. Norris moved to place the audit on file with support from Mr. Balog. The motion carried.

b. Ms. Norris moved to amend our EH Food Services Fee Schedule to reflect the increase to the state surcharge, understanding that the proposed schedule included in the packet contains a clerical error and should read $30 in the state surcharge column, effective March 28, 2019, with support from Mr. Wiley. The motion carried (4-1).

Ms. Norris moved to adjourn the meeting with support from Mr. Wiley. The motion passed and the meeting was adjourned at 10:40 AM.

Respectfully Submitted by:
Theresa Fisher, BS



BRANCH-HILLSDALE-ST. JOSEPH COMMUNITY HEALTH AGENCY | YOUR LOCAL HEALTH DEPARTMENT
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Health Officer's Report to the Board of Health for April 25, 2019
Prepared by: Rebecca A. Burns, M.P.H., R.S.

Agency Updates

Day at the Capitol – The annual MALPH day of advocacy for local public health was held on April 10th. I was able to schedule personal appointments with Representatives Miller and Leutheuser and Senator LaSata and met with a staff member of Senator Shirkey while in Lansing that day. I discussed the activities conducted by the local health department, shared the most recent annual report, shared the updated county health rankings, and discussed the importance of continued funding and increases to that funding. I ended up attending by myself this year as the potential measles exposure in Sturgis kept Yvonne back in the district to help in vaccinating anyone with a potential exposure and Commissioner Pangle was unable to attend due to illness. Unfortunately I was also battling a bad viral cold in my lungs and my meetings with the legislators were brief due to my inability to keep from coughing. I'm sure Representative Leutheuser wanted to walk through a cloud of sanitizer after I had been in his office that morning.

Also that day a Hometown Health Hero award was presented to Laura Brott from the St. Joseph County Human Services Commission. I, along with other HSC executive board members and Laura Sutter, all wrote letters nominating Laura for this honor. The Award is presented annually to individuals and organizations that have made significant contributions to preserve and improve their community's health in the focus areas. Awardees are selected from nominations received. The only way for someone to receive this award is to be nominated. Laura was also honored with a Tribute from Representative Miller and Senator LaSata during the ceremony.

County Health Rankings - I have included the new County Health Rankings in your Board packet today. Branch and Hillsdale both dropped in the rankings while St. Joseph rose. Where there was once a wide difference between Hillsdale and St. Joseph counties, they are moving closer together. In general, Branch and Hillsdale are in about the middle with St. Joseph being in the very bottom of the middle third.

Medical Marihuana Education Grant – The Agency has started to put our plan into motion with Health Educators Kelley Mapes and Rochelle Agar getting the work done. Our focus is on preventing exposure of Medical Marihuana to kids and keeping it locked up. We will have lock boxes for anyone who is interested in having one.

AAA 3C – I would like to set-up a meeting of the Program, Policy, and Appeals Committee within the next month to discuss and review a proposal to formalize the AAA within the local health department and provide for sustainable funding.

Personnel Policy document – The changes proposed to the Personnel Policy document are included in your packet today. I did receive a recommendation from Commissioner Wiley to include language in the policies about recreational marijuana and medical marihuana and we have shared proposed language

with the Agency's attorney. Although nothing is currently in the policy that is specific to this topic, we can bring the document back to the Board of Health once we have language suggested from the attorney.

New Database Updates –

- **HealthSpace:** Progress is moving along; although slower than we would have hoped. The sanitarians working in the well/septic programs have just been able to start testing.
- **Nightingale Notes:** Nightingale Notes training is moving along nicely with a core team of staff on the implementation team working to get the system set-up to go live. Data has been sent for testing up to MICR and that went well.

Health Promotion & Education Updates – The Agency's HPE team has written 3 news releases for local media and posting on our website since the last Board of Health meeting. These include:

- National Nutrition Month: Importance of Breakfast (3-25-2019)
- National Nutrition Month – Importance of Kitchen Safety (3-28-2019)
- Potential Measles Exposure in St. Joseph County, MI (4-8-2019)

There have also been plenty of informative posts to the WIC Facebook page and a number of new car seats installed to protect our tiny new community members. And initial work on the Medical Marihuana Operation and Oversite Grants workplan has been completed by Rochelle and Kelley.

Staff Vacancies/New Staff – The Agency currently has the Clinic Coordinator (RN position) and two EH Sanitarian positions open in the Hillsdale office. One of the EH Sanitarian positions is a previously unfilled opening left vacant during the recession. As EH demand services have increased in recent years the residents in the county have experienced longer wait times for permits due to staffing constraints and the food program is understaffed based on our foodservice establishment volume. This position will be blended with responsibilities for food service inspections and well and septic permit issuance and inspection. The Breastfeeding Peer Support Worker position in St. Joseph county is nearly wrapped up with reference calls being made.

Comprehensive Compensation Study – The company we have engaged, Municipal Consulting Services, LLC, will begin the study on June 1st with a final report due by no later than September 30th. I will keep you informed as this process starts.

Measles – Unfortunately, this once thought to be eradicated disease in the United States is back with outbreaks around the country. In Michigan the outbreak is primarily in Oakland County but we continue to be advised of public places outside of Oakland County that are now a potential exposure risk for anyone unvaccinated. The MMR vaccine (Measles, Mumps, Rubella) is very safe and everyone should receive the recommended doses unless their in a contraindication. In addition to the Michigan outbreak, we also had an Indiana resident visit locations in Sturgis and potential expose the public. We sent out special messaging and held two vaccine clinics in the Sturgis area to get unvaccinated people immunized.

Legislative Updates – None at this time.

Hepatitis A Outbreak – Our "outbreak nurse" has been very busy getting the high risk population immunized in Branch, Hillsdale, and St. Joseph counties. I am very pleased with the activity we are providing.

As I have been reporting, Michigan is in the midst of a serious Hepatitis A outbreak. Current case count as of April 17, 2019 is 913 with 733 hospitalizations and 28 deaths. The case county increased by one from last month. None of the counties in Michigan are considered to be an outbreak county, as you can see from the graphic below. The Agency continues to put special emphasis on increasing our

vaccination rates for adult Hep. A, especially of the high-risk individuals. Hepatitis A vaccination is safe and effective. The following individuals should get the HAV vaccine:

- Persons who are homeless.
- Persons who are incarcerated.
- Persons who use injection and non-injection illegal drugs.
- Persons who work with the high-risk populations listed above.
- Persons who have close contact, care for, or live with someone who has HAV.
- Persons who have sexual activities with someone who has HAV.
- Men who have sex with men.
- Travelers to countries with high or medium rates of HAV.
- Persons with chronic liver disease, such as cirrhosis, hepatitis B, or hepatitis C.*
- Persons with clotting factor disorders.

Confirmed Cases Referred August 1, 2016 - April 17, 2019
Meeting the MI Hepatitis A Outbreak Case Definition

County (or city)	Total Cases		County (or city)	Total Cases
Macomb	223		Saginaw†	4
City of Detroit	173		Gratiot	3
Wayne†	164		Midland†	3
Oakland†	120		Allegan†	2
St. Clair†	33		Mecosta†	2
Ingham†	29		Bay†	1
Genesee†	27		Charlevoix	1
Shiawassee†	22		Clare†	1
Washtenaw†	20		Hillsdale†	1
Monroe†	18		Huron†	1
Calhoun	10		Ionia†	1
Isabella†	8		Leelanau†	1
Lapeer†	7		Lenawee†	1
Clinton†	6		Missaukee	1
Livingston†	6		Newaygo†	1
Sanilac†	6		Schoolcraft†	1
Eaton†	5		Van Buren†	1
Grand Traverse†	4		Other*†	2
Kent†	4			

† Indicates no confirmed case in the past 100 days

*Jackson Michigan Department of Corrections

Indicates counties with outbreak-associated cases that are not currently included in the outbreak jurisdiction

County Health Rankings – Branch County 2019

The Robert Wood Johnson Foundation is collaborating with the University of Wisconsin Population Health Institute to develop these Rankings for each state's counties.

County Health Rankings
Mobilizing Action Toward Community Health
countyhealthrankings.org

	BRANCH COUNTY	ERROR MARGIN	Top U.S. Performers*	MI	RANK (OF 83)
HEALTH OUTCOMES					**45**
Length of Life					**53**
Premature Death–Years of Potential Life Lost before age 75 per 100,000 population (age-adjusted). (2015-17)	**7,800**	6,800-8,800	5,400	7,600	
Quality of Life					**28**
Poor or Fair Health-**% of adults reporting fair or poor health. (age-adjusted) (2016)	**16%**	15-16%	12%	17%	
Poor Physical Health Days–**Average no. of physically unhealthy days reported in past 30 days (age-adjusted). (2016)	**4.1**	3.9-4.4	3.0	4.3	
Poor Mental Health Days–**Average no. of mentally unhealthy days reported in past 30 days (age-adjusted). (2016)	**4.1**	3.9-4.3	3.1	4.4	
Low Birth Weight–% of live births with low birth weight (< 2500 grams).(2011-17)	**7%**	6-8%	6%	8%	
HEALTH FACTORS					**62**
Health Behaviors					**67**
Adult Smoking-**% of adults who are current smokers. (2016)	**19%**	19-20%	14%	20%	
Adult Obesity–% of adults that report a BMI >=30. (2015)	**35%**	29-42%	26%	32%	
Food Environment Index-Index of factors that contribute to a health food environment, 0 (worst) to 10 (best). (2015-16)	**8.4**		8.7	7.1	
Physical Inactivity-% of adults aged 20 and over reporting no leisure-time physical activity. (2015)	**28%**	22-34%	19%	22%	
Access to Exercise Opportunities-% of population with adequate access to locations for physical activity. (2010, 2018)	**62%**		91%	85%	
Excessive Drinking–**% of adults reporting binge or heaving drinking. (2016)	**20%**	19-21%	13%	21%	
Alcohol-impaired Driving Deaths–% of driving deaths with alcohol involvement. (2013-17)	**33%**	24-43%	13%	29%	
Sexually Transmitted Infections–No. of newly diagnosed Chlamydia cases per 100,000 population. (2016)	**203.8**		152.8	462.9	
Teen Births–No. of births per 1,000 female population, ages 15-19 years. (2011-17)	**33**	29-37	14	22	
Clinical Care					**76**
Uninsured-% of population under age 65 without health insurance. (2016)	**8%**	7-9%	6%	6%	
Primary Care Physicians–Ratio of population to primary care physicians. (2016)	**2,070:1**		1,050:1	1,260:1	
Dentists-Ratio of population to dentists. (2017)	**1,810:1**		1,260:1	1,360:1	
Mental Health Providers- Ratio of population to mental health providers. (2018)	**700:1**		310:1	400:1	
Preventable Hospital Stays–Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees. (2016)	**5084**		2765	5188	
Mammography Screening–% of female Medicare enrollees, ages 65-74 that received an annual mammography screening. (2016)	**38%**		49%	43%	
Flu vaccinations–% of fee-for-service (FFS) Medicare enrollees that had an annual flu vaccination. (2016)	**43%**		52%	45%	
Social & Economic Factors					**31**
High School Graduation-% of ninth grade cohort that graduates in 4 years. (2016-17)	**82%**		96%	80%	
Some College–% of adults aged 25-44 years with some post-secondary education. (2013-17)	**52%**	48-56%	73%	68%	
Unemployment–% of population age 16 and older unemployed but seeking work. (2017)	**4.7%**		2.9%	4.6%	
Children in Poverty-% of children under age 18 in poverty. (2017)	**19%**	14-24%	11%	20%	
Income Inequality– ratio of household income at the 80th percentile to income at the 20th percentile. (2013-17)	**3.7**	3.5-3.9	3.7	4.7	
Children in Single-parent Households–% of children that live in a household headed by single parent. (2013-17)	**30%**	25-34%	20%	34%	
Social Associations–No. of membership associations per 10,000 population. (2016)	**12.7**		21.9	9.9	
Violent Crime–No. of reported violent crime offenses per 100,000 population. (2014-16)	**277**		63	443	
Injury Deaths–No. of deaths due to injury per 100,000 population. (2013-17)	**68**	57-79	57	72	
Physical Environment					**80**
Air Pollution-particulate Matter-Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5). (2014)	**11.8**		6.1	8.4	
Drinking Water Violations-Indicator of the presence of health-related drinking violations. Yes indicates the presence of a violation, No indicates no violation. (2017)	**Yes**				
Severe Housing Problems–% of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities. (2011-15)	**15%**	13-17%	9%	16%	
Driving Alone to Work-% of the workforce that drives alone to work. (2013-17)	**84%**	82-86%	72%	83%	
Long Commute-driving Alone –Among workers who commute in their car alone, the % that commutes more than 30 minutes. (2013-17)	**25%**	23-27%	15%	33%	

* 10th/90th percentile, i.e., only 10% are better. Note: Blank values reflect unreliable or missing data. **Data should not be compared with prior years due to changes in definition/methods

BRANCH-HILLSDALE-ST. JOSEPH COMMUNITY HEALTH AGENCY | YOUR LOCAL HEALTH DEPARTMENT

Additional Indicators – Branch County

	BRANCH COUNTY	MI
Demographics		
Population (2017)	43,410	9,962,311
% Below 18 Years of Age (2017)	23.4%	21.8%
% 65 and Older (2017)	17.8%	16.7%
% Non-Hispanic African American (2017)	2.1%	13.8%
% American Indian & Alaskan Native (2017)	0.5%	0.7%
% Asian (2017)	0.7%	3.2%
% Native Hawaiian/Other Pacific Islander (2017)	0%	0%
% Hispanic (2017)	4.7%	5.1%
% Non-Hispanic White (2017)	90.5%	75.2%
% not proficient in English (2013-17)	2%	1%
% Females (2017)	48.4%	50.8%
% Rural (2010)	62.7%	25.4%
Health Outcomes		
Diabetes Prevalence (2015)	11%	11%
HIV Prevalence Rate (2015)	47	175
Premature Age-Adjusted Mortality (2015-17)	380	370
Frequent Physical Distress (2016)	12%	13%
Frequent Mental Distress (2016)	13%	14%
Infant Mortality (2011-17)	8	7
Child Mortality (2014-17)	70	50
Health Behaviors		
Food Insecurity (2016)	12%	14%
Limited Access to Healthy Foods (2015)	1%	6%
Drug Overdose Deaths (2015-17)	18	24
Motor Vehicle Crash Deaths (2011-17)	15	10
Insufficient Sleep (2016)	38%	37%
Health Care		
Uninsured Adults (2016)	10%	8%
Uninsured Children (2016)	5%	3%
Other Primary Care Providers (2018)	1,973:1	1,064:1
Social & Economic Factors		
Disconnected Youth (2013-17)	12%	7%
Median Household Income (2017)	$49,400	$54,800
Children Eligible for Free Lunch (2016-17)	52%	46%
Residential Segregation–black/white (2013-17)	60	73
Residential Segregation–non-white/white (2013-17)	41	60
Homicides (2011-17)		6
Firearm Fatalities (2013-17)	10	12

What Does the Data Mean for My County?

The *Rankings* are based on a model of population health that emphasizes many factors that, if improved, can help make communities healthier places to live, learn, work and play. Michigan's eighty-three counties are ordered according to summaries of a variety of health measures. Those factors having high ranks, e.g. 1 or 2, are considered to be the "healthiest." The model uses the following summary measures:

- **Health Outcomes** are based on an equal weighing one mortality measure and four morbidity measures.
- **Health Factors** are based on weighted scores of four types of factors: Health Behaviors, Clinical Care, Social & Economic and Physical Environment measures. Health Outcomes measures are used to understand the current health status of the population, while Health Factors are used to predict its future health needs.

What are the Public Health Cost Savings Associated with Prevention

Funding public health can result in significant cost savings for local communities. Did you know that:

- Every **$1 spent on immunization saves $6.30** in **medical costs**. In addition, when including indirect costs to society, such as missed work days, death and disability, as well as the direct medical costs, the CDC estimates that every **$1 spent on immunization saves $18.40.**
- On average, a **$52** child safety seat prevents **$2,200** in medical sending. **This is a return of $42 for every $1 invested**. (Child Safety Network and PIRE)
- Every **$1 spent on preventive dental care** could **save $8 to $50 in restorative** and emergency treatment (American Dental Hygienist Assoc.).
- Every **$1 spent on Sexually Transmitted Disease Screening** results in a **$2.50 savings** by preventing Pelvic Inflammatory Disease (Return on Investment Analysis of Local Public Health Funding, MALPH, 2013)
- **Neonatal health care costs related to smoking** are equivalent to **$704 for each maternal smoker**. Randomized controlled trials indicate that a smoking cessation program for pregnant women can save as much as **$6 for each $1 spent** (CDC).
- The OMB has shown that every **$1 spent on WIC** results in a savings of **$1.77 to $3.13 in health care costs**, primarily attributed to reduced rates of low birth weight and improved rates of immunizations.
- Investment of **$10** per person, per year in proven community-based programs that help people increase their physical activity, eat better, and avoid smoking and other tobacco use could save the country more than **$16 billion** annually within five years. This is a return of **$5.60** for every **$1** invested. (Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities, Trust for America's Health.)

* 10th/90th percentile, i.e., only 10% are better. Note: Blank values reflect unreliable or missing data. **Data should not be compared with prior years due to changes in definition/methods

BRANCH-HILLSDALE-ST. JOSEPH COMMUNITY HEALTH AGENCY | YOUR LOCAL HEALTH DEPARTMENT

County Health Rankings – Hillsdale County 2019

The Robert Wood Johnson Foundation is collaborating with the University of Wisconsin Population Health Institute to develop these Rankings for each state's counties.

	HILLSDALE COUNTY	ERROR MARGIN	Top U.S. Performers*	MI	RANK (OF 83)
HEALTH OUTCOMES					**44**
Length of Life					**50**
Premature Death–Years of Potential Life Lost before age 75 per 100,000 population (age-adjusted). (2015-17)	**7,600**	6,600-8,600	5,400	7,600	
Quality of Life					**40**
Poor or Fair Health-**% of adults reporting fair or poor health. (age-adjusted) (2016)	**16%**	15-17%	12%	17%	
Poor Physical Health Days–**Average no. of physically unhealthy days reported in past 30 days (age-adjusted). (2016)	**4.3**	4.1-4.5	3.0	4.3	
Poor Mental Health Days–**Average no. of mentally unhealthy days reported in past 30 days (age-adjusted). (2016)	**4.2**	4.0-4.4	3.1	4.4	
Low Birth Weight–% of live births with low birth weight (< 2500 grams).(2011-17)	**7%**	6-7%	6%	8%	
HEALTH FACTORS					**58**
Health Behaviors					**58**
Adult Smoking-**% of adults who are current smokers. (2016)	**20%**	19-21%	14%	20%	
Adult Obesity–% of adults that report a BMI >=30. (2015)	**38%**	32-44%	26%	32%	
Food Environment Index-Index of factors that contribute to a health food environment, 0 (worst) to 10 (best). (2015-16)	**8.3**		8.7	7.1	
Physical Inactivity-% of adults aged 20 and over reporting no leisure-time physical activity. (2015)	**22%**	18-27%	19%	22%	
Access to Exercise Opportunities-% of population with adequate access to locations for physical activity. (2010, 2018)	**61%**		91%	85%	
Excessive Drinking–**% of adults reporting binge or heaving drinking. (2016)	**19%**	18-20%	13%	21%	
Alcohol-impaired Driving Deaths–% of driving deaths with alcohol involvement. (2013-17)	**27%**	17-38%	13%	29%	
Sexually Transmitted Infections–No. of newly diagnosed Chlamydia cases per 100,000 population. (2016)	**185**		152.8	462.9	
Teen Births–No. of births per 1,000 female population, ages 15-19 years. (2011-17)	**28**	25-31	14	22	
Clinical Care					**70**
Uninsured-% of population under age 65 without health insurance. (2016)	**7%**	6-8%	6%	6%	
Primary Care Physicians–Ratio of population to primary care physicians. (2016)	**3,810:1**		1,050:1	1,260:1	
Dentists-Ratio of population to dentists. (2017)	**3,060:1**		1,260:1	1,360:1	
Mental Health Providers- Ratio of population to mental health providers. (2018)	**800:1**		310:1	400:1	
Preventable Hospital Stays–Rate of hospital stays for ambulatory-care sensitive conditions per 100,000 Medicare enrollees. (2016)	**5,137**		2,765	5,188	
Mammography Screening–% of female Medicare enrollees, ages 65-74 that received an annual mammography screening. (2016)	**39%**		49%	43%	
Flu vaccinations–% of fee-for-service (FFS) Medicare enrollees that had an annual flu vaccination. (2016)	**40%**		52%	45%	
Social & Economic Factors					**34**
High School Graduation-% of ninth grade cohort that graduates in 4 years. (2016-17)	**81%**		96%	80%	
Some College–% of adults aged 25-44 years with some post-secondary education. (2013-17)	**57%**	53-60%	73%	68%	
Unemployment–% of population age 16 and older unemployed but seeking work. (2017)	**5.0%**		2.9%	4.6%	
Children in Poverty-% of children under age 18 in poverty. (2017)	**20%**	15-25%	11%	20%	
Income Inequality– ratio of household income at the 80th percentile to income at the 20th percentile. (2013-17)	**4.1**	3.8-4.3	3.7	4.7	
Children in Single-parent Households–% of children that live in a household headed by single parent. (2013-17)	**28%**	24-33%	20%	34%	
Social Associations–No. of membership associations per 10,000 population. (2016)	**11.4**		21.9	9.9	
Violent Crime–No. of reported violent crime offenses per 100,000 population. (2014-16)	**184**		63	443	
Injury Deaths–No. of deaths due to injury per 100,000 population. (2013-17)	**65**	55-75	57	72	
Physical Environment					**73**
Air Pollution-particulate Matter-Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5). (2014)	**11.3**		6.1	8.4	
Drinking Water Violations-Indicator of the presence of health-related drinking violations. Yes indicates the presence of a violation, No indicates no violation. (2017)	**Yes**				
Severe Housing Problems–% of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities. (2011-15)	**15%**	13-16%	9%	16%	
Driving Alone to Work-% of the workforce that drives alone to work. (2013-17)	**80%**	79-82%	72%	83%	
Long Commute-driving Alone –Among workers who commute in their car alone, the % that commutes more than 30 minutes. (2013-17)	**35%**	32-37%	15%	33%	

* 10th/90th percentile, i.e., only 10% are better. Note: Blank values reflect unreliable or missing data. **Data should not be compared with prior years due to changes in definition/methods

BRANCH-HILLSDALE-ST. JOSEPH COMMUNITY HEALTH AGENCY | YOUR LOCAL HEALTH DEPARTMENT

Additional Indicators – Hillsdale County

	HILLSDALE COUNTY	MI
Demographics		
Population (2017)	45,879	9,962,311
% Below 18 Years of Age (2017)	21.9%	21.8%
% 65 and Older (2017)	19.1%	16.7%
% Non-Hispanic African American (2017)	0.6%	13.8%
% American Indian & Alaskan Native (2017)	0.6%	0.7%
% Asian (2017)	0.5%	3.2%
% Native Hawaiian/Other Pacific Islander (2017)	0.0%	0%
% Hispanic (2017)	2.3%	5.1%
% Non-Hispanic White (2017)	94.8%	75.2%
% not proficient in English (2013-17)	0%	1%
% Females (2017)	50.3%	50.8%
% Rural (2010)	69.1%	25.4%
Health Outcomes		
Diabetes Prevalence (2015)	13%	11%
HIV Prevalence Rate (2015)	39	175
Premature Age-Adjusted Mortality (2015-17)	350	370
Frequent Physical Distress (2016)	13%	13%
Frequent Mental Distress (2016)	13%	14%
Infant Mortality (2011-17)	7	7
Child Mortality (2014-17)	60	50
Health Behaviors		
Food Insecurity (2016)	13%	14%
Limited Access to Healthy Foods (2015)	2%	6%
Drug Overdose Deaths (2015-17)	17	24
Motor Vehicle Crash Deaths (2011-17)	15	10
Insufficient Sleep (2016)	33%	37%
Health Care		
Uninsured Adults (2016)	8%	8%
Uninsured Children (2016)	4%	3%
Other Primary Care Providers (2018)	1,995:1	1,064:1
Social & Economic Factors		
Disconnected Youth (2013-17)	6%	7%
Median Household Income (2017)	$47,600	$54,800
Children Eligible for Free Lunch (2016-17)	51%	46%
Residential Segregation–black/white (2013-17)		73
Residential Segregation–non-white/white (2013-17)	30	60
Homicides (2011-17)		6
Firearm Fatalities (2013-17)	9	12

What Does the Data Mean for My County?

The *Rankings* are based on a model of population health that emphasizes many factors that, if improved, can help make communities healthier places to live, learn, work and play. Michigan's eighty-three counties are ordered according to summaries of a variety of health measures. Those factors having high ranks, e.g. 1 or 2, are considered to be the "healthiest." The model uses the following summary measures:

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What are the Public Health Cost Savings Associated with Prevention

Funding public health can result in significant cost savings for local communities. Did you know that:

- Every **$1 spent on immunization saves $6.30** in **medical costs**. In addition, when including indirect costs to society, such as missed work days, death and disability, as well as the direct medical costs, the CDC estimates that every **$1 spent on immunization saves $18.40.**
- On average, a **$52** child safety seat prevents **$2,200** in medical spending. **This is a return of $42 for every $1 invested**. (Child Safety Network and PIRE)
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- **Neonatal health care costs related to smoking** are equivalent to **$704 for each maternal smoker**. Randomized controlled trials indicate that a smoking cessation program for pregnant women can save as much as **$6 for each $1 spent** (CDC).
- The OMB has shown that every **$1 spent on WIC** results in a savings of **$1.77 to $3.13 in health care costs**, primarily attributed to reduced rates of low birth weight and improved rates of immunizations.
- Investment of **$10** per person, per year in proven community-based programs that help people increase their physical activity, eat better, and avoid smoking and other tobacco use could save the country more than **$16 billion** annually within five years. This is a return of **$5.60** for every **$1** invested. (Prevention for a Healthier America: Investments in Disease Prevention Yield Significant Savings, Stronger Communities, Trust for America's Health.)

* 10th/90th percentile, i.e., only 10% are better. Note: Blank values reflect unreliable or missing data. **Data should not be compared with prior years due to changes in definition/methods

County Health Rankings – St. Joseph County 2019

The Robert Wood Johnson Foundation is collaborating with the University of Wisconsin Population Health Institute to develop these Rankings for each state's counties.

	ST. JOSEPH COUNTY	ERROR MARGIN	Top U.S. Performers*	MI	RANK (OF 83)
HEALTH OUTCOMES					**55**
Length of Life					**51**
Premature Death–Years of Potential Life Lost before age 75 per 100,000 population (age-adjusted). (2015-17)	**7,700**	6,900-8,500	5,400	7,600	
Quality of Life					**58**
Poor or Fair Health-**% of adults reporting fair or poor health. (age-adjusted) (2016)	**17%**	16-17%	12%	17%	
Poor Physical Health Days–**Average no. of physically unhealthy days reported in past 30 days (age-adjusted). (2016)	**4.1**	4.0-4.3	3.0	4.3	
Poor Mental Health Days–**Average no. of mentally unhealthy days reported in past 30 days (age-adjusted). (2016)	**4.1**	4.0-4.3	3.1	4.4	
Low Birth Weight–% of live births with low birth weight (< 2500 grams).(2011-17)	**8%**	7-8%	6%	8%	
HEALTH FACTORS					**45**
Health Behaviors					**61**
Adult Smoking-**% of adults who are current smokers. (2016)	**20%**	19-20%	14%	20%	
Adult Obesity–% of adults that report a BMI >=30. (2015)	**31%**	25-36%	26%	32%	
Food Environment Index-Index of factors that contribute to a health food environment, 0 (worst) to 10 (best). (2015, 2016)	**8.2**		8.7	7.1	
Physical Inactivity-% of adults aged 20 and over reporting no leisure-time physical activity. (2015)	**30%**	24-36%	19%	22%	
Access to Exercise Opportunities-% of population with adequate access to locations for physical activity. (2010, 2018)	**54%**		91%	85%	
Excessive Drinking–**% of adults reporting binge or heaving drinking. (2016)	**20%**	19-21%	13%	21%	
Alcohol-impaired Driving Deaths–% of driving deaths with alcohol involvement. (2013-17)	**35%**	27-42%	13%	29%	
Sexually Transmitted Infections–No. of newly diagnosed Chlamydia cases per 100,000 population. (2016)	**322.9**		152.8	462.9	
Teen Births–No. of births per 1,000 female population, ages 15-19 years. (2011-17)	**37**	34-41	14	22	
Clinical Care					**69**
Uninsured-% of population under age 65 without health insurance. (2016)	**8%**	7-9%	6%	6%	
Primary Care Physicians–Ratio of population to primary care physicians. (2016)	**3,380:1**		1,050:1	1,260:1	
Dentists-Ratio of population to dentists. (2017)	**2,770:1**		1,260:1	1,360:1	
Mental Health Providers- Ratio of population to mental health providers. (2018)	**580:1**		310:1	400:1	
Preventable Hospital Stays–No. of hospital stays for ambulatory-care sensitive conditions per 1,000 Medicare enrollees. (2016)	**4,781**		2,765	5,188	
Mammography Screening–% of female Medicare enrollees, ages 67-69 that receive mammography screening. (2016)	**43%**		49%	43%	
Flu vaccinations–% of fee-for-service (FFS) Medicare enrollees that had an annual flu vaccination. (2016)	**42%**		52%	45%	
Social & Economic Factors					**25**
High School Graduation-% of ninth grade cohort that graduates in 4 years. (2016-17)	**89%**		96%	80%	
Some College–% of adults aged 25-44 years with some post-secondary education. (2013-17)	**50%**	47-54%	73%	68%	
Unemployment–% of population age 16 and older unemployed but seeking work. (2017)	**4.3%**		2.9%	4.6%	
Children in Poverty-% of children under age 18 in poverty. (2017)	**19%**	14-25%	111%	20%	
Income Inequality– ratio of household income at the 80th percentile to income at the 20th percentile. (2013-17)	**3.7**	3.4-3.9	3.7	4.7	
Children in Single-parent Households–% of children that live in a household headed by single parent. (2013-17)	**32%**	27-37%	20%	34%	
Social Associations–No. of membership associations per 10,000 population. (2016)	**14.5**		21.9	9.9	
Violent Crime–No. of reported violent crime offenses per 100,000 population. (2014-16)	**301**		63	443	
Injury Deaths–No. of deaths due to injury per 100,000 population. (2013-17)	**73**	64-83	57	72	
Physical Environment					**47**
Air Pollution-particulate Matter-Average daily density of fine particulate matter in micrograms per cubic meter (PM2.5). (2014)	**12.6**		6.1	8.4	
Drinking Water Violations-Indicator of the presence of health-related drinking violations. Yes indicates the presence of a violation, No indicates no violation. (2017)	**No**				
Severe Housing Problems–% of households with at least 1 of 4 housing problems: overcrowding, high housing costs, or lack of kitchen or plumbing facilities. (2011-15)	**14%**	13-16%	9%	16%	
Driving Alone to Work-% of the workforce that drives alone to work. (2013-17)	**77%**	74-79%	72%	83%	
Long Commute-driving Alone –Among workers who commute in their car alone, the % that commutes more than 30 minutes. (2013-17)	**29%**	26-31%	15%	33%	

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BRANCH-HILLSDALE-ST. JOSEPH COMMUNITY HEALTH AGENCY | YOUR LOCAL HEALTH DEPARTMENT

Additional Indicators – St. Joseph County

	ST. JOSEPH COUNTY	MI
Demographics		
Population (2017)	60,947	9,962,311
% Below 18 Years of Age (2017)	24.7%	21.8%
% 65 and Older (2017)	17.6%	16.7%
% Non-Hispanic African American (2017)	2.5%	13.8%
% American Indian & Alaskan Native (2017)	0.6%	0.7%
% Asian (2017)	0.7%	3.2%
% Native Hawaiian/Other Pacific Islander (2017)	0.0%	0%
% Hispanic (2017)	7.9%	5.1%
% Non-Hispanic White (2017)	86.5%	75.2%
% not proficient in English (2013-17)	1.0%	1%
% Females (2017)	50.3%	50.8%
% Rural (2010)	54.4%	25.4%
Health Outcomes		
Diabetes Prevalence (2015)	12%	11%
HIV Prevalence Rate (2015)		175
Premature Age-Adjusted Mortality (2015-17)	400	370
Frequent Physical Distress (2016)	12%	13%
Frequent Mental Distress (2016)	13%	14%
Infant Mortality (2011-17)	6	7
Child Mortality (2014-17)	60	50
Health Behaviors		
Food Insecurity (2016)	12%	14%
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Residential Segregation–black/white (2013-17)	74	73
Residential Segregation–non-white/white (2013-17)	43	60
Homicides (2011-17)		6
Firearm Fatalities (2013-17)	10	12

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Date: April 2019

To: Local Public Health Partners, Policy Makers and Resource Providers

From: The Michigan Association for Local Public Health (MALPH)

RE: Michigan's System of Local Public Health Departments and Service Delivery

The Michigan Association for Local Public Health (MALPH) is pleased to provide the first version (April 2019) of the ***Local Health Department Services Inventory***.

This publication will provide the reader with up-to-date information regarding local public health services and activities. The one-page local health department service summaries were developed by Anne Barna, MA, Planning, Promotion, and Evaluation Manager and colleagues at the Barry-Eaton District Health Department. This project was supported by funding from the Michigan Department of Health and Human Services (MDHHS) through Cross Jurisdictional Sharing grants.

You can always view this document on the MALPH website at www.malph.org.

Additionally, there are short exhibits concerning:

- *Public Health: It's The Law*
- *Local Public Health's Unique Role*
- *Michigan's Local Public Health History*
- *Map of Local Health Departments*
- *Local Health Department Directory Resource*

Local public health departments are the first line of defense in mitigating numerous communicable, chronic, and environmental health hazards. Current efforts include programs to combat opioid use/abuse, ensure clean water-free from lead, per- and poly-fluoroalkyl (PFAS) contaminants, and finding and treating Hepatitis A cases.

It is expected this ***Inventory*** will inform the reader regarding most local public health services and provide a link to contact individual local public health departments.

Your continued support for local public health services, policy, and resources is greatly appreciated.

Yours for better public health,

The MALPH Board of Directors

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426 South Walnut | Lansing, Michigan 48933 | www.malph.org

Table of Contents

Public Health – It's the Law

MICHIGAN ASSOCIATION FOR LOCAL PUBLIC HEALTH

State of Michigan Constitution – Section 51: Public Health and General Welfare

The public health and general welfare of the people of the state are hereby declared to be matters of primary public concern. The legislature shall pass suitable laws for the protection and promotion of the public health.

Public Health Code – Act 368 of 1978 ~ Part 22 (State Department of Public Health)

Section: 333.2221 - Organized programs to prevent disease, prolong life, and promote public health; duties of department.
Sec. 2221. (1) Pursuant to section 51 of article 4 of the state constitution of 1963, the department shall continually and diligently endeavor to prevent disease, prolong life, and promote the public health through organized programs, including prevention and control of environmental health hazards; prevention and control of diseases; prevention and control of health problems of particularly vulnerable population groups; development of health care facilities and agencies and health services delivery systems; and regulation of health care facilities and agencies and health services delivery systems to the extent provided by law.

Section 333.2224 - Promotion of local health services; coordination and integration of public health services.
Sec. 2224. Pursuant to this code, the department shall promote an adequate and appropriate system of local health services throughout the state and shall endeavor to develop and establish arrangements and procedures for the effective coordination and integration of all public health services including effective cooperation between public and nonpublic entities to provide a unified system of statewide health care.

333.2475 - Reimbursement for costs of services; equitable distribution; schedule; local expenditure in excess of prior appropriation.
Sec. 2475. (1) The department shall reimburse local governing entities for the reasonable and allowable costs of required and allowable health services delivered by the local governing entity as provided by this section. Subject to the availability of funds actually appropriated reimbursements shall be made in a manner to provide equitable distribution among the local governing entities and pursuant to the following schedule beginning in the second state fiscal year beginning on or after the effective date of this part:
(a) First year, 20%. (b) Second year, 30%. (c) Third year, 40%. (d) Fourth year and thereafter, 50%.
(2) Until the 50% level is reached, a local governing entity is not required to provide for required services if the local expenditure necessary to provide the services is greater than those funds appropriated and expended in the full state fiscal year immediately before the effective date of this part.

Public Health Code – Act 368 of 1978 ~ Part 24 (Local Health Departments)

333.2433 - Local health department; powers and duties generally.
Sec. 2433. (1) A local health department shall continually and diligently endeavor to prevent disease, prolong life, and promote the public health through organized programs, including prevention and control of environmental health hazards; prevention and control of diseases; prevention and control of health problems of particularly vulnerable population groups; development of health care facilities and health services delivery systems; and regulation of health care facilities and health services delivery systems to the extent provided by law.

333.2451 - Imminent danger to health or lives; informing individuals affected; order; noncompliance; petition to restrain condition or practice; "imminent danger" and "person" defined.

Sec. 2451. (1) Upon a determination that an imminent danger to the health or lives of individuals exists in the area served by the local health department, the local health officer immediately shall inform the individuals affected by the imminent danger and issue an order which shall be delivered to a person authorized to avoid, correct, or remove the imminent danger or be posted at or near the imminent danger. The order shall incorporate the findings of the local health department and require immediate action necessary to avoid, correct, or remove the imminent danger. The order may specify action to be taken or prohibit the presence of individuals in locations or under conditions where the imminent danger exists, except individuals whose presence is necessary to avoid, correct, or remove the imminent danger.

333.2453 - Epidemic; emergency order and procedures; involuntary detention and treatment.

Sec. 2453. (1) If a local health officer determines that control of an epidemic is necessary to protect the public health, the local health officer may issue an emergency order to prohibit the gathering of people for any purpose and may establish procedures to be followed by persons, including a local governmental entity, during the epidemic to insure continuation of essential public health services and enforcement of health laws. Emergency procedures shall not be limited to this code.

333.2455 Building or condition violating health laws or constituting nuisance, unsanitary condition, or cause of illness; order; noncompliance; warrant; assessment and collection of expenses; liability; judicial order; other powers not affected.

Sec. 2455. (1) A local health department or the department may issue an order to avoid, correct, or remove, at the owner's expense, a building or condition which violates health laws or which the local health officer or director reasonably believes to be a nuisance, unsanitary condition, or cause of illness.

333.2492 - Status report; appropriation for development and implementation of evaluation and related training.

Sec. 2492. (1) At the end of the second full state fiscal year after the effective date of this part, the department shall report to the governor and legislature as to the status of required and allowable health services in relation to standards, costs, and health needs of the people of this state. (2) An amount equal to 1% of the estimated total expenditures for the required and allowable local health services shall be appropriated to the department annually for the development and implementation of evaluation and related training for local health departments and department staffs in the delivery of the required and allowable health services authorized under sections 2471 to 2498.

###

Local Public Health's Unique Role

MICHIGAN ASSOCIATION FOR LOCAL PUBLIC HEALTH

Local Health Departments (LHD) protect and improve community well-being by preventing disease, illness and injury and impacting social, economic and environmental factors fundamental to excellent health. The LHD is the foundation of the local public health system that comprises public- and private-sector health care providers, academia, business, the media, and other local and state governmental entities.

- ***Track and investigate health problems and hazards in the community.*** LHDs gather and analyze data on the community's health to determine risks and problems. This information drives specific programs and activities designed to control multiple threats: both communicable and chronic diseases; food, water, insect and other "vector-borne" outbreaks; biological, chemical and radiological hazards; and public health disasters.

- ***Prepare for and respond to public health emergencies.*** As a result of extensive and ongoing preparation, LHDs respond quickly and effectively to disease outbreaks and other public health events—they are trained extensively to respond to the increase of the incidence of diseases, natural disasters, and acts of terrorism. They coordinate delivery of drugs, supplies, and provisions to victims and populations at risk. They keep the public informed and serve as the network hub for community hospitals, physicians, and other health care providers.

- ***Develop, apply and enforce policies, laws and regulations that improve health and ensure safety.*** Acting on their knowledge about their community, LHDs create data-driven policies to meet health needs and address emerging issues. They help craft sound health policies by providing expertise to local, state and federal decision makers. LHDs also inform individuals and organizations about public health laws while monitoring and enforcing compliance.

- ***Lead efforts to mobilize communities around important health issues.*** With local and state government agencies, businesses, schools, and the media, LHDs spearhead locally organized health promotion and disease prevention campaigns and projects. They galvanize the community to tackle disease prevention and personal health care needs. LHDs also educate and encourage people to lead healthy lives through community forums; public workshops and presentations; and public service announcements.

- ***Link people to health services.*** LHDs connect people with personal health services, including preventive and health promotion services, either in the community or as close to the community as possible. They also advocate for development of needed programs and services in underserved populations and continuously monitor the quality and accessibility of public health services.

- ***Achieve excellence in public health practice through a trained workforce, evaluation, and evidence-based programs.*** LHDs recruit and develop skilled workers with expertise in core public health competencies. They ensure that public health workers update their knowledge and skills through continuing education, training and leadership development activities. They regularly evaluate the effectiveness of all programs and activities using evidence-based standards and strive to adapt successful interventions.

The State of Michigan Constitution, the Public Health Code, and Michigan's Local Public Health History

Section 51 of Michigan's Constitution provides for the Public Health and General Welfare of Michigan residents.

> *"The public health and general welfare of the people of the state are hereby declared to be matters of primary public concern. The legislature shall pass suitable laws for the protection and promotion of the public health."*

Michigan has a nationally recognized Public Health Code, PA 388 of 1978, outlining the structure, nature, and responsibility for provision of Michigan's public health services.

Specifically, Part 24 of PA 368 of 1978 bestows powers and duties authority upon Michigan's system of Local Health Departments (LHDs).

Until the 1990's, most public health coordination was directed by the then Michigan Department of Public Health. In 1996, via Executive Orders, public health state responsibilities were split, for the most part, among the now Departments of Agriculture and Rural Development (MDARD), Environmental Quality (MDEQ), Licensing and Regulatory Affairs (DLARA), and Health and Human Services (MDHHS).

Today, the Michigan Association for Local Public Health (MALPH) and the LHDs collaborate mainly with those four departments to deliver public health services and programs to Michigan citizens and businesses.

Unique in the nation, MALPH was founded in 1985 as a private, non-profit, 501(c)3 state association, and is organized to represent Michigan's 45 city, county and district local health departments, interacting with state and federal legislative and executive branches of government.

MALPH's Mission: To strengthen Michigan's system of local public health departments and local governing boards.

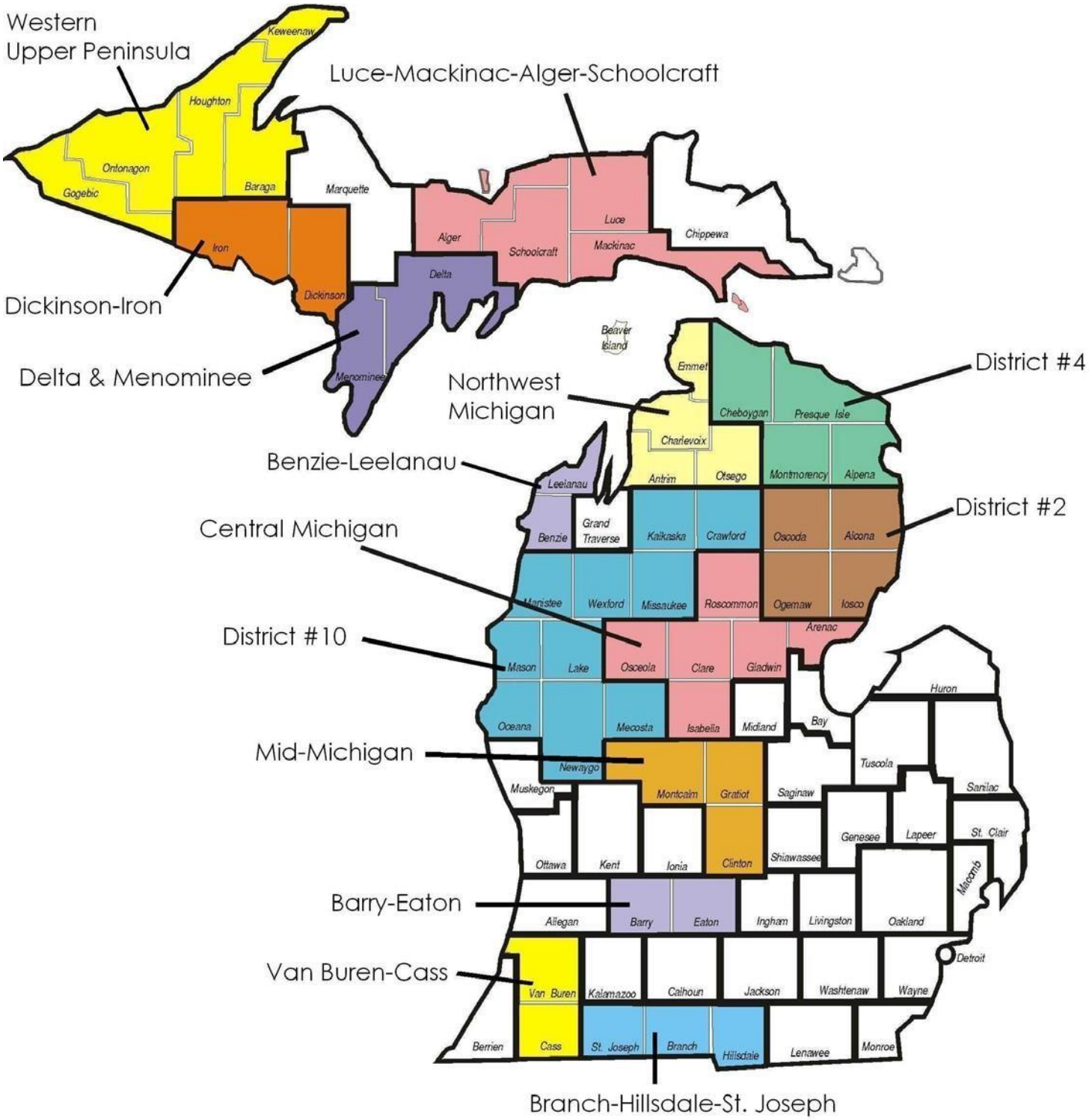
Local health departments serve to promote, prevent, and protect all people living, playing, and working in Michigan and to improve the overall health of people and visitors in communities, leading to increased competitiveness and economic stability.

Sources:

Constitution of Michigan of 1963. Website:
http://www.legislature.mi.gov/documents/mcl/pdf/mcl-chap1.pdf

PA 368 of 1978. Michigan's Public Health Code. Website:
http://www.legislature.mi.gov/documents/mcl/pdf/mcl-act-368-of-1978.pdf

Michigan Local Health Departments



Local Health Department Directory

www.malph.org

https://www.malph.org/resources/directory

April 2019

PO Box 13276 | Lansing, Michigan 48901 | [p]: 517.485.0660 | [f]: 517.485.6412
426 South Walnut | Lansing, Michigan 48933 | www.malph.org

The Michigan Association for Local Public Health (MALPH)

Local Health Department Services Inventory

April 2019

PO Box 13276 | Lansing, Michigan 48901 | [p]: 517.485.0660 | [f]: 517.485.6412
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Local Health Department

Access to Healthcare Outreach and Enrollment

Access to health care impacts one's overall physical, social, and mental health status and quality of life, but getting access to health care can be challenging, especially for people who have low or moderate incomes. Health care coverage can be expensive, and navigating the Health Insurance Marketplace or Medicaid can be confusing. Local health department staff understand the unique challenges that come with enrolling in health care, and are available to help individuals enroll in a health plan that is right for them.

Key Positions
Health Educators
Public Health Nurse
Clerical Staff

In 2015, more than1 in 10 adults in Michigan had no form of health care coverage.

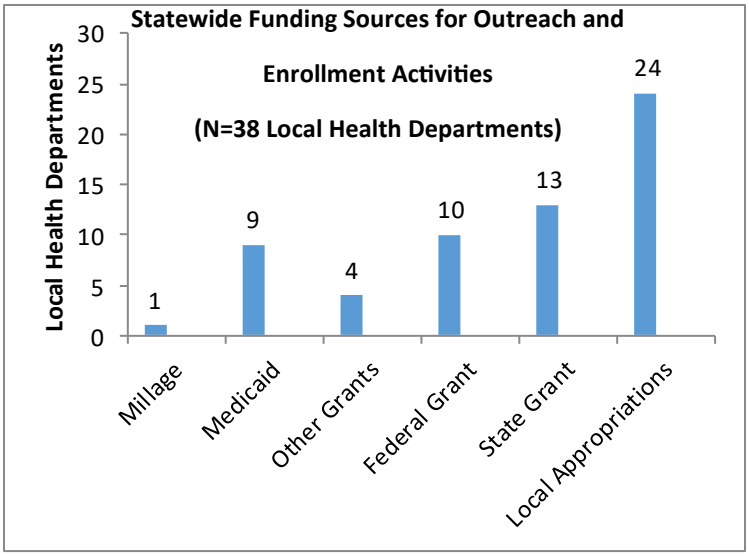
Meets Public Health Standards:

✓	Michigan Public Health Code
	Michigan Local Public Health Accreditation
✓	Public Health Accreditation Board

Services:

Local health department health educators and clinical staff help to connect people with tools and information on different health insurance options. This includes helping people apply for Medicaid, the Healthy Michigan Plan, MIChild, or another affordable health insurance program. Local health department staff can also help people navigate the Health Insurance Marketplace.

Additionally, at some local health departments, staff conduct outreach at health fairs and other events to increase knowledge and awareness of health care coverage and assistance.



Goals:

Local health department outreach and enrollment activities aim to:

- Help persons in the community gain access to appropriate and affordable health insurance
- Promote the use of preventative health care to prevent disease
- Prevent financial crises in persons due to unexpected medical emergencies

Impact:

Uninsured people receive less medical care and less timely care, they have worse health outcomes, and lack of insurance is a financial burden for them and their families. Having access to health insurance helps people overcome barriers when visiting the doctor for routine health check-ups, and can help them in the event of a major health emergency.

Created by the Barry-Eaton District Health Department for the Michigan Association of Local Public Health with funding from the Michigan Department of Health and Human Services. August 2018.

*38 of Michigan's local health departments indicated that they participate in outreach and enrollment activities (of 41 who participated in the survey). Participants might not have answered each question.

Local Health Department

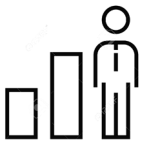
Adult Immunizations

MICHIGAN ASSOCIATION FOR LOCAL PUBLIC HEALTH

Immunizations keep adults safe and healthy by protecting them from serious diseases. All local health departments in Michigan offer recommended adult vaccinations in order to minimize and prevent the occurrence of vaccine preventable diseases within our state. Local health departments also provide continuing education about immunizations and ensure accurate immunization reporting to the state health department.

Key Positions
Public Health Nurses
Immunization Technicians
Program Coordinators
Billing and Support Staff

Impact:



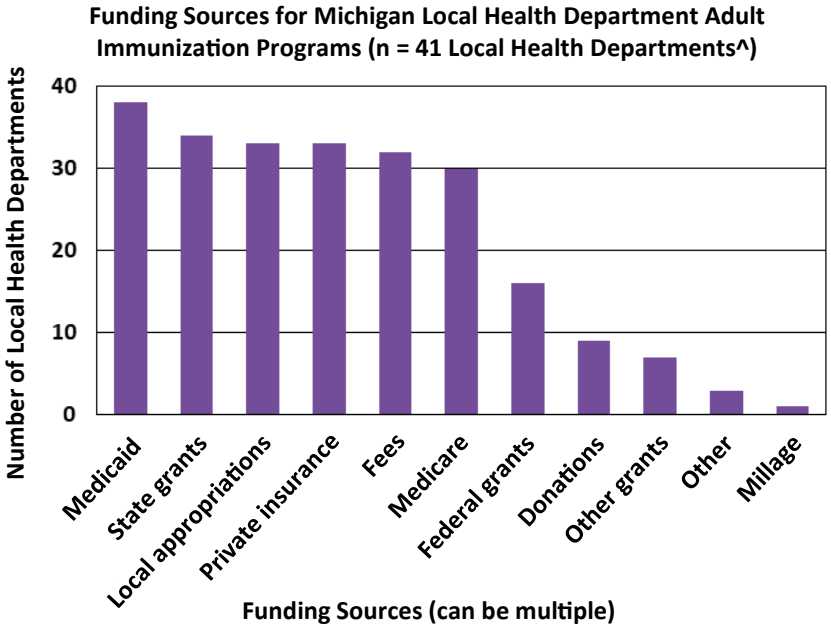
In 2017, local health departments administered over 155,000 vaccine doses to adults in Michigan. This was 6.4% of adult vaccinations.*

Meets Public Health Standards:

✓	Michigan Public Health Code
✓	Michigan Local Public Health Accreditation
	Public Health Accreditation Board

Services:

Fully-trained public health nurses and other immunization staff at local health departments support and implement immunization programs that help ensure adults throughout Michigan receive their recommended vaccinations, especially those that may not be able to obtain vaccination elsewhere. Many local health departments conduct a variety of immunization-related activities, including health care provider education and site visits, travel clinics, worksite-based clinics, data analysis, and community education.



Goals:

Adult immunization programs conducted by local health departments work to:

- Protect adults from vaccine-preventable diseases
- Remove barriers so that adults receive recommended vaccinations
- Provide education to health care providers and the community about immunizations
- Ensure timely reporting to the state health department

*Of vaccinations reported to the Michigan Care Improvement Registry. Reporting of adult vaccinations is not required by Michigan law.
**41 out of 45 of Michigan's local public health departments participated in the survey at least partially. Participants might not have answered each question.

Created by the Barry-Eaton District Health Department for the Michigan Association of Local Public Health with funding from the Michigan Department of Health and Human Services. August 2018.

Local Health Department
Behavioral Health Services

MICHIGAN ASSOCIATION FOR LOCAL PUBLIC HEALTH

Mental illnesses and substance use disorders are common in the United States, affecting tens of millions of people each year. Mental illness and substance use can affect physical health and reduce quality of life. Several local health departments (LHDs) offer behavioral health services to provide substance use treatment and recovery and improve mental health. These services may include early intervention, outpatient care, intensive outpatient care, and education for mental illnesses and substance use. These services provide clients with resources that they need to address their behavioral health.

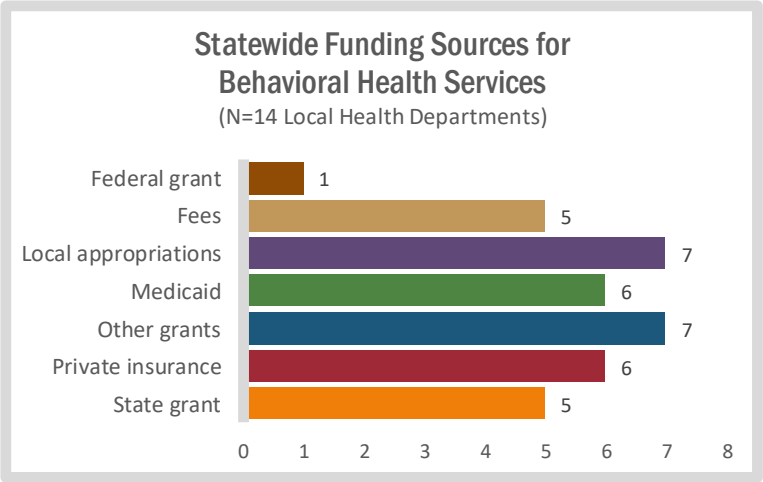
Key Positions

Behavioral Health Therapists
Behavioral Health Secretaries
Behavioral Health Supervisors

In Michigan, the rate of drug-related traffic crash injuries and drug-related traffic crash deaths among adult drivers increased by 31% and 30%, respectively, from 2006 to 2015.

Meets Public Health Standards:

	Michigan Public Health Code
	Michigan Local Public Health Accreditation
	Public Health Accreditation Board



Services:

Local health departments that participate in substance use treatment and recovery services offer:

- Assessments
- Therapy
- Coordinating Care
- Specialty Programs
- Treatment Enhancements
- Prevention/Early Intervention
- Outpatient
- Intensive Outpatient

Goals:

Behavioral health services:

- Reduce individual use of alcohol and other substances
- Help individuals accomplish their version of hopeful, healthy and meaningful lives through prevention, treatment and recovery supports
- Facilitate a community where people can become the best versions of themselves through wellness and recovery

Impact:

Alcohol and drug use can be significant causes of illness and death. Addressing addiction is a public health priority for many communities.

Created by the Barry-Eaton District Health Department for the Michigan Association of Local Public Health with funding from the Michigan Department of Health and Human Services. August 2018.

Local Health Department

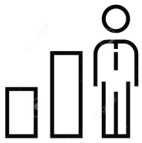
Childhood Immunizations

MICHIGAN ASSOCIATION FOR LOCAL PUBLIC HEALTH

Immunizations keep children safe and healthy by protecting them from serious diseases. All local health departments in Michigan offer required childhood vaccinations in order to minimize and prevent the occurrence of vaccine preventable diseases within our state. Local health departments also provide continuing education about immunizations and ensure accurate immunization reporting to the state health department.

Key Positions
Public Health Nurses
Immunization Technicians
Program Coordinators
Billing and Support Staff

Impact:



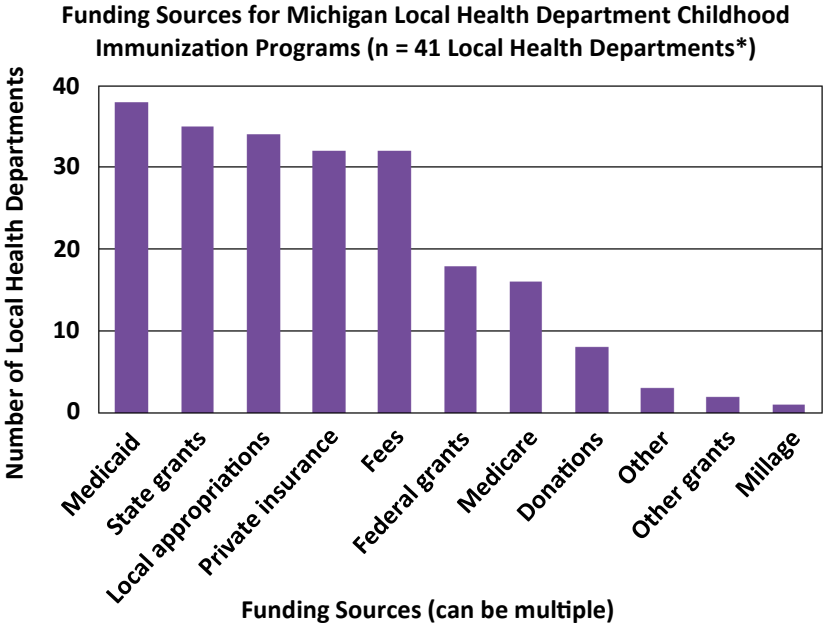
In 2017, local health departments administered 311,376 vaccine doses to Michigan children. This was 8.1% of all Michigan child vaccinations.

Meets Public Health Standards:

✓	Michigan Public Health Code
✓	Michigan Local Public Health Accreditation
	Public Health Accreditation Board

Services:

Public health nurses and other immunization staff at local health departments provide immunization programs that ensure children throughout Michigan receive the recommended childhood vaccinations, especially those that may not be able to obtain vaccination elsewhere. Local health departments implement the State/Federal Vaccines for Children program (VFC) in partnership with local providers to increase access to immunizations for needy children across the community. Many local health departments conduct a variety of immunization-related activities, including health care provider education and site visits, travel clinics, school-based clinics, data analysis, and community education.



Goals:

Childhood immunization programs conducted by local health departments work to:

- Protect children from vaccine-preventable diseases
- Remove barriers, such as cost, so that children receive recommended vaccinations
- Provide education to health care providers and the community about immunizations
- Ensure timely reporting to the state health department
- Provide mandated immunization waiver education

Created by the Barry-Eaton District Health Department for the Michigan Association of Local Public Health with funding from the Michigan Department of Health and Human Services. August 2018.

*41 out of 45 of Michigan's local public health departments participated in the survey at least partially. Participants might not have answered each question.

Local Health Department

Children's Special Health Care Services

MICHIGAN ASSOCIATION FOR LOCAL PUBLIC HEALTH

Children's Special Health Care Services is a program that assists with health care for children 20 years or under and some adults with special health care needs. Assistance can include medical bills, transportation for medical care, coordination of services, and connection to community-based resources. The majority of Michigan local health departments provide CSHCS services.

Key Positions
Public Health Nurses
Program Representatives
Clerical Staff

In 2017, over 12,000 children received coverage from MDHHS's Children's Special Health Care Services programs

Meets Public Health Standards:

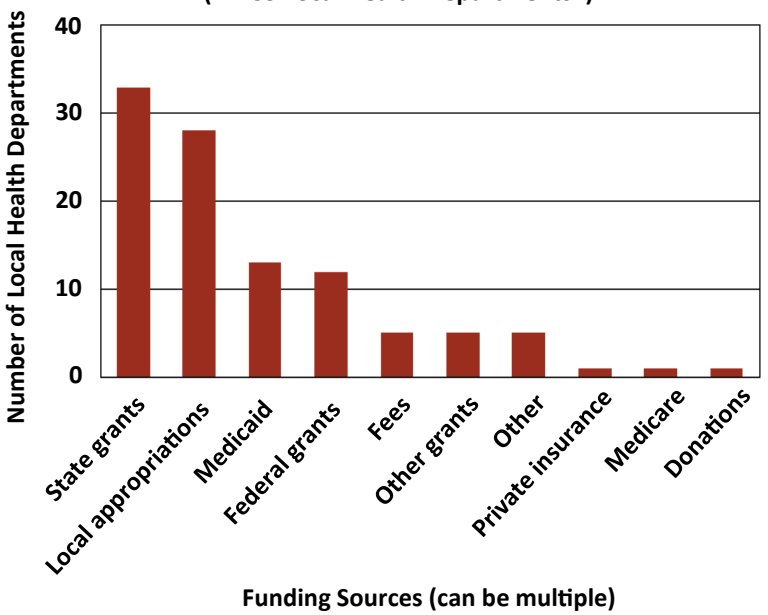
	Michigan Public Health Code
✓	Michigan Local Public Health Accreditation
	Public Health Accreditation Board

Services:

Local health departments that participate in the Children's Special Health Care Services program can assist in finding coverage and referrals for eligible patients specialty services based on the person's health problems. More than 2,700 diagnoses are eligible for CSHCS coverage, including asthma, cancer, cerebral palsy, cleft palate, liver disease, club foot, limb abnormalities, spina bifida, certain vision disorders, paralysis or spinal injuries, cystic fibrosis, hemophilia, insulin-dependent diabetes, muscular dystrophy, certain heart conditions, epilepsy, kidney disease, and more. Additionally, those enrolled in Children's Special Health Care Services will receive assistance in care coordination to pull together the services of many different providers who work within different agencies.

Funding Sources for Michigan Local Health Department CSHCS Programs in FY17

(n = 39 Local Health Departments*)



Goals:

Children's Special Health Care Services conducted by local health departments are meant to:

- Assist individuals with special health care needs in accessing appropriate medical care, health education and supports.
- Assure delivery of these services and supports in an accessible, family centered, culturally competent, community based and coordinated manner.
- Remove barriers that prevent individuals with special health care needs from achieving these goals.

Impact: Thousands of children are able to receive the specialty health care services they need to have a higher quality of life. These children and their families are able to seek care without worrying about the financial burden.

Created by the Barry-Eaton District Health Department for the Michigan Association of Local Public Health with funding from the Michigan Department of Health and Human Services. August 2018.

*39 of Michigan's local health departments indicated that they offer CSHCS services (of 41 who participated in the survey). Participants might not have answered each question.

Local Health Department

Communicable Disease Control

MICHIGAN ASSOCIATION FOR LOCAL PUBLIC HEALTH

Communicable diseases are infectious diseases that can be transmitted (spread) to humans. Some ways in which communicable diseases are spread include person-to-person, contact with contaminated surfaces, through air or water, or by a vector, such as an insect. In Michigan, there are currently almost 100 reportable diseases. Michigan local health departments work with a variety of health care and laboratory partners to control the spread of communicable diseases through testing, treatment, prevention, control, and education.

Key Positions
CD Coordinator
Public Health Nurse
Billing/Support Staff
Public Health Physician
Regional Epidemiologist

From 2014 to 2017, the reported number of Michigan communicable disease cases has increased by 58%.

Meets Public Health Standards:

✓	Michigan Public Health Code
✓	Michigan Local Public Health Accreditation
✓	Public Health Accreditation Board

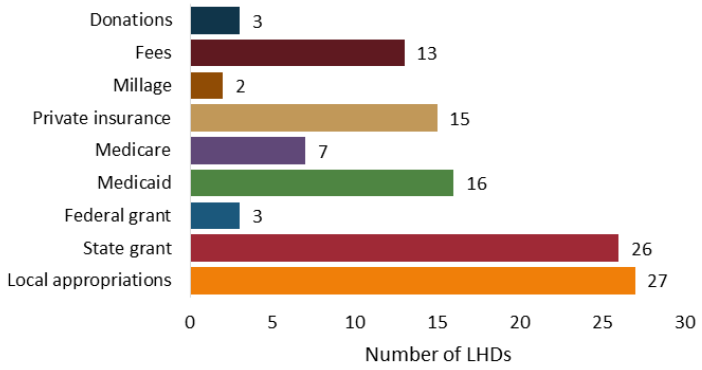
Services:

Local health departments that participate in communicable disease control offer services such as communicable disease screenings and communicable disease treatment, depending on the capacity of the health department. Additional activities in communicable disease prevention in local health departments can include contact tracing, expedited partner therapy (in cases of STDs), health promotion and education, and disease prevention when applicable (i.e. immunizations).

Communicable disease control is a collaborative effort between health department staff, regional epidemiologists, community partners and local health providers and hospitals.

Statewide Communicable Disease Control Funding Sources

(N=32 Local Health Departments)



Goals:

Local health department communicable disease programs prevent and control the spread of infectious diseases by:

- Identifying cases through testing and reporting
- Conducting surveillance and data analysis
- Recommending and instituting infection control measures to slow and stop outbreaks
- Providing education to patients, health care providers, and the community
- Ensuring timely reporting of cases to the state health department

Impact:

Since 2016, 35 local jurisdictions have responded to a statewide hepatitis A outbreak. Over 200,000 adult hepatitis A vaccines were given in outbreak jurisdictions. This effort has helped to contain the one of the largest hepatitis A outbreaks in recent history.

Created by the Barry-Eaton District Health Department for the Michigan Association of Local Public Health with funding from the Michigan Department of Health and Human Services. August 2018.

*32 of Michigan's local health departments indicated that they offer communicable disease screening and/or treatment services (of 41 who participated in the survey). Participants might not have answered each question.

Local Health Department

Emergency Preparedness

MICHIGAN ASSOCIATION FOR LOCAL PUBLIC HEALTH

Public health emergencies can include epidemics and pandemics; biological, chemical, and radiological terrorism; and natural disasters. Being prepared to respond promptly, effectively, and efficiently to these public health emergencies is a key function of local health departments. Because many agencies would be involved in responding to such emergencies, building good partnerships with other community service providers is vital to emergency preparedness. Additionally, educating the public on self-preparedness and how to respond to a public health emergency is essential to local public health emergency preparedness.

Key Positions
Emergency Preparedness Coordinator
Public Information Officer

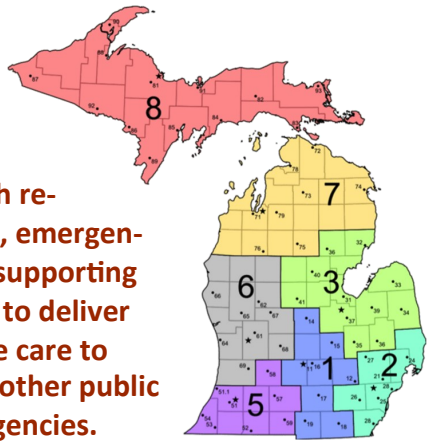
In Michigan, all local health departments implement a standard work plan formulated by MDHHS and the CDC ensuring consistent response across the state.

Meets Public Health Standards:

✓	Michigan Public Health Code
✓	Michigan Local Public Health Accreditation
✓	Public Health Accreditation Board

Services:

All local health departments are required to have a full-time emergency preparedness coordinator (EPC). The EPC is responsible for ensuring the health department is prepared to respond to public health emergency, carrying out planning exercises, building health department partnerships with other emergency response entities, and providing community education related to emergency preparedness. Emergency preparedness activities can be supported by local, state, and federal funding.



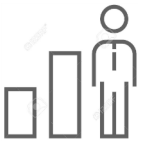
There are eight healthcare coalitions in Michigan that work with local partners within each region to prepare hospitals, emergency medical services, and supporting healthcare organizations to deliver coordinated and effective care to victims of terrorism and other public health/healthcare emergencies. Each region maintains one full-time regional coordinator and one part-time medical director.

Goals:

The goals for emergency preparedness include:

- Preparing local health departments to respond to emergencies, through work plans, exercises, and written plans and plan reviews
- Educating the community on how to prepare for and react to emergencies
- Developing and strengthening relationships with other emergency response partners, including state departments and local police and fire

Impact:



Recently, local health departments' emergency preparedness divisions have been involved in the response to several large-scale public health emergencies, including two hepatitis A outbreaks (one linked to frozen strawberries and one originating in southeast Michigan), the Flint water crisis, Ebola response planning, and large-scale flooding.

Local Health Department
Environmental Health: General Services

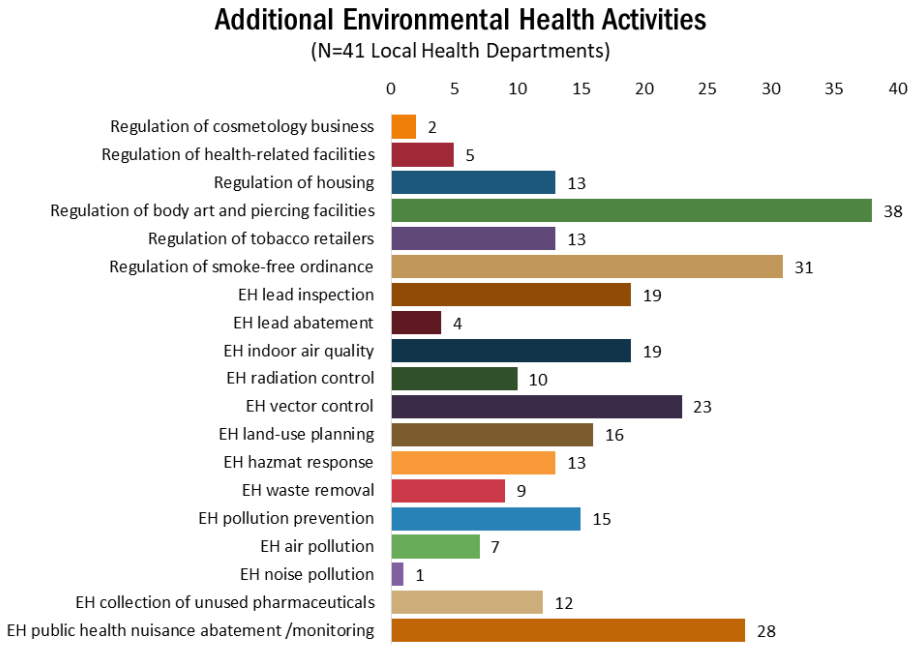
Local health departments (LHDs) are responsible for a variety of services that help keep our environments safe and healthy. These services include inspections of daycares, schools, and body art facilities; radiation control and hazardous waste management; response to nuisance complaints; air and water pollution prevention; vector control; environmental contamination response; and land-use planning. These inspections, assistance in planning, and interventions help to ensure the environment is protected and homes are safe from hazards.

Key Positions

Environmental Health Sanitarians
Environmental Health Secretaries
Environmental Health Supervisors

Meets Public Health Standards:

✓	Michigan Public Health Code
	Michigan Local Public Health Accreditation
✓	Public Health Accreditation Board



Services:

Local health department sanitarians provide monitoring, inspection, regulation, and/or licensing services including:

- School and daycare facility inspections
- Smoke free air law/ordinances
- Nuisance abatement and monitoring
- Body art facility inspections
- Lead inspections
- Indoor air quality
- Radiation control
- Radon testing and outreach
- Land-use planning
- Hazardous waste collections
- Pollution prevention and control
- Collection of unused pharmaceuticals
- Medical waste facility inspections

Goals:

Regulation, inspection, and licensing activities around recreational facilities are meant:

- To ensure that homes and facilities in the community are safe and healthy
- To protect our environment from pollution and contamination
- To correct any potential health hazards in homes, and other facilities

Impact:

Maintaining a healthy environment is central to increasing quality of life and years of healthy life.

Created by the Barry-Eaton District Health Department for the Michigan Association of Local Public Health with funding from the Michigan Department of Health and Human Services. August 2018.

*41 of Michigan's local health departments indicated that they participate in general environmental health activities (of 41 who participated in the survey). Participants might not have answered each question.

Local Health Department

Epidemiology and Surveillance

MICHIGAN ASSOCIATION FOR LOCAL PUBLIC HEALTH

Federal, state, and local health entities regularly collect and analyze data to understand the extent of health risk behaviors, preventive care practices, and the burden of chronic diseases to assess progress of public health programs and provide public health professionals and policy makers with timely information for effective decision making.

Key Positions
Data Analyst/ Epidemiologist
Communicable Disease Nurse
MDHHS Regional Epidemiologist

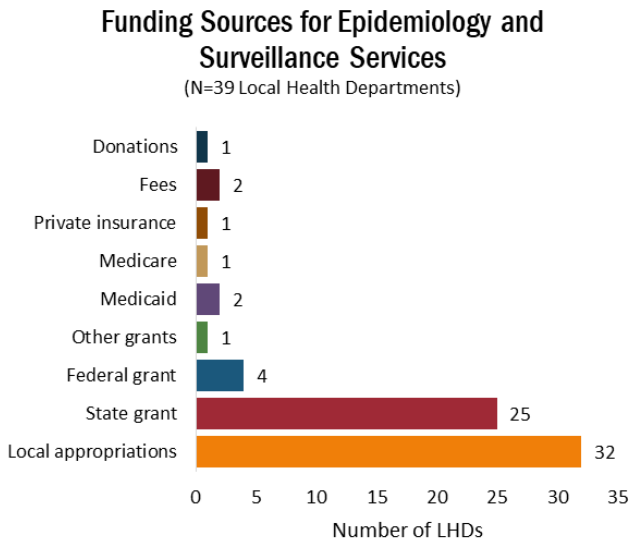
A *Community Health Assessment* looks at a wide variety of available health data to identify the priority health issues in a community.

Meets Public Health Standards:

✓	Michigan Public Health Code
✓	Michigan Local Public Health
✓	Public Health Accreditation Board

Services:

Local health department epidemiology and surveillance activities can include regularly analyzing and reviewing county, state, and national data to assess the health of the community. Using this data, local health department epidemiologists or data analysts can identify trends in communicable and chronic diseases, accidents, and morbidity and mortality. These trends or changes help to guide other activities in the health department by identifying areas for public health intervention. Additionally, local health departments can use epidemiology and surveillance data to report to stakeholders and funders and inform Community Health Assessments (CHA) and Community Health Improvement Plans (CHIP).

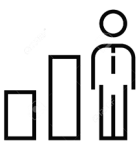


Goals:

Local health department epidemiology and surveillance activities are meant to:

- Identify and monitor trends in morbidity and mortality in the community
- Provide data to inform necessary public health interventions

Impact:



Reports like the Behavioral Risk Factor Surveillance Survey and Community Health Assessments help to guide public health programing at both the state and local levels by identifying population trends in diseases and behaviors.

Created by the Barry-Eaton District Health Department for the Michigan Association of Local Public Health with funding from the Michigan Department of Health and Human Services. August 2018.

*39 of Michigan's local health departments indicated that they participate in epidemiology and surveillance activities of 41 who participated in the survey). Participants might not have answered each question.

Local Health Department

Family Planning

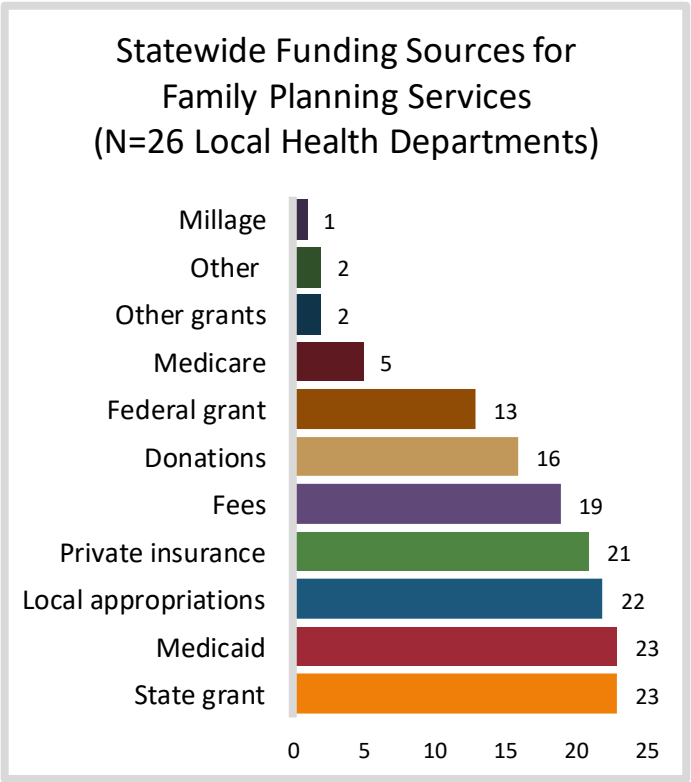
MICHIGAN ASSOCIATION FOR LOCAL PUBLIC HEALTH

Local health departments who participate in Michigan's Family Planning Program provides high quality reproductive health care to women, men, and teens at low or no-cost. Family Planning is a public health service that helps individuals and families to plan for their desired family size and spacing of children or to prevent an undesired pregnancy.

Key Positions
Public Health Nurse
Nurse Practitioner
Billing and Support Staff
Health Educators

Meets Public Health Standards:

	Michigan Public Health Code
✓	Michigan Local Public Health Accreditation
	Public Health Accreditation Board



Services:

Local health departments that participate in family planning services offer:

- Information on birth control and sexual health
- Help choosing the birth control method that best fits client lifestyles
- Help planning a healthy pregnancy
- Pregnancy testing and counseling
- Testing and treatment for sexually transmitted infections (STIs)
- Preventive health exams to screen for cancer or other health issues

Goals:

Family planning services:

- Help prevent unplanned pregnancy and STI transmission
- Support healthy pregnancies by addressing planning and spacing

Impact:

Births resulting from unintended pregnancies can have negative consequences including birth defects and low birth weight.

Created by the Barry-Eaton District Health Department for the Michigan Association of Local Public Health with funding from the Michigan Department of Health and Human Services. November 2018.

Local Health Department

Food Service Sanitation

MICHIGAN ASSOCIATION FOR LOCAL PUBLIC HEALTH

Foodborne illness outbreaks have the potential to affect large numbers of people, cause illness and distress, and can even be deadly. One critical function of public health is to prevent foodborne illness outbreaks from happening in food service facilities (such as restaurants) serving the public. Local health departments (LHDs) in Michigan provide a variety of services related to food service. All LHDs perform activities surrounding food service establishment evaluation, foodborne illness investigation, and food safety education. Some LHDs are also involved in regulation related to food processing and other activities.

Key Positions
Environmental Health Sanitarians
Environmental Health Secretaries
Environmental Health Supervisors

The CDC estimates that each year 48 million people get sick from a foodborne illness in the United States.

Meets Public Health Standards:

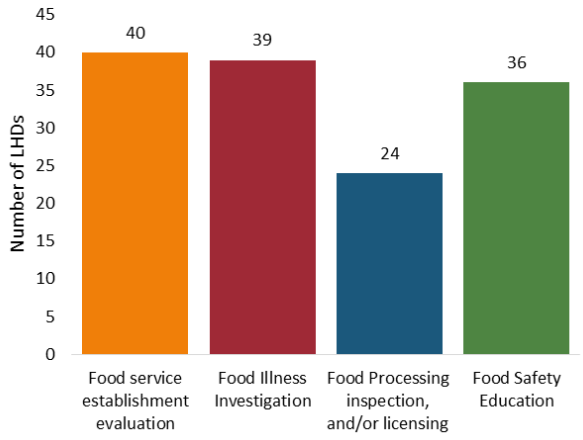
✓	Michigan Public Health Code
✓	Michigan Local Public Health Accreditation
✓	Public Health Accreditation Board

Services:

Food service sanitarians inspect local food service establishments (such as restaurants) twice per year to ensure that they are meeting the standards set in Michigan's Food Code. Other local food service operations, such as mobile food vendors, temporary kitchens and special events are inspected as needed. Many health departments teach Food Safety Manager certification courses throughout the year. Finally, food service sanitarians investigate food and restaurant complaints and conduct foodborne illness and outbreak investigations (in partnership with communicable disease nurses and epidemiologists).

Food Service Sanitation Activities

(N=40 LHDs)



Goals:

Local health department food service sanitation licensing, inspection and regulation aims:

- To assess the facility's control over the most common risk factors for foodborne illness.
- To identify restaurant and facility conditions that pose a potential threat to health and ensure their correction.
- To reduce the incidence of foodborne illness and outbreaks.
- To promote the food safety education of operators and workers.
- To rapidly respond to any customer complaints or foodborne incidents/events.

Primary Funding Sources for Food Service Sanitation Activities:

FEES | LOCAL FUNDING | STATE GRANTS

Impact:

Local health department sanitarians educate food service workers on the major food safety risk factors: temperature, cleanliness, worker hygiene, and safe suppliers.

Created by the Barry-Eaton District Health Department for the Michigan Association of Local Public Health with funding from the Michigan Department of Health and Human Services. August 2018.

*40 of Michigan's local health departments indicated that they participate in food sanitation activities (of 41 who participated in the survey). Participants might not have answered each question.

Local Health Department

Health Promotion, Prevention, and Education

MICHIGAN ASSOCIATION FOR LOCAL PUBLIC HEALTH

The primary purpose of population-based health promotion and education is to prevent disease, illness, and injury. Preventing these problems before they happen can lead to reduced demands on the healthcare system; better health outcomes for individuals; and overall healthier, safer, and more engaged communities. All local health departments in Michigan carry out at least some health promotion and education activities, often in conjunction with community partners and coalitions. Addressed topics can include injury prevention, chronic disease, lead poisoning, and mental health, among countless others.

Key Positions
Health Educator
Data Analyst or Epidemiologist
Manager

Each local health department has a designated Public Information Officer, who assures timely and accurate information is provided to the public.

Meets Public Health Standards:

✓	Michigan Public Health Code
✓	Michigan Local Public Health Accreditation
✓	Public Health Accreditation Board

Services:

Health promotion, prevention, and education services vary widely by health department. Some health departments have robust departments that conduct intensive assessment and planning activities and collaborate intensively with other community organizations, whereas others focus efforts on the education of individuals. Some are heavily involved in environmental, policy, and systems change, while still others focus on personal interventions with individuals to prevent adverse health outcomes. The topics that health departments work cover a wide range and are often dependent on community wants, needs, and readiness. Funding is often a determining factor for the breadth of promotion, prevention, and education activities that health departments perform.

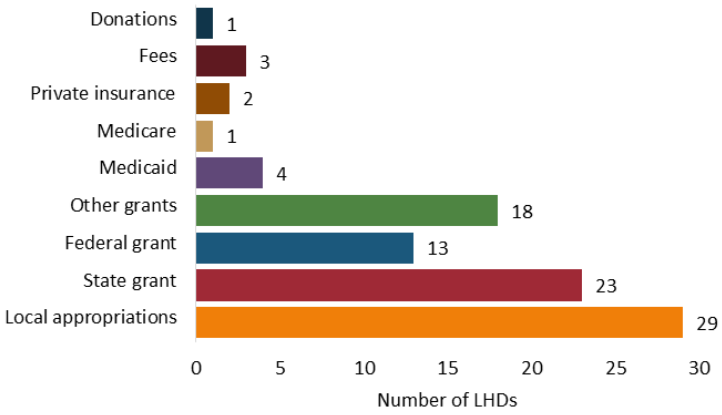
Goals:

Health promotion, prevention, and education activities are meant to:

- Prevent adverse health outcomes.
- Engage the community and partners in improving health.
- Address health outcomes that need to be improved, often with evidence-based interventions.

Statewide Health Promotion and Education Funding Sources

(N=39 Local Health Depatments)



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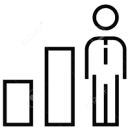


Many local health departments serve as conveners of local coalitions that work to improve health. These local coalitions assure that partners work collaboratively on efforts, avoiding duplication and maximizing collective impact.

Created by the Barry-Eaton District Health Department for the Michigan Association of Local Public Health with funding from the Michigan Department of Health and Human Services. August 2018.

*39 of Michigan's local health departments indicated that they offer health promotion and education (of 41 who participated in the survey). Participants might not have answered each question.

Local Health Department

Hearing and Vision Screening

MICHIGAN ASSOCIATION FOR LOCAL PUBLIC HEALTH

The ability to hear and see can affect learning, which is key to a child's success. Undiagnosed hearing and vision problems can interfere with children's development. Early detection and treatment of hearing and vision problems can help children succeed in school. All local health departments in Michigan conduct free hearing and vision screening, often in schools. Youth are screened at specified intervals from pre-kindergarten through high school.

Key Positions
Hearing and Vision Technicians
Program Coordinator

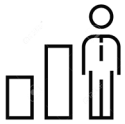
Meets Public Health Standards:

✓	Michigan Public Health Code
✓	Michigan Local Public Health Accreditation
	Public Health Accreditation Board

Services:

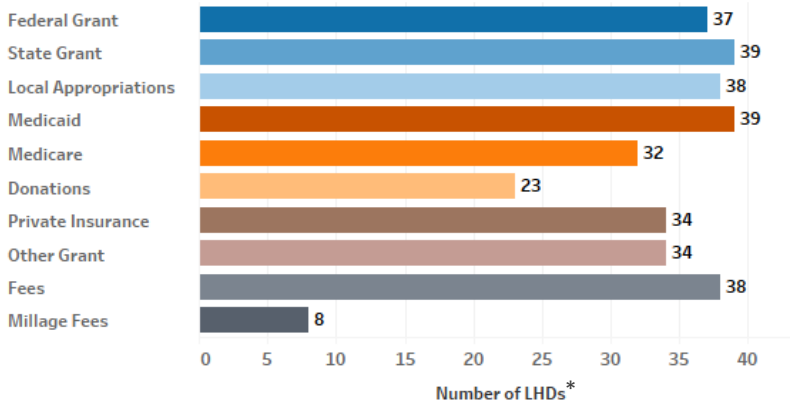
Fully-trained hearing and vision technicians at each health department comprehensively screen children's hearing and vision free of charge. Screenings take place at schools, preschools, Head Starts, and health departments. Students are screened for vision before they enter kindergarten and when they are in 1st, 3rd, 5th, 7th, and 9th grades. Students are screened for hearing at least once between the ages of 3 to 5 years old, in kindergarten, 2nd, and 4th grades. The parents of students who do not pass the screening are notified and recommendations are made to follow up with an eye/ear professional or a family doctor.

Impact:



Each year, more than 1.1 million children are screened. About 18,000 children screened for hearing are referred to doctors, and more than 70,000 children screened for vision are referred to optometrists and ophthalmologists.

Statewide Funding Sources for Hearing and Vison Activities



Goals:

Hearing and vision screening is meant to:

- Detect hearing and vision problems early.
  - ◊ Hearing problems can include hearing loss and middle ear pathology. Vision problems can include lazy eye, nearsightedness, and farsightedness.
- Refer children to providers that can help correct hearing and vision problems, if necessary.
- Remove barriers, such as cost, to children having their hearing and vision screened.

"... Right now the prognosis for Samantha's brain tumor is very good...without your program there never would have been a CT Scan and the discovery of the tumor may not have happened until significant damage had occurred. ...
"... Our family is an example of how a program such as yours can save the life of a beautiful child."

—Lee Ann, mother of Samantha from Livonia, MI

Created by the Barry-Eaton District Health Department for the Michigan Association of Local Public Health with funding from the Michigan Department of Health and Human Services. August 2018.

*41 of Michigan's local health departments indicated that they offer hearing and vision screening services (of 41 who participated in the survey). Participants might not have answered each question.

Local Health Department

HIV/AIDS Programs

MICHIGAN ASSOCIATION FOR LOCAL PUBLIC HEALTH

Local health departments are key partners in the fight against transmission of the human immunodeficiency virus (HIV) and the resulting Acquired Immunodeficiency Syndrome (AIDS). No cure exists for HIV, but with proper medical care, HIV can be controlled. Therefore, prevention of HIV transmission, identification of new cases, and proper treatment of current patients are critical public health activities.

Key Positions

Public Health Nurses
Prevention Specialist/Counselor
Laboratory Technicians
Program Coordinators
Public Health Physicians

In 2016, there were over 700 new diagnoses of HIV in Michigan.

Over 15,600 Michigan residents currently live with HIV.

Meets Public Health Standards:

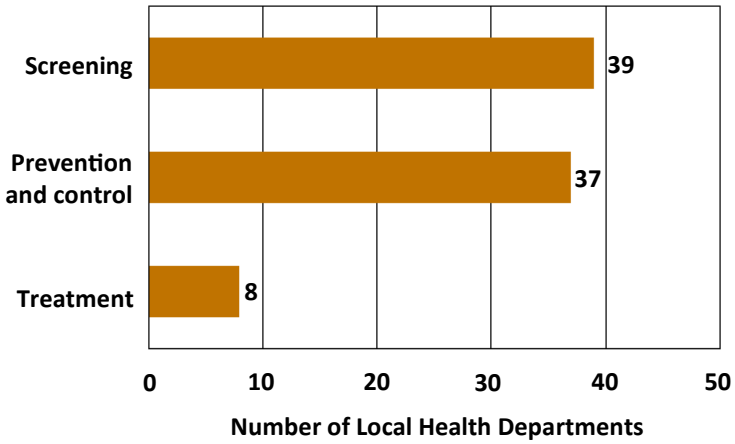
✓	Michigan Public Health Code
✓	Michigan Local Public Health Accreditation
	Public Health Accreditation Board

Services:

Local health departments conduct a variety of HIV/AIDS-related activities, which are usually centered around the goals of prevention, screening, and treatment. Examples of services include HIV testing for individuals, linking individuals who test positive for HIV to medical care, helping individuals remain HIV negative through education and prevention practices, and working with partners who may be at risk for HIV. Local health departments may also analyze local data in order to understand trends in transmission and utilization of HIV services.

If a local health department is unable to offer HIV testing or treatment, then it must be able to refer individuals to outside agencies which offer those services.

Michigan Local Health Departments Directly Providing HIV Services (n = 41 Local Health Departments*)



Impact:

In 2016, 81% of Michigan residents living with HIV were linked to care for their HIV diagnosis.

Goals:

HIV/AIDS prevention, screening, and treatment programs conducted by local health departments:

- Prevent transmission of HIV and decrease the number of new HIV infections
- Work to suppress the overall viral load of communities at risk
- Educate health care providers and communities
- Link patients to treatment and other resources
- Improve the lives of Michigan residents, especially those living with HIV/AIDS

Created by the Barry-Eaton District Health Department for the Michigan Association of Local Public Health with funding from the Michigan Department of Health and Human Services. August 2018.

*41 out of 45 of Michigan's local public health departments participated in the survey at least partially. Participants might not have answered each question.

Local Health Department

Lead Screening and Response

MICHIGAN ASSOCIATION FOR LOCAL PUBLIC HEALTH

Lead is a metal that can be found in many places, including in chips of old paint, household dust, imported toys, and, less often, water contaminated by lead pipes. Exposure to lead is bad for everyone, but young children are often most at risk. Making sure that children aren't exposed to lead is important to their long-term health. Even low levels of lead in blood can affect children's development.

Key Positions
Public Health Nurse
Billing and Support Staff
Health Educators

The only way to find out if a child has lead poisoning is through a blood test.

Meets Public Health Standards:

✓	Michigan Public Health Code
	Michigan Local Public Health Accreditation
	Public Health Accreditation Board

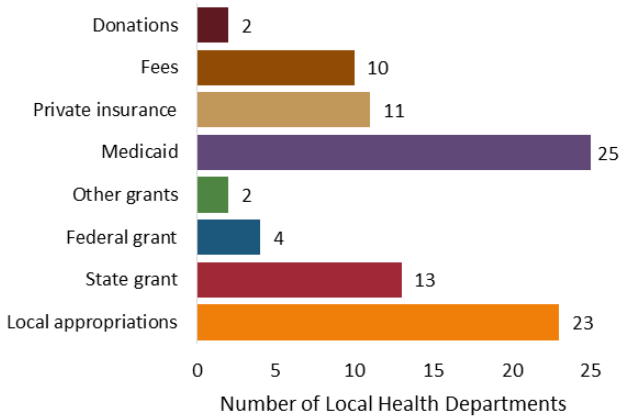
Services:

Local health departments that participate in blood lead screening will screen Medicaid-eligible children in the WIC program. This screening is done by a finger prick. Children can also be screened by their primary care provider. If a child has high lead levels (above 5 micrograms/dL), his/her family will be contacted by a public health nurse or lead program staff for additional testing, education, environmental evaluation, and follow-up.

Michigan's Lead Safe Home Program (MDHHS) provides inspections and assistance to qualifying families, as well as rental property owners, in making their homes lead-safe for children. Through collaboration between local health departments and the Lead Safe Home Program, families can receive lead abatement and remediation to their home for little to no cost, resulting in a safer and healthier home environment for the child.

Funding Sources for Blood Lead Level Screening

(N=37 Local Health Departments)



Goals:

Local health department blood lead screening programs aim to:

- Detect and eliminate lead exposures in children
- Promote healthy brain development in children

Impact:

Screening for and responding to lead exposure in children can help to ensure that children do not develop behavior and learning problems, lower IQ and hyperactivity, slowed growth, hearing problems, and anemia.

Created by the Barry-Eaton District Health Department for the Michigan Association of Local Public Health with funding from the Michigan Department of Health and Human Services. August 2018.

*37 of Michigan's local health departments indicated that they participate in lead screening and response activities (of 41 who participated in the survey). Participants might not have answered each question.

Local Health Department

Maternal Infant Health Program (MIHP)

The Maternal Infant Health Program (MIHP) is Michigan's largest, evidence-based home visitation program for Medicaid eligible pregnant women and infants. MIHP is administered by a network of certified provider agencies throughout the state in rural, urban, and native communities. Providers are located in private freestanding offices, hospital-based clinics, federally qualified health centers, and in local/regional public health departments

Key Positions
Public Health Nurse
Dietitian
Social Worker
Program Supervisor

Participation in MIHP reduces the risk of infant death, both in the newborn stage and in later infancy.

Meets Public Health Standards:

	Michigan Public Health Code
	Michigan Local Public Health Accreditation
	Public Health Accreditation Board

Services:

MIHP provides support to promote healthy pregnancies, good birth outcomes, and healthy infants. By enrolling in MIHP, families receive services from a team of nurses, social workers, and dietitians to connect them with the information and support needed to have a healthy pregnancy and baby. All pregnant women and/or infants under the age of one that are Medicaid-eligible are eligible for the MIHP program. Services include:

- Maternal and infant health assessment completed by registered nurse or licensed social worker
- Coordination of MIHP services with the patients' health care provider and Medicaid Health Plan
- A team of registered nurses, licensed social workers, and registered dietitians offer home or office visits to provide education and support based on the needs of each family
- Transportation services as needed
- Referrals are made to local community services (e.g., mental health, substance abuse, domestic violence, basic needs assistance) as needed
- Referral to local childbirth education or parenting classes

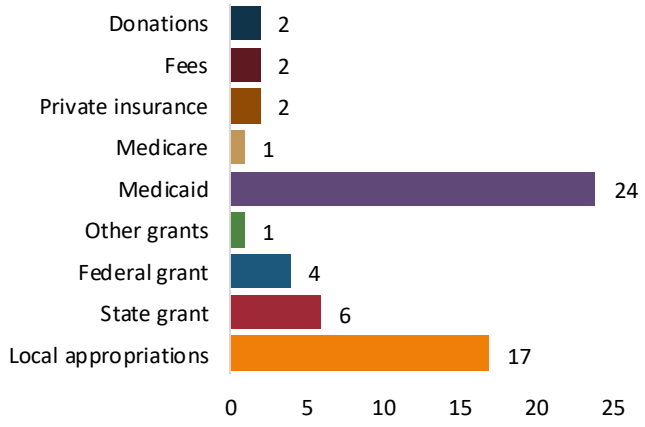
Goals:

Local health department MIHP programs aim to:

- Reduce maternal and infant morbidity and mortality
- Promote healthy pregnancies, positive birth outcomes, and healthy infant growth and development.

Statewide Funding Sources for MIHP Programs

(N=30 Local Health Departments)



Impact:

MIHP programs help to improve health and well-being of pregnant women and infants — pre-natal and post-natal care is better, and infants are more likely to get well-child checkups.

Created by the Barry-Eaton District Health Department for the Michigan Association of Local Public Health with funding from the Michigan Department of Health and Human Services. August 2018.

*30 of Michigan's local health departments indicated that they offer MIHP Programs (of 39 who participated in the survey). Participants might not have answered each question.

Local Health Department

Recreational Facility Safety

MICHIGAN ASSOCIATION FOR LOCAL PUBLIC HEALTH

Public places like pools and spas, beaches, children's camps, campgrounds, and RV parks are important community recreation places. They can also be prime locations for waterborne and communicable diseases to be spread. Environmental Health (EH) divisions at local health departments regularly inspect and monitor these recreational facilities to ensure that they are safe and healthy. Inspections include sampling pool and beach waters, checking that community wells are functioning properly and free of contaminants, and ensuring that human waste is disposed safely.

Key Positions

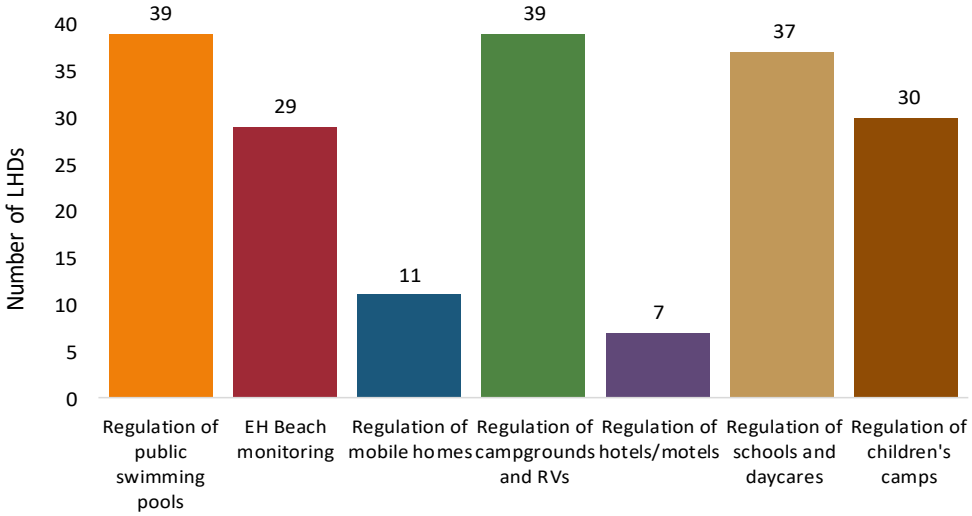
Environmental Health Sanitarians
Environmental Health Secretaries
Environmental Health Supervisors

Meets Public Health Standards:

✓	Michigan Public Health Code
✓	Michigan Local Public Health Accreditation
	Public Health Accreditation Board

Environmental Health Recreational Facility Activities

(N=41 Local Health Departments)



Services:

Local health department Environmental Health (EH) sanitarians provide inspection, regulation, and licensing services for public swimming pools and spas, public bathing beaches, children's camps, and public campgrounds and RV parks. Many of these activities are seasonal, in the warmer months. Campground, and RV park, and pool inspection programs are conducted independently by health departments; beach and camp inspection programs are conducted in partnership with the State. Most local health departments (LHDs) in Michigan conduct one operational inspection per year for pools and spas, however, some conduct two yearly inspections.

Goals:

Regulation, inspection, and licensing activities around recreational facilities are meant to

- Assess facilities and recreation areas and/or educate operators on various EH factors that could negatively impact the health and safety of the public.
- Reduce the incidence of injuries, illnesses, and deaths.
- Promote healthy recreation and public awareness.

Primary Funding Sources for Recreational

Impact:

In 2015, 98 beaches reported 212 incidents of E. coli exceeding accepted water quality standards. These reports helped to alert beach goers of the hazardous water, and prevent the spread of disease.

Created by the Barry-Eaton District Health Department for the Michigan Association of Local Public Health with funding from the Michigan Department of Health and Human Services. August 2018.

*41 of Michigan's local health departments indicated that they participate in recreational facility activities (of 41 who participated in the survey). Participants might not have answered each question.

Local Health Department

Sewage Management Activities

MICHIGAN ASSOCIATION FOR LOCAL PUBLIC HEALTH

Proper sewage system design, installation, and maintenance can prevent premature failures and contamination problems from occurring. This helps keep the community and our water resources healthy. It also helps ensure that sewage systems operate effectively throughout their expected lifetime. Replacing a sewage system is costly, so proper maintenance makes good economic sense. On-Site Sewage (Septic) System Programs are meant to help residents avoid exposure to untreated sewage and to reduce contamination of groundwater and surface water resources.

Key Positions
Environmental Health Sanitarians
Environmental Health Secretaries
Environmental Health Supervisors

Wastewater is water that has been used in the home, in a business, or as part of an industrial process.

Meets Public Health Standards:

✓	Michigan Public Health Code
✓	Michigan Local Public Health Accreditation
✓	Public Health Accreditation Board

Services:

Local Health Department Environmental Health (EH) sanitarians provide inspection and regulation services for all on-site sewage (septic) systems. Other activities can include:

- Alternative on-site wastewater treatment (sometimes called engineered systems)
- Operational maintenance inspections
- Time of sale or transfer evaluations
- Vacant land evaluations
- Septage hauler inspections and regulation
- Sewage system design and inspection
- Complaint investigation including illicit discharges
- Licensure of sewage system installers

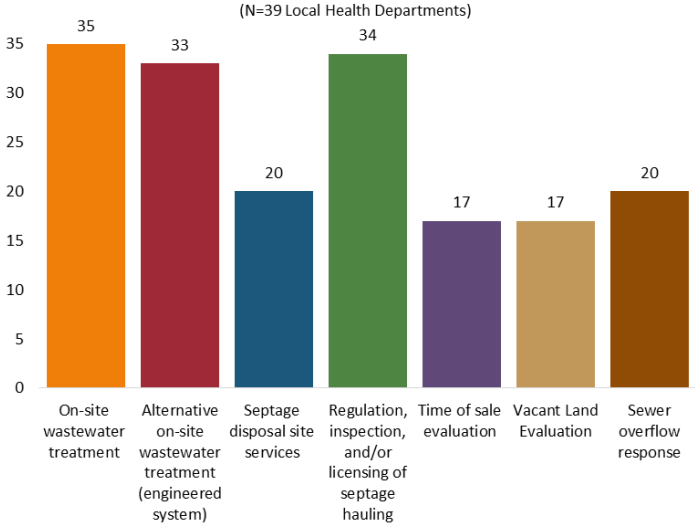
Goals:

Regulation, inspection, and licensing activities around sewage systems are meant to:

- Help residents in the district avoid exposure to untreated sewage
- Reduce contamination of groundwater and surface water resources
- Educate land owners on how improper sewage (septic) system maintenance could negatively impact the health and safety of the public.

Sewage Management Activities

(N=39 Local Health Departments)



Primary Funding Sources for Sewage Management Activities:

Impact:

Proper sewage management activities help to improve the quality of the ground and surface water in our communities, and help to protect the Great Lakes.

Created by the Barry-Eaton District Health Department for the Michigan Association of Local Public Health with funding from the Michigan Department of Health and Human Services. August 2018.

39 of Michigan's local health departments indicated that they participate in sewage management activities (of 41 who participated in the survey). Participants might not have answered each question.

Local Health Department

Sexually Transmitted Infections

MICHIGAN ASSOCIATION FOR LOCAL PUBLIC HEALTH

Sexually transmitted infections (STIs) are infectious diseases that are passed from one person to another through intimate physical contact and sexual activity. Due to the large numbers of cases and the potential for serious health consequences, STIs are a nationwide public health problem. Local health departments work to control the spread of STIs through testing, treatment, prevention, and education.

Key Positions
Public Health Nurses
Laboratory Technicians
Program Coordinators
Public Health Physicians

In 2016, there were almost 62,000 new cases of chlamydia, gonorrhea, and syphilis reported in Michigan.

Meets Public Health Standards:

✓	Michigan Public Health Code
✓	Michigan Local Public Health Accreditation
✓	Public Health Accreditation Board

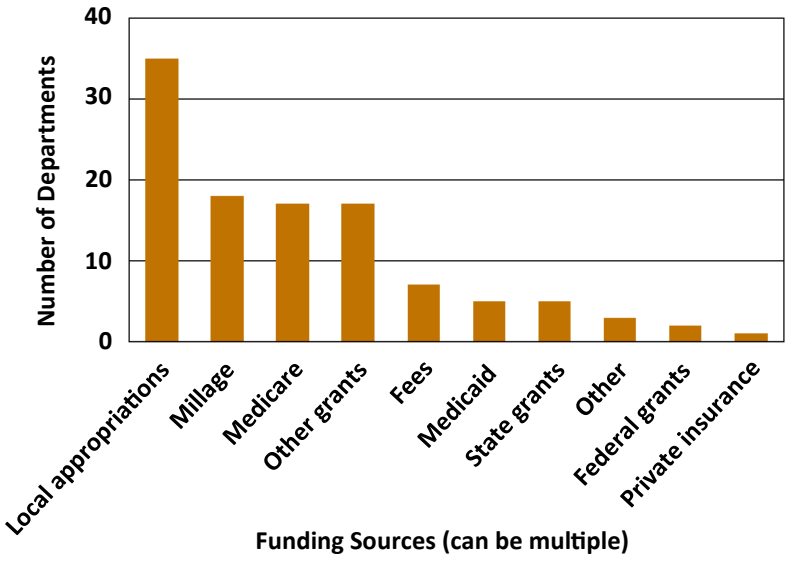
Services:

Public health nurses and other local health department staff implement sexually transmitted infections programs that help ensure residents throughout Michigan receive prevention, testing, and treatment for a range of sexually transmitted diseases. Prompt identification of STIs is important to prevent the spread of disease. Serious health problems, such as pelvic inflammatory disease, infertility, and health complications for infants can also result from STIs, so linking patients to treatment at either the health department or community partners is an essential function of STI programs.

Local health departments may conduct a variety of additional STI programs, such as health care provider education and site visits, school-based clinics, condom distribution, expedited partner therapy, and community education.

Trends: **From 2001-2016, Michigan cases of chlamydia have increased by 53%. Gonorrhea cases have decreased by 29% during this time period.**

Funding Sources for Michigan Local Health Department STI Programs (n = 41 Local Health Departments*)



Goals:

Sexually transmitted infections programs conducted by local health departments serve to prevent and control the spread of sexually transmitted diseases by:

- Identifying cases through testing and reporting
- Removing barriers, such as cost and access, to testing and treatment
- Providing education to patients, health care providers, and the community
- Ensuring timely reporting of cases to the state health department

Created by the Barry-Eaton District Health Department for the Michigan Association of Local Public Health with funding from the Michigan Department of Health and Human Services. August 2018.

*41 out of 45 of Michigan's local public health departments participated in the survey at least partially. Participants might not have answered each question.

Tobacco Prevention and Control

MICHIGAN ASSOCIATION FOR LOCAL PUBLIC HEALTH

Smoking tobacco increases the risk for chronic diseases like cancer, heart disease, chronic obstructive pulmonary disease (COPD), and stroke. It is the leading cause of preventable death. Not smoking, or quitting smoking (for current smokers) can greatly reduce the risk for developing diseases like this, and can prolong life. Tobacco prevention is important in creating healthy communities. New tobacco and nicotine products are emerging constantly, making tobacco prevention more important than ever.

Key Positions

Health Educators

Smoking-related health problems cost Michigan more than $4.5 billion per year.

Meets Public Health Standards:

✓	Michigan Public Health Code
✓	Michigan Local Public Health Accreditation
✓	Public Health Accreditation Board

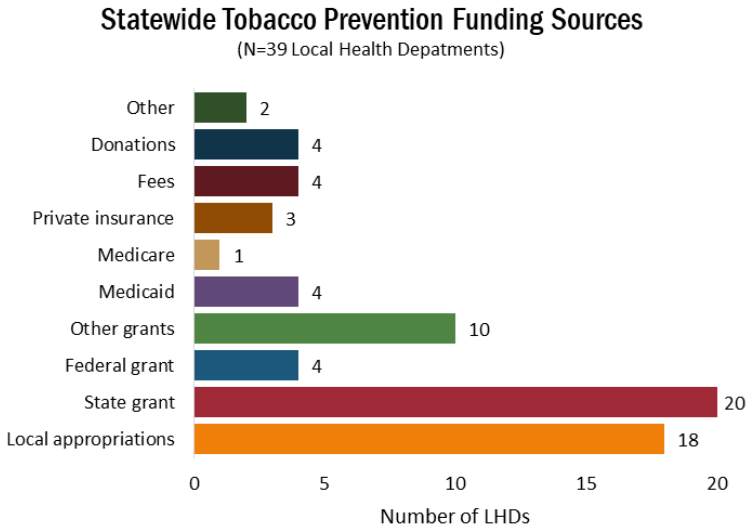
Services:

Local health departments that participate in tobacco prevention conduct tobacco compliance checks, vendor education, and general outreach regarding cessation resources. Additionally, many local health departments partner with local coalitions that focus on tobacco reduction or substance abuse. These partnerships help to raise awareness of the dangers of tobacco products in the community and enable the community members to educate themselves so they can take action for tobacco prevention and cessation.

Goals:

Local health promotion, prevention, and education activities centered on tobacco prevention are meant to:

- Prevent adverse health outcomes associated with long term tobacco or nicotine product use
- Create awareness in the community about the dangers of tobacco and nicotine addiction
- Prevent youth from using tobacco and nicotine products



Impact:

Over 1,500 calls were placed to the Michigan Tobacco Quit Line between October 1st, 2016 and March 31st, 2017.

Created by the Barry-Eaton District Health Department for the Michigan Association of Local Public Health with funding from the Michigan Department of Health and Human Services. August 2018.

*39 of Michigan's local health departments indicated that they offer tobacco prevention services (of 41 who participated in the survey). Participants might not have answered each question.

Local Health Department

Tuberculosis Control

MICHIGAN ASSOCIATION FOR LOCAL PUBLIC HEALTH

Tuberculosis (TB) is a communicable disease caused by the bacterium *Mycobacterium tuberculosis*. TB is transmitted (spread) through the air from one person to another. If not treated properly, TB disease can be fatal. Michigan local health departments work with a variety of health care and laboratory partners to control the spread of TB through testing, treatment, prevention, control, and education.

Key Positions
Public Health Nurses
Clinic Support Staff
Public Health Physicians

252 cases of active and latent tuberculosis were reported in Michigan during 2017.

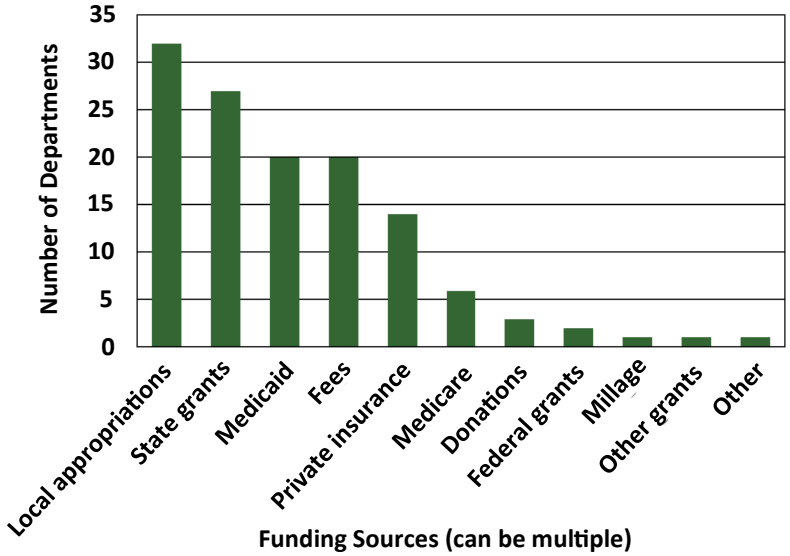
Meets Public Health Standards:

✓	Michigan Public Health Code
✓	Michigan Local Public Health Accreditation
✓	Public Health Accreditation Board

Services:

Local health departments are the primary local agency responsible for preventing and controlling TB. However, TB control is a complex undertaking and requires the collaborative efforts of a broad range of persons, organizations, and institutions inside and outside the public health sector. The essential roles of local health departments are to plan, coordinate, and evaluate TB control and prevention efforts. To fulfill these roles, local health departments may engage in and provide oversight on TB planning and policy development, contact investigations, clinical and diagnostic services for TB patients and their contacts, training and education, surveillance, data management, and monitoring and evaluation.

Funding Sources for Michigan Local Health Department TB Screening Programs (n = 41 Local Health Departments*)



Goals:

Local health department TB control programs prevent and control the spread of TB by:

- Identifying cases through testing and reporting
- Treating active cases through directly observed therapy
- Recommending and instituting infection control measures
- Providing education to patients, health care providers, and the community
- Ensuring timely reporting of cases to the state health department

Impact:

Local health departments may have to monitor each active TB patient for 6 to 12 months to ensure their TB disease is cured.

Created by the Barry-Eaton District Health Department for the Michigan Association of Local Public Health with funding from the Michigan Department of Health and Human Services. August 2018.
*41 out of 45 of Michigan's local public health departments participated in the survey at least partially. Participants might not have answered each question.

Local Health Department

Water Supply Quality and Safety

Having a safe drinking water supply is important to the public's health. Contaminants in drinking water could affect many people because we use water every day. Some contaminants in water are naturally found in the environment, and some are human made. Examples of contaminants are bacteria, viruses, parasites, arsenic, chemicals, and fertilizers. Contaminants in drinking water can be a threat to human health, especially the health of young children, the elderly, and pregnant women. Local, state, and federal drinking water protection programs play a key role in providing safe drinking water.

Key Positions
Environmental Health Sanitarians
Environmental Health Secretaries
Environmental Health Supervisors

Local health departments respond to hazards in water supplies such as disease-causing bacteria, or chemicals such as PFAS (Per- and Polyfluoroalkyl Substances)

Meets Public Health Standards:

✓	Michigan Public Health Code
✓	Michigan Local Public Health
✓	Public Health Accreditation Board

Services:

All local health departments (LHDs) participate in public and private drinking water regulation, which leads to ground water protection. Some LHDs do more water supply quality and safety activities including complaint response, long-term groundwater quality monitoring programs, sample collection, geographic information system (GIS) mapping, drinking water testing outside of permitting requirements, laboratory specimen testing, testing of contaminated sites, geothermal well construction, water records and abandoned well tracking.

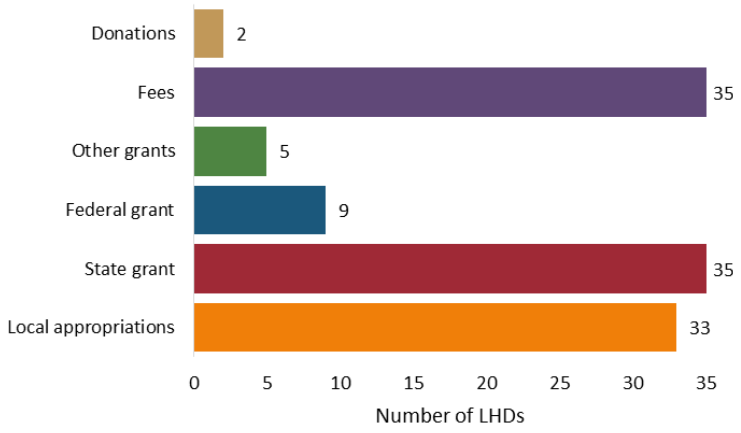
Goals:

Regulation, inspection, and monitoring activities around water supply quality and safety are meant to:

- Reduce contamination of groundwater and surface water resources
- Maintain the quality of drinking water for county residents
- Protect natural resources from contamination

Statewide Funding Sources for Water Supply Quality and Safety Activities

(N=39 Local Health Departments)



Impact:

Clean and safe drinking water can prevent diseases like E.coli, and reduce rates of waterborne disease.

Created by the Barry-Eaton District Health Department for the Michigan Association of Local Public Health with funding from the Michigan Department of Health and Human Services. August 2018.

*39 of Michigan's local health departments indicated that they participate in water supply safety and quality services (of 41 who participated in the survey). Participants might not have answered each question.

Local Health Department

Women, Infants, and Children Program

MICHIGAN ASSOCIATION FOR LOCAL PUBLIC HEALTH

The Women, Infants, and Children (WIC) program is a health and nutrition program that helps women who are pregnant, breastfeeding, or postpartum, and infants and children up to 5 years old, eat well, be active, and stay healthy. The WIC program has demonstrated a positive effect on pregnancy outcomes and child growth and development. The majority of Michigan local health departments provide WIC services.

Key Positions
WIC Coordinators
Dietitians/Nutritionists
Public Health Nurses
Clinical and Support Staff
Breastfeeding Peer Mentors

Each month, more than 200,000 moms, babies, and children receive nutritious food from the Michigan WIC Program.

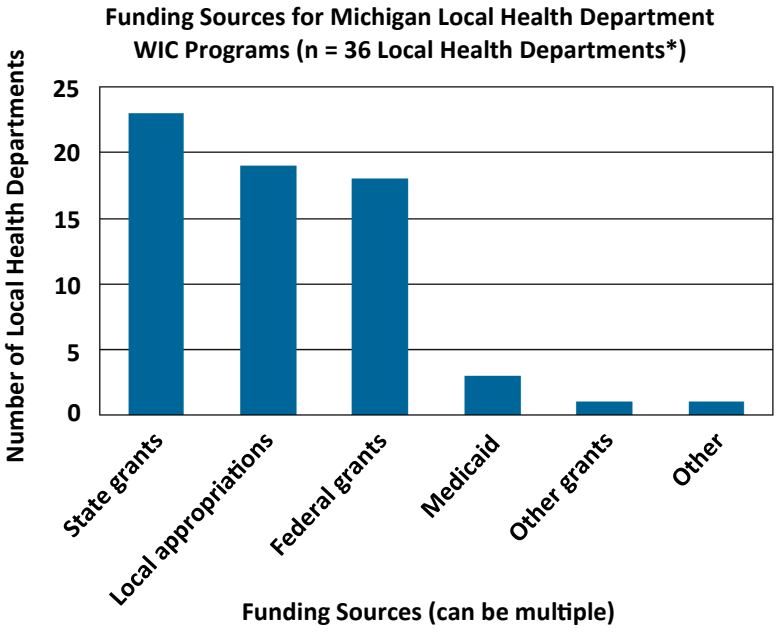
Meets Public Health Standards:

	Michigan Public Health Code
✓	Michigan Local Public Health Accreditation
	Public Health Accreditation Board

Services:

Local health departments that conduct WIC programming offer a number of services to WIC clients, including nutrition education and counseling, breastfeeding support, food benefits through WIC EBT cards to buy healthy food, and referrals to health care, immunizations, and other programs. WIC staff help pregnant women and families determine if they qualify for WIC benefits and assist with the enrollment process. In Michigan, 81% of WIC programs are conducted by local health departments.

Many local health departments also foster relationships with Michigan agricultural producers to support WIC Project FRESH. The program provides WIC participants with local, fresh produce from authorized farmers, farmers' markets, and roadside stands.



Goals:

Women, Infants, and Children programs conducted by local health departments

- Improve pregnancy outcomes and child growth and development
- Provide women who are pregnant, have recently given birth, or are breastfeeding with education and resources about the birthing process, nutrition during and after pregnancy, breastfeeding and breast pumps, and other health issues
- Support young children and families by providing nutritious food and infant formula

Impact: **For every dollar spent by the WIC program, more than 3 dollars in subsequent health care costs are saved.**

Created by the Barry-Eaton District Health Department for the Michigan Association of Local Public Health with funding from the Michigan Department of Health and Human Services. August 2018.

*36 of Michigan's local health departments indicated that they offer WIC services (of 41 who participated in the survey). Participants might not have answered each question.

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An Ounce of Prevention:

What Public Health Means for Michigan

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An Ounce of Prevention: What Public Health Means for Michigan

In a Nutshell

- Public health is a central and yet broadly misunderstood function of government that focuses on prevention of disease and injury, and management of environmental factors (physical and social) that affect health. Medicine improves the health of one individual at a time; public health improves the health of entire communities.
- In recent years, the state has invested little more than what was needed to draw down federal public health funding. This leaves the state heavily reliant on diminishing federal funds. This disinvestment has affected the ability of state and local health departments to provide essential services and leaves Michigan lagging the nation in both per-capita funding for public health and measures of population health.
- Improvement may be needed for Michigan's system of public health service delivery that is exceedingly fragmented between multiple state departments. A "Health in All Policies" approach should be adopted statewide so that every government policy (from schools to roads to criminal justice) includes assessment of associated health risks and/or benefits. State and local health departments should endeavor to coordinate public health across sectors and elevate the public's understanding of public health.

Summary

When someone hears "public health" they are apt to think of Medicare or Medicaid, but these programs are not what is commonly understood to be public health. Medicare and Medicaid are publicly-provided health insurance programs that facilitate an individual's access to health care. Public health is much broader and refers to a constellation of activities that assess the health status of communities, design policies and interventions to improve health, and assure that health needs are met by monitoring and evaluating health services and programs. In practice, these activities include preventing disease, poisoning, and injury by:

- Controlling the spread of infectious diseases and other factors that cause harm
- Guaranteeing the safety and quality of food and drinking water
- Ensuring safe and clean environments
- Certifying the quality of the health care workforce and facilities
- Addressing the reasons that some people are more likely to suffer poor health than others
- Educating and empowering individuals to improve their health

Stated more succinctly, public health is the science of protecting and improving the health of people and their communities, and a substantial proportion of the health and well-being each individual enjoys is due to public health. Average life expectancy has more than doubled since the mid-1800s. While medical care might look like the obvious hero, more than 80 percent of this improvement is because of advances in public health.

The water emergency in Flint brought international attention to the perverse irony that citizens of the Great Lakes State were unable to secure potable water. Ongoing, contemporaneous threats from a cornucopia of contaminants—PFAS, dioxane, harmful algal blooms—affect water systems throughout the state, suggesting that lead may be the least of Michigan's water woes. Yet lead remains a longstanding occupant of aging and increasingly unsafe housing found throughout the state from Detroit to Grand Rapids. Moreover, while water seems to have a special importance in Michigan, air and soil contamination are no less cause for concern:

every source of pollution compromises and erodes the health of the public.

What we eat affects our health as much as the water we drink and the air we breathe. Older residents of the state might recall the horror caused in the 1970s when millions were exposed to polybrominated biphenyl (PBB) through contaminated meat, dairy, and eggs. Packaged food remains a source of human infection from pathogens like *E. coli* and *Salmonella*. Unsafe food handling and preparation can also lead to food contamination and the spread of disease, playing a factor in Michigan's largest-in-the-nation outbreak of Hepatitis A that began in 2016.

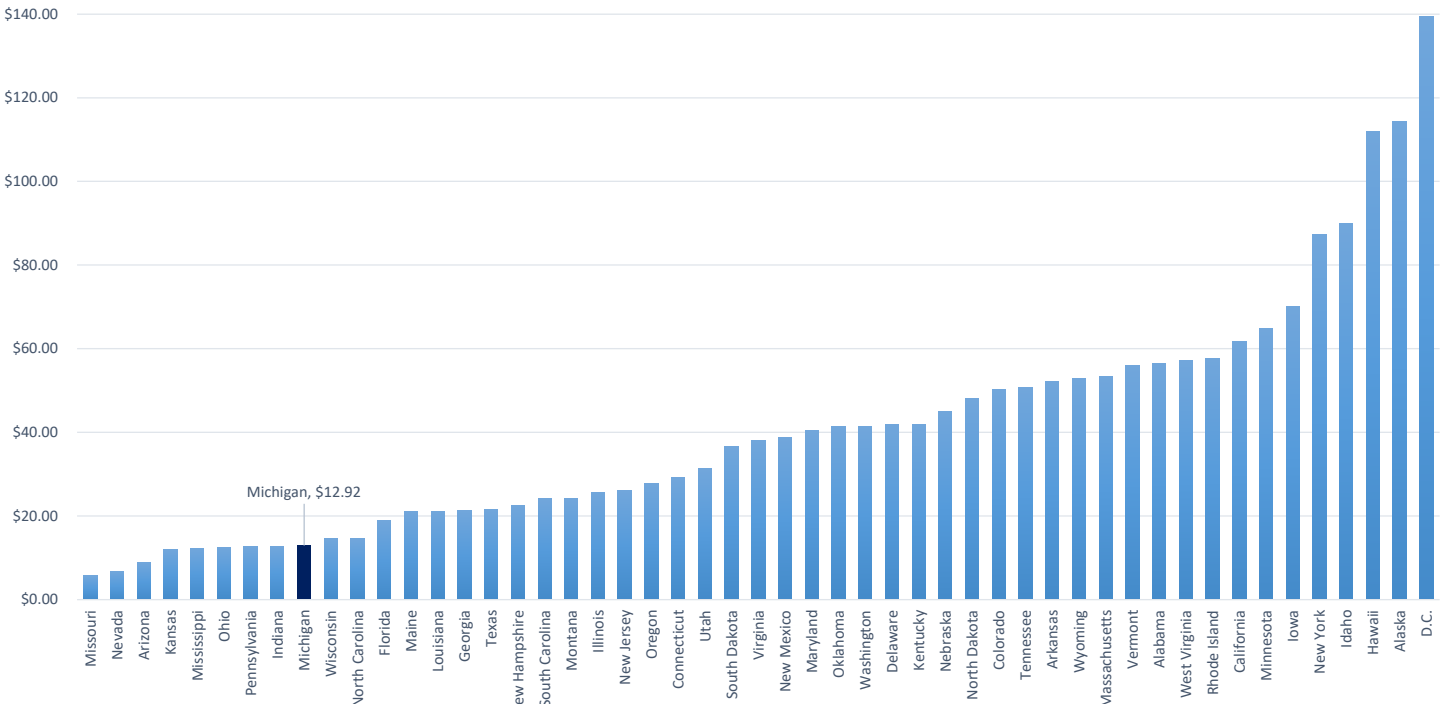
Hepatitis A is highly contagious, and, like many infectious diseases, can spread through a population like wildfire if not contained. Reports of other vaccine-preventable diseases, such as measles, mumps, pertussis, and varicella, continue to occur in Michigan. Influenza is responsible for numerous hospitalizations and deaths each year. Additionally, the ease of global travel means that emerging diseases (like Ebola virus) can find their way to Michigan. Infectious diseases are cause for continued (perhaps heightened) concern.

While events like outbreaks and environmental contaminations create clear and immediate threats, ongoing social and environmental factors in communities can also have a profound, insidious effect on health over time. These factors (such as poverty, stress, lifestyle, education, and environment) account for at least 60 percent of health outcomes and premature death. The importance of these social determinants of health has been understood for decades, yet they continue to receive inadequate attention from many policymakers and health care professionals. Public health enables this focus on the underlying factors that contribute to poor health.

It is difficult to put a dollar amount on diseases that people didn't catch, on injuries they didn't sustain, or on poisonings that didn't happen. It's also difficult to monetize incremental changes in health quality throughout the course of a person's life. These benefits are invaluable, however, leading to decades of added life and the potential for productivity and prosperity. It is far less expensive to prevent a disease, injury,

Chart A

Per-Capita State Funding for Public Health, FY2017



Source: Trust for America's Health

or poisoning than to medically treat them once they have occurred. Yet, Michigan has disinvested in public health over the past 15 years.

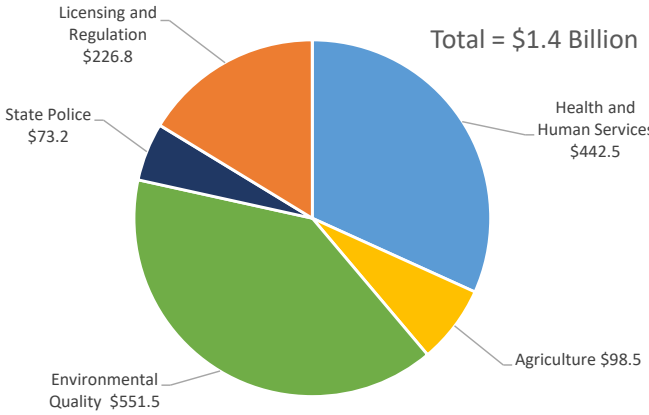
State-supported public health expenditures in Michigan have dropped by 16 percent from an inflation-adjusted high point of $300 million in FY2004. This is not to say that funding was adequate at this expenditure apex. Compared to other states, Michigan ranks near the bottom for its investment in public health (See **Chart A**). Taking away federal funding and programs, Michigan's FY2017 state public health investment totaled $128.3 million (just $12.92 per capita).

After multiple past executive reorganizations and administrative restructuring, public heath responsibilities have been spread across several state departments (rather than remaining the purview of the state health department – presently the Michigan Department of Health and Human Services). The Department of Environmental Quality and Department of Agriculture and Rural Development have assumed important public health roles, and public health functions are also fulfilled by the State Police and the Department of Licensing and Regulatory affairs. This fragmentation might be considered both a symptom and a cause of the marginalization of public health in Michigan.

While the Michigan Department of Health and Human Services has the largest budget of any state department, public health appropriations within this budget have accounted for less than one percent of the total state budget and less than one percent of the state's general fund. A total of $1.4 billion was appropriated to all five departments with public health responsibilities in rough estimation. This suggests that as much as 2.5 percent of Michigan's $55.8 billion state budget is dedicated to public health. (See **Chart B**.) Given the centrality and importance of public health, this proportion may be inadequate.

Chart B

Public Health Appropriations in Michigan, FY2018
(dollars in millions)



Source: CRC Analysis of State Line Item Appropriations

Michigan relies heavily on federal funding to support state and local public health activities, yet federal funding for public health appears increasingly scarce. The combined low levels of funding from both federal and state sources have left Michigan in a state of public health subsistence. Michigan has managed to do what is necessary to generally protect the public's health, but this minimal funding leaves the state potentially unprepared for future crises. Moreover, without additional funding, the state will be far less able to develop new policies or programs to address mounting public health concerns and needs in Michigan.

Michigan, largely because of the social, economic, and physical condition of its communities, has higher than average prevalence of many chronic diseases like heart disease and diabetes (See **Table A**). More Michiganders smoke and/or are obese than the national average. Relatedly, Michigan has a higher rate of infant mortality and its residents have a shorter life expectancy at birth than the U.S. average. Viewed collectively, these broad strokes paint one strikingly clear picture: Michigan pays a price for not prioritizing and funding public health.

That price is evident in Flint and other communities that experience health threats from their water, food, and environment. The insidious nature of this price is revealed in Northern Michigan's "disability belt" and in the communities struggling with opioid addiction. The unfair character of this price is paid especially by low-income communities and communities of color where people live much shorter, sicker lives and watch infants perish at more than twice the rate of other communities. Additionally, Michigan cannot afford to continue to spend massive amounts on health insurance policies and costly medical interventions while failing to invest in population-level health promotion and disease prevention, or, more generally, in social well-being.

Moreover, Michigan cannot afford to be seen as a state that fails to protect the safety and well-being of its people.

The health issues facing Michigan are complex. In contrast, a large part of the solution to these health issues is very simple. Michigan needs greater investment in public health. Investment certainly means greater appropriation of fiscal resources; investment also means greater philosophical buy-in. Each of Michigan's departments, agencies, and local governments should prioritize safeguarding the public health and adopt a "Health in All Policies" philosophy and approach to governance. The public must develop a deeper understanding of public health, assume greater individual responsibility for personal and community health, and hold public leaders accountable for failures to protect the public's health.

Table A

Age-Adjusted Mortality Rates* for the Ten Leading Causes of Death in Michigan, 2016

*Rates are per 100,000 persons

	U.S.	Michigan	Detroit
Heart Disease	165.5	200.8	322.9
Cancer	155.8	167.1	192.7
Chronic Lower Respiratory Diseases	40.6	44.7	33.9
Unintentional Injuries	47.4	50.8	71.9
Stroke	37.3	39.1	47.4
Alzheimer's Disease	30.3	33.8	20.1
Diabetes Mellitus	21	21.5	27.6
Kidney Disease	13.1	14.5	23.5
Pneumonia/Influenza	13.5	13.7	21
Intentional Self-harm	13.5	13.4	8.9
All Causes of Death	728.8	787.8	1,027.4

Source: Detroit Health Department

A Health in All Policies approach can only be realized by forging strategic partnerships across the public and private sectors, and by increasing public understanding of the importance of public health. In particular, it is important for public health leaders to bring together relevant partners and collaborators and work to explicitly address the upstream factors that determine health. While Michigan has a comprehensive public health code, a well-trained public health workforce, and nationally accredited university programs to train the next generation of public health professionals, it will be impossible to improve the future health of the public absent the public's support, consent, and buy-in. This makes the adoption of well-organized, collaborative, and transparent public health delivery systems essential.

Health underpins every individual's ability to pursue their own happiness and to make productive contributions to their community. Michigan faces numerous health challenges and large numbers of people continue to experience notable health disparities. Greater attention to public health will work to deconstruct physical and social barriers to healthy, productive lives, and to safeguard the health and well-being of all citizens on this pair of pleasant peninsulas.

An Ounce of Prevention: What Public Health Means for Michigan

Introduction

When people think of health, they are apt to imagine that health is what happens in a hospital or physician's examination room. In reality, the majority of a person's health is determined by factors in their household and community. The concept of health, therefore, includes the health and well-being of communities, the activities that can prevent illness or injury, and the various underlying factors that contribute to a person's overall health. In other words, thinking about health should include thinking about public health.

Public health is the science of protecting and improving the health of people and their communities. Rather than simply treating illnesses or injuries when they occur, public health seeks to prevent them from happening in the first place. While medicine works to help people one at a time, public health works to help entire populations. Moreover, public health relies on the understanding that health is not merely the absence of disease, but rather a state of complete physical, mental, and social well-being.

While medicine works to help people one at a time, public health works to help entire populations.

When public health is working to keep people healthy, it often goes unnoticed. In contrast, it becomes quickly apparent when something goes wrong. Many issues in Michigan might be averted or better addressed by greater emphasis on public health:

- The spread of infectious diseases and the threat of emerging diseases.
- Harm from food that has been contaminated or is otherwise unsafe.
- Exposure to environmental hazards in the air, water, and soil.
- High rates of chronic diseases, substance use and abuse, and obesity.
- Other social and physical factors that contribute to poor health.

From the water emergency in Flint and the Hepatitis A outbreak in Southeast Michigan to sites of contamination and occurrences of preventable diseases throughout the state, it is clear that Michigan needs to pay greater attention to public health.

Michigan's infant mortality rate and age-adjusted mortality for many of the leading causes of death exceed national averages. Michigan also exceeds the national averages in prevalence of tobacco use and obesity—important factors in the development of diseases that lead to premature death. Not surprisingly, the life expectancy at birth is lower in Michigan than in other states on average.

Viewed collectively, the above broad strokes paint one strikingly clear picture: **Michigan is a tremendously unhealthy state.**

Poor health presents clear costs to individuals, shortening the length and impairing the quality of their lives. That these costs are due to preventable factors makes them all the more intolerable. Moreover, the costs of poor health are not restricted to only the sickest individuals; poor health affects families and communities, and ultimately exacts high costs on society.

Poor health also impairs educational efforts in Michigan schools. Children struggling with physical and/or psychological health issues (often linked to factors in the home or community) will have a difficult time performing well in school and progressing through their education. Environmental hazards and psychosocial trauma can also lead to cognitive impairment.

Poor health also impairs workforce development. An individual's reliability and performance capacity as an employee can be greatly hindered by health issues. Poor health can also lead to functional limitations and

disabilities that prevent people from joining the workforce or causing them to exit the workforce prematurely.

Poor health also may hinder efforts to attract people to visit or relocate to Michigan. Laughter is contagious, but so too are stress, violence, depression, obesity, and substance abuse. The health of a community is central to attracting new talent. Every dollar spent on the "Pure Michigan" campaign to promote the state is more than offset by national news of infectious diseases, environmental contamination, or widespread illnesses caused by foodborne contamination.

Poor health increases the consumption of health care resources and inflates the already high health insurance costs borne by individuals and businesses in Michigan. While Michigan's high-quality system of health providers can work to prolong life and reverse damage caused by a disease outbreak or environmental contamination, it is much less costly to prevent these events than it is to mitigate the damage once they occur. Likewise, chronic diseases are both costly and preventable.

Poor health is not an inevitability. Clean air and water, nutritious food, safe neighborhoods, quality schools, healthy lifestyles, and greater social support are all attainable goals. Healthcare alone cannot prevent diseases, poisonings, and injuries – preventing harm and securing the health of all people requires a robust public health system.

Michigan can do better. Public health is a public good that works to give each person the opportunity to be as healthy as possible and provides benefits far beyond each dollar of investment. Greater emphasis on public health will therefore enable state and local governments to better assess potential problems, develop policies to address problems that are identified, and provide assurance of the public's health and safety.

Despite its critical importance, public health has rarely been top of mind for state and local government policymakers.

Michigan has suffered because of a disinvestment in public health. Additionally, a series of executive reorganizations of state functions has created a very fragmented organization of public health services across several state departments. Greater attention in the budgeting process is therefore only part of the solution if Michigan is to improve the health and well-being of its citizens. New service delivery models should also be considered

Despite its critical importance, public health has rarely been top of mind for state and local government policymakers. Greater public demand for public health services and the infusion of public health into the policymaking process would ingrain an assessment of health risks and/or benefits into policy making at all levels of government. All policies in Michigan would benefit from greater consideration of public health.

What is Public Health?

Public health is the science of protecting and improving the health of people and their communities.[1] It seeks to prevent disease and other forms of harm, to address ongoing population health needs, to respond to emergencies when they occur, and to improve the overall health of the population. Public health also seeks to ensure that each person has an opportunity to be as healthy as possible and defines health in a way that recognizes that it is not merely the absence of disease or infirmity, but rather "a state of complete physical, mental, and social well-being."[2]

In practice, public health does these things by applying scientific evidence and inquiry to develop solutions to a broad range of health problems, and by utilizing public policy to apply these solutions in ways that promote and protect the health and well-being of all individuals. Public health works to monitor disease outbreaks, guarantee the safety and quality of food, ensure the safety of environments, and certify the quality of the health care workforce and systems.[3] It also works to educate and empower individuals with health information, promote wellness and encourage healthy behaviors, and to determine and address the reasons that some individuals are more likely to suffer poor health than others.[4] By focusing on whole communities, public health also places a great emphasis on health equity and reducing health disparities.

The term public health is frequently discussed and yet rarely well-defined. Perhaps this is due to the broad range of subject matter and professional activities that are encompassed by the term public health. For example, professionals commonly engaged in public health might include epidemiologists, toxicologists, and sanitarians, as well as health administrators, researchers, and educators. Public health also overlaps with nursing and social work in its clinical application, health promotion, and disease prevention activities. The field of public health includes policies and actions to preserve clean air and water, guarantee safe food, monitor infectious diseases and prevent epidemics, screen for health risks, promote healthy behaviors, and develop multidisciplinary interventions to address threats to individual and community well-being, such as obesity and depression.

Another source of obfuscation regarding public health might be the frequent conflation of public health with medicine or health care. Health care provided by the government (as with the Veterans Health Administration) or government-administered health insurance (like Medicare) are not public health, despite being financed by taxpayer funds and administered by public agencies. Conversely, privately administered health screening and surveillance, disease prevention, occupational and environmental safety, and health education and promotion are examples of public health activities.

Public health applies a multi-disciplinary scientific approach to identify threats to health and well-being and seeks large-scale solutions that preempt the emergence of disease or injury.

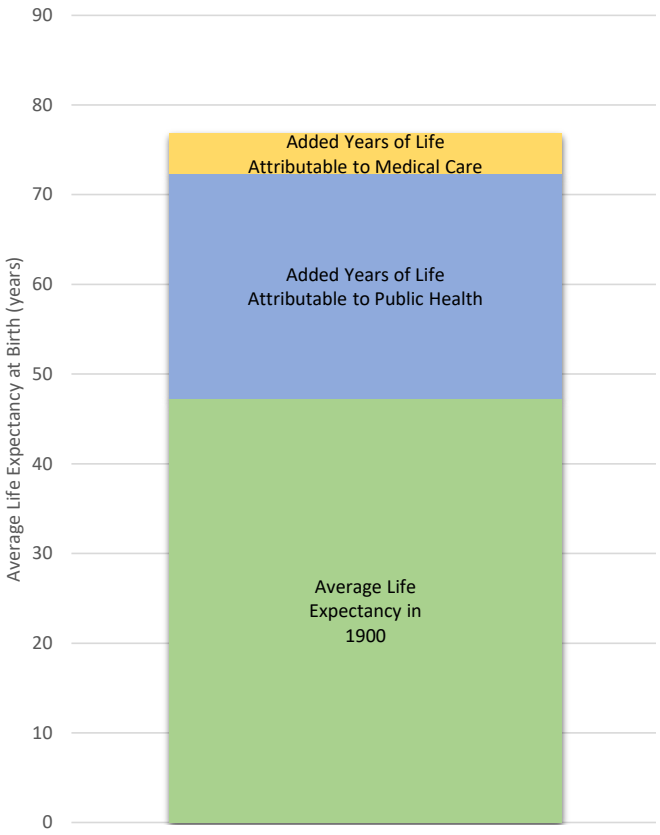
The primary differences between public health and medicine relate to sequence and scope. Public health focuses on prevention: While medicine seeks to treat existing diseases or injuries, public health attempts to prevent diseases or injuries from occurring and, when they do occur, seeks to prevent them from spreading or reoccurring. Public health also focuses on the community rather than the individual: While medicine treats individuals, public health focuses on entire populations or subpopulations. Public health constructs broad interventions to improve the health of groups of individuals whether they're small neighborhoods, entire states, or countries. It applies a multi-disciplinary scientific approach to identify threats to health and well-being and seeks large-scale solutions that preempt the emergence of disease or injury.

The impact of public health has been profound. Since 1900, life expectancy in the U.S. has increased by more than 30 years. At least 25 of these extra years of life are attributable to the major achievements of public health, including infectious disease control, vaccination, better nutrition and safer food, occupational/workplace safety,

motor vehicle safety, maternal health and family planning, and remediation of environmental hazards and toxins.[5] The remaining fraction of the change in life expectancy may be attributed to improvements in medicine (see **Chart 1**). If this timeline is expand further to the mid-19th century (when average life expectancy at birth was just 39 years), it is fair to say that public health has very nearly doubled individuals' lifespans and substantially improved quality of life.

Chart 1

Proportion of Added Average Life Expectancy Attributable to Public Health Efforts in the Year 2000



Source: CDC Life Expectancy Estimates and "10 Great Public Health Achievements"

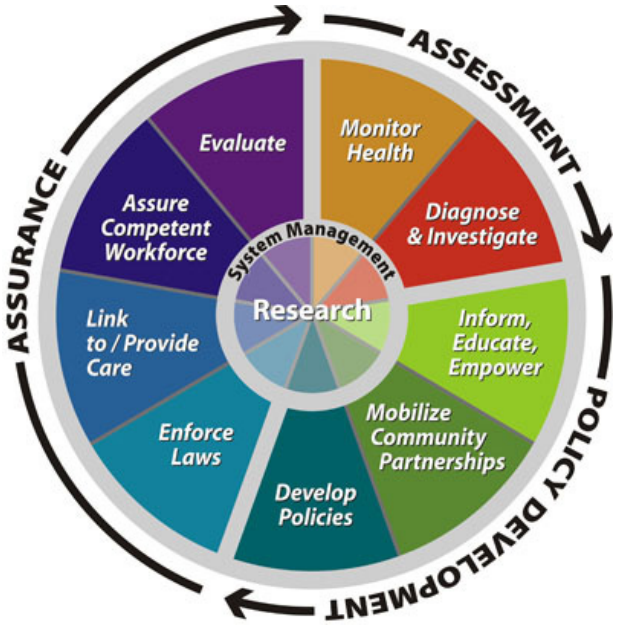
Core Functions of Public Health

The three core functions of public health first outlined by the Institute of Medicine (now called the National Academy of Medicine) are assessment, policy development, and assurance (see **Figure 1**).[6]

- *Assessment* describes the process of monitoring and determining the health status of populations by way of health screenings, testing for environmental hazards, observing the incidence and prevalence of various health conditions, tracking infectious disease, monitoring health disparities, and surveilling air and water for evidence of bioterrorism or chemical weapons.
- *Policy development* describes the process of constructing new interventions to improve health, establishing goals and standards for health service delivery and population health, and setting priorities for the distribution of health resources.
- *Assurance* describes the implementation and evaluation of programs and services, the guarantee of quality and safety (as through licensure or inspection), and the education and empowerment of the public (to self-manage health) with the goal of assuring that all health needs are effectively and safely met.

Figure 1

Core Functions of Public Health



Source: Centers for Disease Control and Prevention.

The 10 Essential Public Health Services that were adopted by the Centers for Disease Control and Prevention (CDC) in 1994 describe the public health activities that all communities should undertake.[7]

1. Monitor health status to identify and solve community health problems
2. Diagnose and investigate health problems and health hazards in the community
3. Inform, educate, and empower people about health issues
4. Mobilize community partnerships and action to identify and solve health problems
5. Develop policies and plans that support individual and community health efforts
6. Enforce laws and regulations that protect health and ensure safety
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable
8. Assure competent public and personal health care workforce
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services
10. Research for new insights and innovative solutions to health problems.

Public Health as a Public Good

Public health, as the name implies, has generally been regarded as a public good—that is to say, a product or service that benefits everyone and is not used up or degraded by usage. Public goods have usually been viewed as best provided by government. Environmental factors like clean air and water benefit entire communities, and one person's benefit from clean air is not diminished by another enjoying that benefit. Moreover, even if a community member decided(s) he didn't want to pay for clean air, there would be no way to prevent that person from enjoying the benefit of clean air if others paid for it. Similarly, it is difficult to put an individual price on prevention activities that keep diseases from spreading and/or injuries from happening throughout communities. Health care providers typically charge patients for diseases or injuries that are treated, not those that are prevented and never require treatment. Because of this, governments continue to have a central role and responsibility for protecting the public's health.

The integration of public health with primary care in the health sector is essential for disease and injury prevention and health promotion efforts.

Despite clear public-sector centrality in public health administration and service delivery, public health spans the public, private, and non-profit sectors. The public health system includes not only state and local health agencies, but also public, private, and/or non-profit entities involved in health care, public safety, human services, education, arts and culture, recreation, transportation, economic development, philanthropy, and the environment. Public health therefore relies on voluntary support and contributions from a wide range of entities across all sectors.

Just as public-private partnerships have become an important vehicle for infrastructure development, there is also an increasing role for non-governmental actors in promoting and improving public health. In particular, the integration of public health with primary care in the health sector is essential for disease and injury prevention and health promotion efforts. Community-based organizations are also essential partners for addressing the specific health needs of a given community and for ensuring that efforts are continued (or expanded) after an initial health program and/or intervention. An emergent ethos of corporate responsibility seems to be leading the business community to consider ways private industry can improve the well-being of communities, such as enhancing the capacity, impact, and sustainability of public health efforts. Ultimately, healthy employees and healthy customers are necessary for healthy businesses.

Health Equity

Health equity is a guiding priority and core value of public health practitioners.[8] Health equity refers to attainment of the highest level of health for all people, but this is only an attainable priority if various health inequalities and disparities are addressed.[9] Differences in health can be observed on the basis of differences in income, education, geography, and race/ethnicity, and may also be observed in relation to disability, veteran status, sexual orientation, gender identity, and a variety of other personal characteristics. The cards that a person are dealt (vis-à-vis their physical and social environment) can lead to a life of compromised health, with exposure to various hazards and traumas worsening a person's health through no fault of their own. Health equity, therefore, prioritizes eliminating these unfair health outcomes and making sure that everyone can have an opportunity to live a healthy life, regardless of where they are born or how much money they make.

Improving health equity is as much about providing equal opportunity as it is about striving for equal outcomes.

Improving health equity is as much about providing equal opportunity as it is about striving for equal outcomes. It is nearly impossible to be healthy without safe homes and neighborhoods, and without access to good schools and employment opportunities. If certain individuals and communities do not have the opportunities to live healthy lives, it will be nearly impossible for them to achieve desirable health outcomes. This is especially important to consider as gaps in health status are large, persistent, and increasing across the U.S.[10] While personal responsibility plays an important role in health, the massive differences in health between different communities suggests that the reasons for health inequities are more complex than differences in individual regard for health.

To pursue health equity in Michigan, policymakers need to recognize that "a person's zip code has become a stronger determinant of health than their genetic code."[11] Consider that the average life expectancy at birth in several Detroit zip codes is just 70 years. This is 8.5 years fewer than the U.S. average and a full 15 years fewer than the residents of the Northville zip code (48168) on the opposite side of Wayne County where the life expectancy at birth is 85 years.[12] This loss of 15 years of life (on average) between communities in the same region reflects the differing proportions in each community of various factors that worsen health over time and lead to a shorter life. Illustrating that an even starker degree of inequity that can occur between regions, the differences in average life expectancy among U.S. counties exceeds 20 years.[13]

Health inequities are not exclusive to Michigan's largest city and region, but rather affect communities in all parts of the state. While analyzing Michigan's ostensible urban and rural divide, the Citizens Research Council found that individuals in Michigan's rural communities experience more disease and disability, shorter life expectancies, and higher proportions of pain and despair than do their urban and suburban counterparts.[14] The reasons for these differences are complex, and are primarily related to factors such as income, education level, availability of jobs, access to transportation, access to health care services, housing quality, and social norms and attitudes (i.e., social determinants of health). These interrelated factors in the social, economic, and physical environments have a tremendous impact on health throughout a person's life and lead to inequitably impaired health and eventually premature death..[15]

The Broad Reach of Public Health

The roots of public health extend into a rich history predating its modern existence as a scientific discipline and area of governmental organization and service. Community interest in public health was evident from some of the first written health codes (that appear in the Biblical book of Leviticus). Early descriptions of what is clean and/or safe to eat are paralleled in modern food labeling and health and safety warnings. The community benefits of public health were evident from early sanitation practices among the Romans and have been continued by the creation of modern agencies tasked with ensuring a healthy environment like the U.S. Environmental Protection Agency (EPA) or the Michigan Department of Environmental Quality (DEQ). The security threats that public health must address became evident with the weaponization of plague-ridden corpses by the Mongols during the siege of Kaffa in 1345. These threats remain plainly evident today and are addressed by modern biological, radiological, and chemical weapon surveillance.[16]

Throughout its history of struggles against infectious diseases, environmental toxins, and, more recently, inequitable social structures, public health has grown and evolved into a complex science.

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In Michigan today, this means public health should work to ensure:[17]

- Infectious diseases are monitored and contained
- Drinking water is safe
- Air is clean
- Sewage is contained
- Grocers and restaurants provide safe, untainted food
- Sources of foodborne illness are identified and investigated
- Health care emergency response plans are in place for natural and human-made disasters
- Children are vaccinated to protect against diseases
- Screening programs are available to identify possible health risks
- Health care services are accessible for all segments of the population
- The underlying causes of disease and injury (including social factors) are identified and addressed.

These various functions of public health are continuously at work in Michigan, the U.S., and around the globe to promote health and prevent harm.

Infectious Diseases

Infectious diseases are caused by pathogens, such as viruses, bacteria, fungi, or parasitic organisms. Infectious diseases may be spread from human to human or may be transmitted from other animals (then referred to as zoonotic diseases).[18] In addition to spreading naturally, infectious diseases may also be spread through malicious human activity, such as bioterrorism. While years of public health activities have worked to suppress and mitigate infectious diseases, they remain a significant threat to human health that require robust public health systems and emergency planning and preparedness to manage.

The plague of Justinian that afflicted the Byzantine Empire, the Black Death that spread through Eurasia and North Africa during the 14th century, and the smallpox epidemic that ravaged the indigenous population of the Americas in the 17th century, provide examples of how infectious diseases have shaped human history as a constant and looming threat. A quick listing of familiar names— SARS, MERS, Ebola, Zika—provides a reminder that epidemics remain an ever-present threat to human health and safety. Infectious diseases are now emerging in greater numbers and spreading more quickly than at any time in human history.[19] Advances in mobility mean that an epidemic in one part of the world is just a few hours of travel away from threatening other parts of the globe.

Infectious diseases are now emerging in greater numbers and spreading more quickly than at any time in human history.

Michigan continues to suffer from a large outbreak of Hepatitis A that emerged in July of 2016 and has led to 856 cases, 692 hospitalizations, and 27 deaths.[20] The Hepatitis A outbreak offers a local example to observe how public health professionals determine the source of an outbreak, identify high risk individuals, and deploy resources to stop the spread of disease.[21] Public health officials also work to educate the public about steps to take to protect themselves and what to do if they believe they have been infected.[22]

The Hepatitis outbreak in Michigan overlapped with a high severity 2017-18 influenza season that affected many Michiganders.[23] Influenza is an ongoing problem for human health, perhaps epitomized by the 1918 influenza pandemic that caused the death of 675,000 Americans and 50 million people worldwide.[24] While recent U.S. flu seasons may not measure up to the 1918 pandemic in scope and magnitude, they have still been responsible for 12,000 – 56,000 seasonal deaths and 140,000 – 710,000 hospitalizations annually since 2010.[25] Influenza can lead to additional complications (such as pneumonia) and is among the leading cause of deaths in Michigan.[26] Yet, only 44.2 percent of people six months of age and older received a flu shot during the 2016-2017 influenza season.[27]

Vaccination's benefit is, of course, not limited to influenza; a broad range of vaccines have been and continue to be developed to protect children, adolescents, and adults from disease. Vaccines are a safe and effective preventative measure to control the spread of infectious diseases and prevent sickness and death. Immunization is a core component of disease prevention, and works together with disease surveillance, screening and testing guidelines to keep people safe from infectious diseases.

Foodborne Illnesses and Food Safety

Safe and nutritious food is vitally important for human health and well-being. Because of the tremendous advances in food safety made over the last 50-100 years, it is often taken for granted that the food we buy from grocers and restaurants can be consumed without harming us. Clear and accurate labeling is also often underappreciated. Despite its daily importance for people, however, food is also an important vehicle for disease, injury, or poisoning that warrants continued special consideration.

The 2016 Michigan outbreak of Hepatitis A discussed above illustrates the importance of infectious disease control to prevent an outbreak from spreading, but it also illustrates the importance of safe practices in food handling and preparation since Hepatitis A is a foodborne/waterborne disease. While the virus can spread through close, personal contact with an infected individual, Hepatitis A is usually spread by ingestion of the virus through food/beverages/objects that are contaminated by small, undetectable amounts of feces from someone who is infected.[28]

Older residents of the state might recall the horror caused in the 1970s when millions were exposed to polybrominated biphenyl (PBB) through contaminated meat, dairy, and eggs. Numerous recent occurrences of other diseases have been linked to contaminated food as well. A 2018 multistate outbreak of *E. coli* that was traced back to contaminated romaine lettuce caused 210 reported infections (including five in Michigan) and 96 hospitalizations, leading to five deaths and 27 cases of hemolytic uremic syndrome (a type of kidney failure).[29] Overlapping with this *E.coli* outbreak, a multistate outbreak of *Salmonella* Adelaide linked to pre-cut melon has led to 70 cases as of June 19, 2018, (including 38 in Michigan) and 34 hospitalizations.[30] A 2018 outbreak of *Salmonella* Mbandaka that led to 73 illnesses and 24 hospitalizations led to a recall of Honey Smacks cereal from Michigan's own Kellogg Company.[31]

Detection, control, and, more importantly, prevention of foodborne illnesses require a robust, adequately funded public health system.

Detection, control, and, more importantly, prevention of these kinds of outbreaks require a robust, adequately funded public health system.

Environmental Hazards

Like safe foods, safe environments are something that people tend to take for granted. The Flint water emergency that began in 2014 served to bring the ongoing problems of environmental contamination and (and, in particular, lead exposure) back into state and national conversations; however, Michigan already had some of the worst rates of lead exposure in the nation prior to the 2014 emergency in Flint.[32] Moreover, the primary source of lead exposure in children continues to be lead-based paint from pre-1978 housing (not water).[33]

Lead is not the only environmental contaminant to threaten the health of the people of Michigan. Toxins abound in Michigan's air and water. A contamination of 1,4-dioxane was discovered in residential drinking wells in Washtenaw County in 1985; the chemical does not break down quickly, and a large plume remains in soil and water surrounding Ann Arbor and Scio Township.[34] Cyanotoxins from harmful algal blooms have threatened water safety throughout Michigan and the Great Lakes.[35] Sixty-five hazardous waste sites in Michigan appear on the National Priorities List (and an additional two have been proposed).[36]

Per- and polyfluoroalkyl substances (PFAS) provide a timely example of a contemporary environmental threat. PFAS are a group of industrially manufactured and utilized chemicals that are persistent in the environment and human body. They are found in a wide range of consumer products, as well as food and drinking water, and evidence suggests that exposure to them harms human health.[37] While the effects of this range of chemicals is still being studied, research suggests that exposure may affect infant development, lead to hormonal changes, increase cholesterol levels, and affect the body's immune system.[38] Certain PFAS may also increase the risk of cancer.[39] As of May 2, 2018, there are 31 known contamination sites across throughout Michigan.[40]

What do these and other environmental issues mean for health? Nearly a quarter of all deaths globally are attributable to preventable environmental factors.[41] The Lancet Commission on pollution and health found that diseases caused by pollution are responsible for three times as many deaths globally as AIDS, tuberculosis, and Malaria combined.[42] Moreover, pollution related diseases also cause productivity losses and increased health care spending leading to $4.6 trillion in annual losses (6.2 percent of the global economy).[43] Environmental factors tend to have the greatest impact on those who already have the greatest health risks and who often have the fewest resources to respond, adapt, or cope.

The health impact of pollution is often farther reaching than many realize. While respiratory illnesses are commonly associated with air pollution, polluted air can also lead to cancer, heart disease, and kidney disease. Additionally, a recently published longitudinal cohort study in *The Lancet* that was funded by the U.S. Department of Veterans Affairs found that $PM_{2.5}$[a] exposure was significantly associated with increased risk of diabetes.[44]

a $PM_{2.5}$ refers to small atmospheric particulate matter that have a diameter less than or equal to 2.5 micrometers.

Chronic Disease Burden and the Cost of Health Care

In 2016, total United States health expenditures amounted to $3.3 trillion (17.9 percent of GDP).[45] Around 75 percent of this health care spending is on people with chronic diseases such as heart disease, diabetes, hypertension, and other conditions that may be avoidable through public health interventions.[46] Although chronic diseases are among the most common and most costly maladies, they are also the most preventable.[47] Evidence suggests that communities with greater investment in public health have fewer deaths from preventable causes like heart disease and diabetes, as well as lower rates of infant mortality.[48]

Evidence suggests that communities with greater investment in public health have fewer deaths from preventable causes like heart disease and diabetes, as well as lower rates of infant mortality

Despite the focus that public health places on prevention, less than three percent of total U.S. health expenditures are directed at public health measures to prevent diseases before they occur and need to be treated.[49] Health spending has grown at a rate far in excess of GDP since the 1960s, and yet spending on public health and prevention have not enjoyed this same kind of growth. According to a study published in the American Journal of Public Health, the share of total health expenditures devoted to public health was 2.65 percent in 2014 (about double the figure from 1960); however, the proportion of health expenditures for public health is projected to fall to 2.40 percent in 2023."[50] Some have characterized this as a funding crisis for public health and safety.[51]

The Social Determinants of Health

Public health seeks to identify the underlying causes of poor health, and it has long been recognized that social factors are substantial contributors to the health of individuals and communities. When it comes to the factors contributing to premature mortality, genetics account for around 30 percent, medical care accounts for 10 percent, and the remaining 60 percent is attributable to social circumstances, environment, and related behaviors.[52] Of course, it is difficult to separate these factors from one another. For instance, diseases often develop due to the combination of genetic and social/environmental and/or behavioral factors. Access to medical care is often related to an individual's social circumstances, as are an individual's environment and behaviors. The social circumstances and factors that impact health throughout a person's life are generally referred to as the social determinants of health.

According to the U.S. Office of Disease Prevention and Health Promotion, social determinants of health are conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.[53]

Examples of social determinants of health include:

- Economic conditions (poverty and the stress that accompanies poverty)
- Quality of education and job training
- Availability of social support and community resources (family, church, public spaces)
- Social norms (discrimination, racism, attitudes on education, distrust of government)
- Public safety/exposure to violence/crime
- Language/literacy
- Culture

The social determinants of health are at the core of why Michigan is less healthy than other states, why preventable chronic diseases are so prevalent, and why consumption of expensive health care resources is so high. Because these determinants vary between individuals and communities based on factors like socioeconomic status, geography, race/ethnicity, disability, veteran status, sexual orientation, and gender identity, the social determinants of health are also related to many of the health disparities and inequities discussed in this report.

History of Public Health in Michigan

The creation of Michigan's State Board of Health in 1873 might be viewed as the beginning of Michigan's formal commitment to public health.[54] Michigan's was the fifth such agency in the U.S. (Massachusetts established the first state health department in 1869).[55] As understandings of germ theory and sanitation expanded, Michigan passed laws to create a bacterial laboratory and give the State Board of Health jurisdiction over water supply in the first decade of the 20th century. In 1923, Dr. John H. Kellogg (who had become a member of the State Board of Health in 1878) bemoaned that there was almost no inspection of important food supplies even though food should be just as free from bacteria as the water supply, stating that "any farmer can kill any old thing in the dirtiest possible place, and make it up into sausages or hamburger steak and sell it for food."

The Public Health Code maintained the autonomy of existing local health departments while also creating the framework for a more robust, professionalized state-level public health department.

In 1917, the formation of health districts composed of townships and villages was authorized. A decade later in 1927, counties were granted the authority to establish local health departments to address the growing need for health services. Local health departments became important agents for protecting and enhancing public health in communities across Michigan. By 1961, 69 of Michigan's 83 counties were served by local health departments, and by 1966, all counties were served by full time health departments.[56]

At the same time, the state department of health continued to grow, and in 1949 it contained seven major divisions:

- Local Health Administration
- Laboratories
- Administrative Services
- Disease Control
- Records, and Statistics
- Engineering
- Industrial Health
- Tuberculosis and Venereal Disease Control

In 1964, the Department was designated as Michigan's air pollution control agency, and in 1965, the department was renamed the Department of Public Health and incorporated most of the functions of the former State Health Commissioner, Crippled Children Commission, Board of Alcoholism, and Veterans' Facility. During the same year, the department assumed authority to license solid waste disposal sites, initiated the Ground Water Quality Control Program, and conducted 24 hour/day air sampling to monitor radiation.[57]

Since 1978, public health in Michigan has been underpinned by the Public Health Code—Public Act 368 of 1978—that defines various roles and responsibilities in the public health system.[58] When it was adopted, the Public Health Code maintained the autonomy of existing local health departments while also creating the framework for a more robust, professionalized state-level public health department. The Department of Public Health included five agencies:[59]

- Public Health
- Food Safety
- Health Facilities Licensing
- Occupational Safety and Health Regulation
- Division of Water Supply

Other health-related functions were performed by the Department of Mental Health and the Department of Social Services (that housed the Medicaid program that had been enacted in 1966).

In 1996, as part of a major state government reorganization by executive orders, the Department of Public Health was broken apart and combined with other departments and agencies. The Department of Public Health, the Medical Services Administration (formerly in the Department of Social Services), and the Department of Mental Health were put together to form the Michigan Department of Community Health (DCH).[60] [61] DCH took responsibility for Medicaid, public

Public Health Advisory Commission

Recognizing emerging public health challenges, as well as the growing role of public health in securing the social, economic, and physical well-being of Michigan residents, Governor Rick Snyder established a Public Health Advisory Commission through Executive Order 2016-19.[i] The purpose of the Commission was to assess the public health delivery system by examining the organization of public health functions between various state departments, as well as the division of responsibilities between state and local health authorities. The Commission also considered the regulatory framework established by Michigan's Public Health Code.

While the Commission failed to reach consensus on an optimized public health delivery system for the state, it offered several consensus recommendations to improve public health. These recommendations included a review of funding for public health and increased consideration of public health impacts in all state policy making activities. The Commission also highlighted the importance of a permanent Public Health Advisory Council as a resource to the executive branch and other public health stakeholders, and as a forum to address emerging state and local public health threats and issues.[ii]

The 20-member Public Health Advisory Council, established through Executive Order 2017-10, is chaired by the state's Chief Medical Executive.[iii] The Council is made up of 19 other voting members who are specified representatives from various public health stakeholder groups appointed by the governor. The council is to include:

- an epidemiologist
- a toxicologist
- a food safety expert
- an environmental health expert
- a local public health official
- a local director of public works
- a representative of a non-profit health or environmental organization
- a representative from a school of public health
- a hospital administrator
- a physician
- a registered nurse
- a veterinarian
- and a representative of a nationally-accredited medical school.

The Council also includes non-voting positions for the directors of the five executive departments that have public health responsibilities:

- the Department of Agriculture and Rural Development
- the Department of Environmental Quality
- the Department of Health and Human Services
- the Department of Licensing and Regulatory Affairs, and
- the Department of State Police.

i Michigan Executive Order 2016-19, www.michigan.gov/documents/snyder/EO_2016-19_535206_7.pdf
ii Michigan Public Health Advisory Commission. (2017) Final Report. www.michigan.gov/documents/snyder/PHAC_Final_Report_556718_7.pdf
iii Michigan Executive Order 2017-10, www.michigan.gov/documents/snyder/EO_2017-10_606473_7.pdf

health, mental health, drug control policy, services for the aging, and crime victim services.

At the same time, many public health functions were spread out among other departments, continuing a historic trend of fragmenting public health across state (and local) governments. Departments taking on additional public health functions included the Department of Environmental Quality (absorbing the Division of Water Supply), Department of Agriculture (absorbing Food Safety functions), and the Department of Commerce (taking on Health Facilities Licensing and Occupational Safety and Health Regulation).[62]

This reorganization might be seen as an improvement in efficiency on the one hand (by consolidating food safety with other food-related functions in the Department of Agriculture or water safety with other environmental functions in the MDEQ). Alternatively, it might be argued that the diffusion of public health functions has marginalized public health, eliminating the central role public health plays in securing the health and well-being of all residents.

Through another executive order in 2015, the Department of Community Health was merged with the Department of Human Services to create the Michigan Department of Health and Human Services (MDHHS).[63] By merging the responsibility for social services and child/adult care facilities of the Department of Human Services with the various responsibilities of the Department of Community Health, this reorganization made MDHHS the largest of Michigan's executive departments.

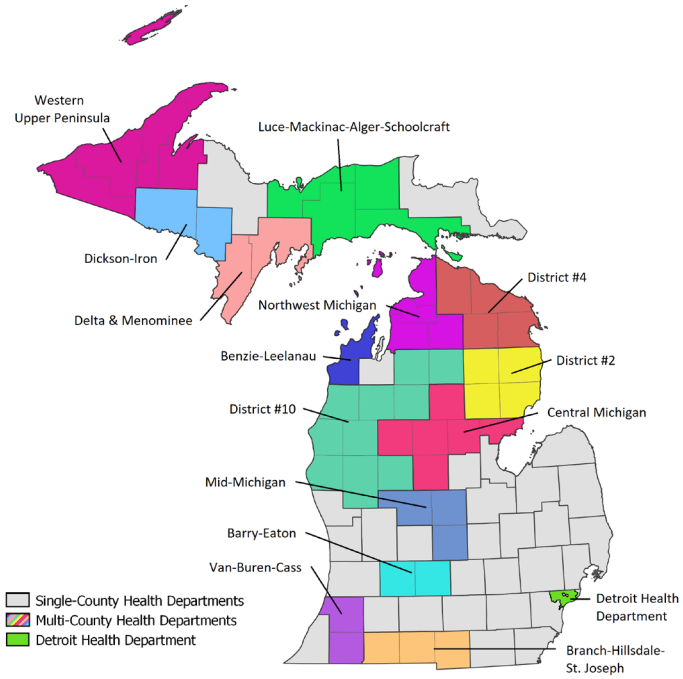
This latest reorganization might be seen as an efficient way to bring all of Michigan's health care and public assistance programs for low-income, disabled, or otherwise vulnerable individuals under the same administrative authority. The reorganization also highlights the substantial link between social and health services, possibly enabling the new department to better address the social determinants of health by bringing programs to address behavioral, psychosocial, and pathophysiological factors together within the same administrative structure. However, the reorganization buried public health within the largest state bureaucratic consolidation—a department with many disparate responsibilities—and may have served to further marginalize public health. It is unlikely that a public health agency whose functions have been stripped away and given to other departments, and whose funding and staffing are a small fraction of the department in which it is situated, can exercise optimal authority to protect and improve the public's health.

The fragmentation of public health at the state-level in Michigan is further complicated in the context of a system of autonomous local health departments. Section 24 of the Public Health Code outlines powers and responsibilities of local health departments, in many cases making local health departments the primary entities responsible for the organization, coordination, and delivery of public health services within their respective jurisdictions. Local health departments work in tandem with the Department of Health and Human Services, Department of Agriculture and Rural Development, and Department of Environmental Quality to provide essential public health services in all parts of the state.

Michigan's 83 counties are served by 45 local health departments, 30 of which serve a single county while 14 serve multiple counties (see **Map 1**). Detroit, as the state's largest city, operates its own department.

Map 1

Michigan's Local Health Departments



Public Health Investment in Michigan

The Difficulty of Assessing Public Health Funding

It is necessary to have a clear and consistent definition of what constitutes public health to determine how much funding is allocated to all combined public health programs and services. Because international, national, state, and local entities often package differing combinations of services within a general 'public health' basket, it is also exceptionally difficult to interpret given estimates and make comparisons between governmental jurisdictions and across levels of government.[64]

At the state level in Michigan (and many other jurisdictions), public health funding exists in multiple budget areas for the various departments and divisions that perform public health functions. As a result, there is no single "public health" budget area in Michigan. Numerous appropriation units across several departmental budgets must be analyzed to begin to quantify how Michigan funds its public health delivery system. Even then, because of the fragmented responsibility for public health, it is impossible to determine what proportion of some line items are expended for public health functions; control of zoonotic (animal-borne) diseases is important for the public's health, but performance of this function within a department of agriculture might also be implemented in ways that maximize service to industrialized animal-based agriculture. Revenue flowing into the state budget to support public health-related spending includes federal funds, state general fund revenue, local revenue captured by the state, fee-generated revenue, and private revenue. Local health department budgets likewise utilize federal, state, local, and private revenue sources.

Imprecise definition, inconsistent line items across years, and an overall fragmented delivery system each muddle attempts to assess funding for public health.

Imprecise definition, inconsistent line items across years and appropriation units, and an overall fragmented delivery system each muddle attempts to assess funding for public health. Combined, these factors make it a challenge to assemble a comprehensive picture of public investment. This complexity contributes to a lack of public transparency surrounding public health spending, and perhaps also a lack of clear focus for legislative bodies charged with prioritizing, overseeing, and monitoring state and local spending on public health (and other government functions). This lack of transparency can render oblique the lines of accountability, obscuring which department or division within the state has ultimate authority over and responsibility for a given service or government function.

Michigan's Public Health Expenditures

Many departments and agencies perform activities and services that fall under the general definition of public health. Given the central role performed by the Michigan Department of Health and Human Services (containing the Population Health Administration), this analysis turns its focus to disease prevention and population health funding within the MDHHS.

The MDHHS budget accounts for around 45 percent of the state's nearly $56 billion budget, drawing in substantial federal funding for various public assistance and health programs, such as Medicaid and the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC). Similarly, this budget equals around 43 percent of the $10 billion general fund/general purpose (GF/GP) budget (the budget for state dollars not already designated and reserved for a specific purpose). While MDHHS has the largest budget of any state department, public health appropriations within this budget account for less than one percent of the total state budget and less than one percent of the GF/GP budget.[65]

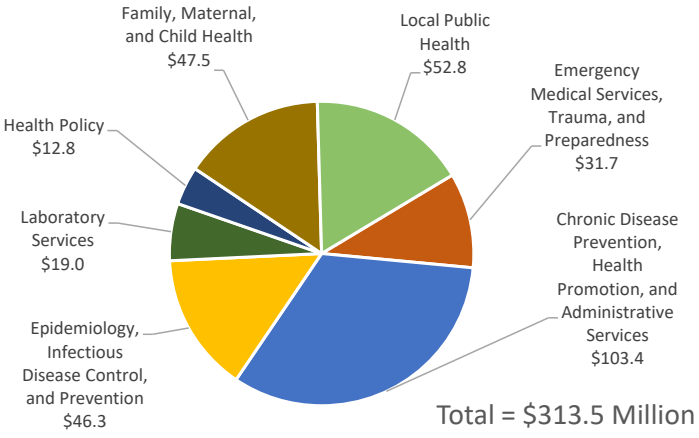
In the six MDHHS budget areas that might be considered primarily public health – Health Policy, Laboratory Services, Epidemiology/Disease Control and Prevention, Local Health, Family/Maternal/Child Health, and Emergency Medical Services/Bioterrorism Preparedness – FY2017 spending totaled around $314 million.[b] Of this amount, more than half ($177 million) came from federal sources while less than a quarter ($73

b This total excludes the federal Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

million) came from state GF/GP appropriations (mostly for Local Public Health), with the remaining funds coming from private revenue, fees, local revenue, and restricted funding sources (see **Chart 2**).

Chart 2

State Expenditures for Public Health, FY2017
(dollars in millions)



Source: Michigan State Budget Office

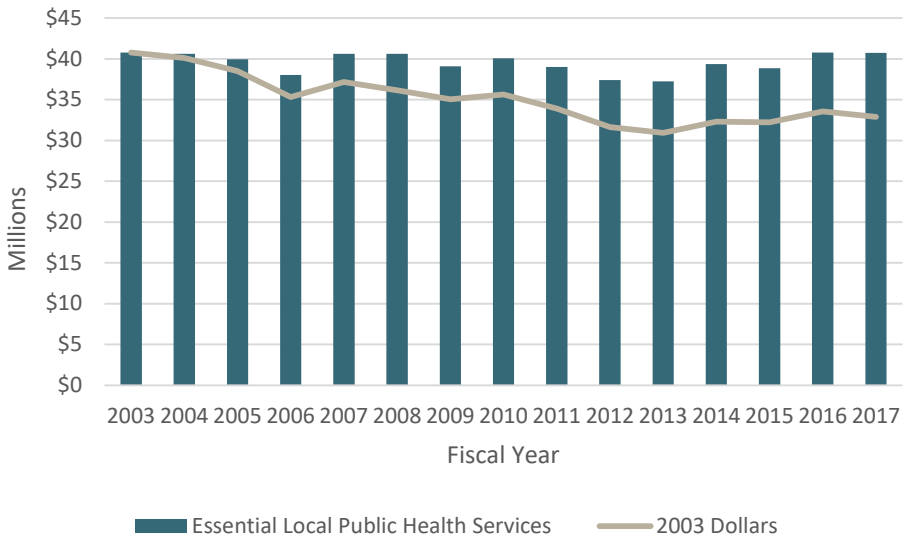
Within the funding for Local Public Health, about $41 million was designated for locally-administered Essential Public Health Services, approximately the same amount allocated in FY2003. While funding for this budget area has ebbed and flowed, it remained basically flat over the 15-year period (see **Chart 3**). After adjusting for inflation using the average Consumer Price Index (CPI) for each state fiscal year, the amount of funding has declined from $40.8 million in FY2003 to $32.9 million in FY2017. Holding 2003 dollars constant, this indicates an approximate 20 percent state-level disinvestment in funding for the Essential Public Health Services delivered by Local Health Departments.

This report does not examine the totality of funding for local health departments. Local health departments also receive funding from local units of government, fees, grants, and private sources that do not pass through the state budget. Section 2475 of the Public Health Code specifies that the state department will reimburse local entities for 50 percent of the costs for providing required and allowable health services.[66] State reimbursement is prohibited for direct capital expenditures for facilities, expenditures used to match other state funds, services specifically excluded by state rules, federal and state categorical health program funds, as well as any otherwise reimbursable required and allowable health services that are reimbursed from another source (e.g., fees or federal funding).

Total public health expenditures have also shown marginal growth in recent years (see **Chart 4**, see page 16). This growth is isolated in three areas, Infectious Disease Control (a 21.7 percent increase), Local Public Health (a 15.7 percent increase), and Family, Maternal, and Child Health (a 25.7 percent increase). Conversely, there has been little new investment in chronic disease prevention, preparedness for emergencies, state public health laboratory services, or statewide health policy initiatives and functions (e.g., health innovation grants or human trafficking intervention services). There has also been a more than 20 percent reduction in funding for vital records and health statistics since FY2008, even though health data are essential for public health research and evaluation.

Chart 3

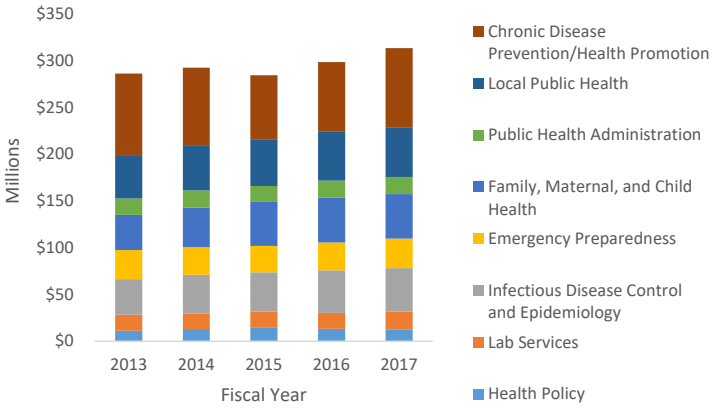
Essential Local Public Health Services Expenditures, FY2003 - FY2017



Source: Michigan State Budget Office

Chart 4

State Public Health Expenditures by Area, FY2013-2017



Source: Michigan State Budget Office

The small amount of growth seen in **Chart 4** recently, however, comes after 15 years of relatively flat total funding (see **Chart 5**). In fact, nominal FY2017 public health expenditures exceeded those in FY2004 by fewer than $10 million (representing just a three percent increase across the 13-year period). This slow rate of growth is inadequate to meet the increasing cost and demand for services. Adjusted for inflation using the average CPI for each state fiscal year, FY2017 expenditures are $20 million below expenditures in FY2003. During the 15-year period, public health expenditures have dropped by 16 percent from the inflation-adjusted high point of $300 million in FY2004.

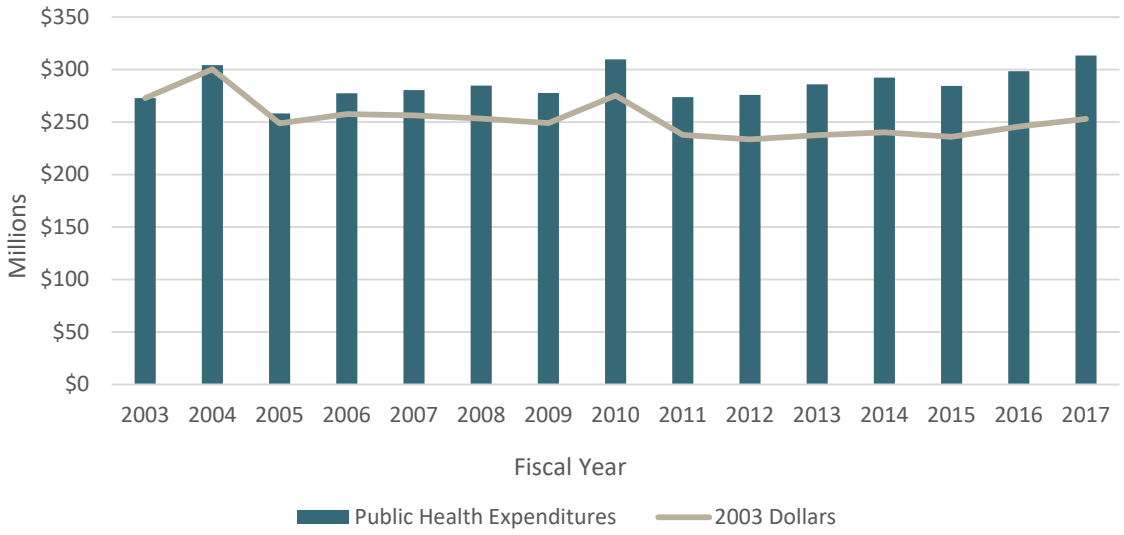
Public Health Investment in Michigan Compared to Other States

Because of differences in the types of services each state calls "public health" and differences in service delivery models, comparison between states is difficult and admittedly imprecise. To make comparisons across state lines, Trust for America's Health has used a broad definition of "public health" to include all state health funding (with the exception of health insurance coverage programs for low income residents like Medicaid and CHIP). Additionally, the criteria exclude federal funds from state totals, and eliminate predominately federally funded programs like WIC.[67] The remaining result offers a measure of state investment in population health absent federal support and programs.

Using these criteria, Michigan ranked 37th in state public health funding per capita during FY2012 ($17.41 per capita). In each subsequent fiscal year, Michigan has remained among the states investing the least amount in public health and one of the states drawing the fewest per-capita federal dollars to support public health funding.[68] Trust for America's Health found that Michigan's FY2017 state public health investment totaled $128.3 million (just $12.92 per capita).[69] **Chart**

Chart 5

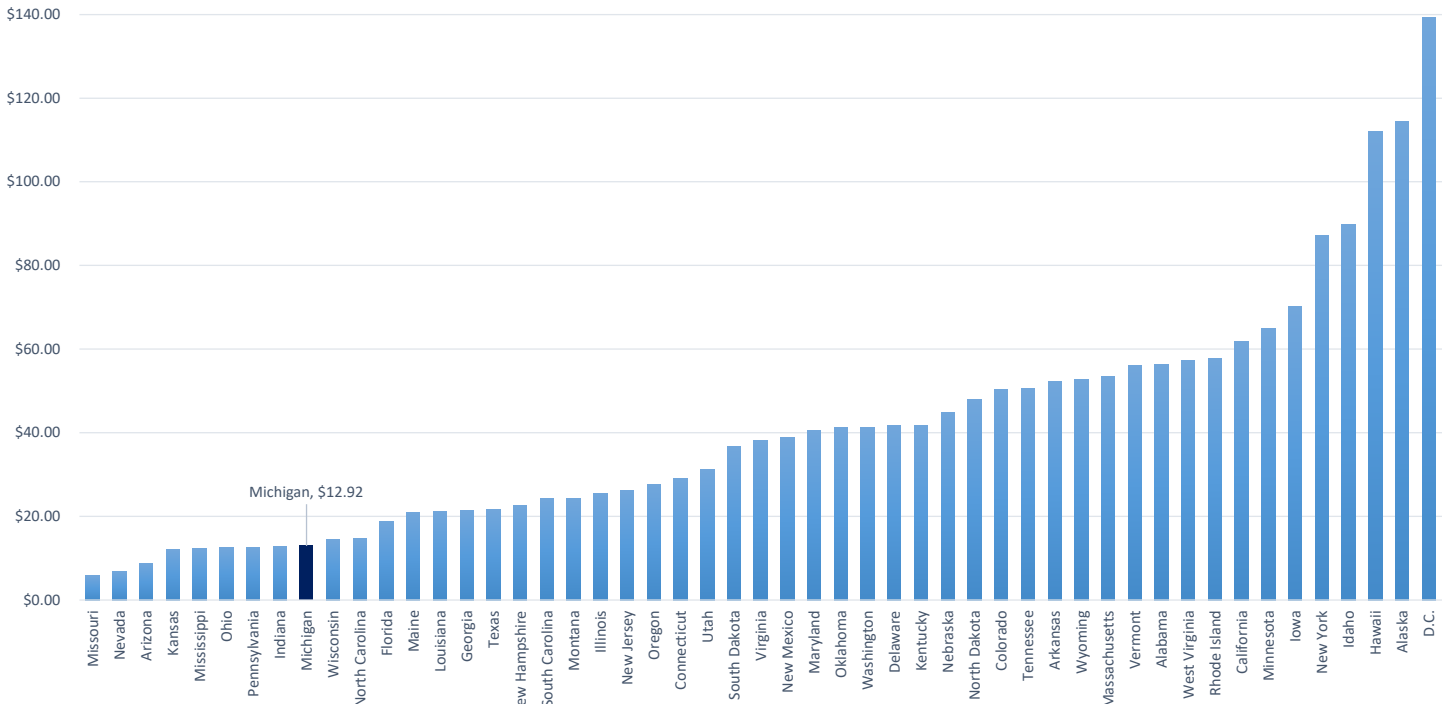
Total Public Health Expenditures, FY2003-2017



Source: Michigan State Budget Office

Chart 6

Per-Capita State Funding for Public Health, FY2017



Data Source: Trust for America's Health

6 displays per-capita funding for all 50 states plus Washington, D.C.

Reliance on Federal Funding for Public Health

A study published in the American Journal of Public Health determined that national public health expenditures fell by 17 percent between 2002 and 2014.[70] Moreover, federal funding for the Centers for Disease Control and Prevention (CDC) declined by 10 percent from FY2005 to FY2016 before adjusting for inflation (from a high point of $7.07 billion down to $6.34 billion).[71] Around 75 percent of CDC funds are distributed to state and local governments for the prevention of illness and harm, such as from infectious disease, substance use, and obesity.[72]

Michigan's FY2016 state funding per capita from the CDC was $18.80. Compared to a national average of $21.31 per capita, Michigan ranked 43rd in state CDC funding.[73] Despite this low ranking, Michigan is highly reliant on federal public health funding from the CDC and other sources (given the low level of state investment highlighted in the previous section). This reliance on federal funding affects Michigan in two key ways.

First, because about one-half of Michigan's public health funds during FY2017 came from federal sources (whereas only a quarter came from the state's general fund), the state is highly sensitive to changes in federal funding. A period of reduced federal funding for public health has coincided with stagnant state public health budgets. Any additional decreases in federal funding will have substantial consequences for public health service delivery in Michigan.

Second, the combined low levels of funding from both federal and state sources have left Michigan in a state of public health subsistence. Michigan has managed to do what is necessary to generally protect the public's health, but this minimal funding leaves the state potentially unprepared for future crises. Moreover, without additional funding, the state will be far less able to address mounting public health concerns in Michigan.

Public Health Funding in Other Departments

While many public health functions remain the responsibility of the state health department (MDHHS), other state departments play important roles in regulating and delivering public health services.

Michigan Department of Agriculture and Rural Development

Funding for the Michigan Department of Agriculture and Rural Development (MDARD) supports numerous crucial public health functions. The Department protects the public from food-borne illness, as well as fraud, deception, and adulteration in the sale of food products. The Department also inspects sites involved in the production, processing, distribution, and sale of food, and oversees local public health restaurant and food safety inspections (under the Public Health Code). Additionally, the department is charged with animal disease surveillance and testing, the regulation and management of pesticides, and environmental stewardship activities.[74]

To assess what proportion of the appropriations in the MDARD budget might be considered designated for "public health," the Citizens Research Council first examined total appropriations to the department by appropriations unit. The Fairs and Exhibitions and the Agriculture Development appropriations units were then excluded. While all remaining appropriations units represent important public health functions, it is difficult to parse further (even at the line item level) the proportion of funding that might be considered public health versus those dollars used primarily in support of Agricultural Industries. Because MDARD's funding is holistically integral to public health, these remaining areas are included with the understanding that this might partially overstate the actual amount of funding Michigan is investing in public health.

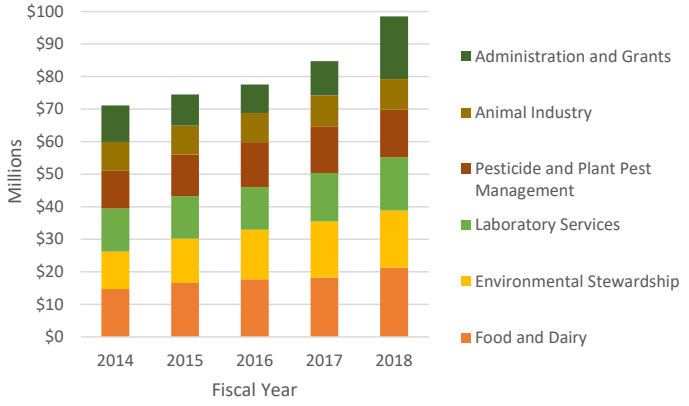
Appropriations for MDARD's units and divisions performing public health activities have increased steadily over the last five years (see **Chart 7**). The majority (58 percent) of the FY2018 MDARD budget came from general fund appropriations; just 10 percent of the budget came from federal funding.[75]

Michigan Department of Environmental Quality

The Department of Environmental Quality has been responsible for regulatory programs since the department was created in 1995; today, that includes

Chart 7

Appropriations for Public Health Functions in the Michigan Department of Agriculture and Rural Development, FY2014-2018



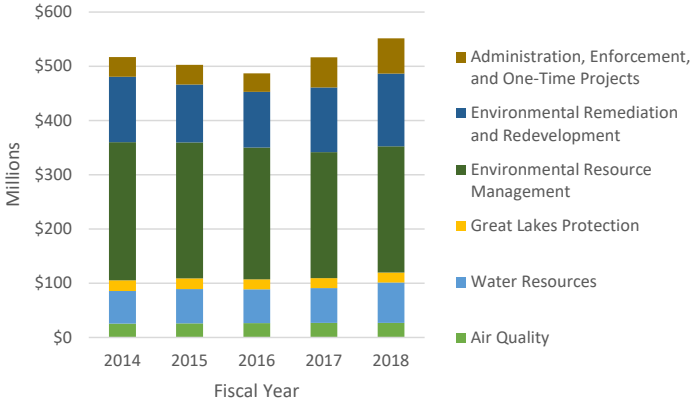
Source: House Fiscal Agency

management of air quality, water quality, underground storage tank, and waste, as well as pollution prevention, environmental investigations/cleanups, and Great Lakes stewardship.[76] Because of the central role of the environment in determining both length and quality of life, the entirety of funding for the DEQ is considered central to public health.

An overview of this funding may be observed in **Chart 8**, including the five most recent years' appropriations. More than half of the DEQ budget is comprised of state restricted revenue (coming from 53 different funds); almost one third of the budget is made up of federal fund-

Chart 8

Appropriations for the Michigan Department of Environmental Quality, FY2014-2018



Source: House Fiscal Agency

ing, and just 11 percent comes from the state general fund.[77] A bump in one-time funding may be observed beginning in FY2017; this is largely due to the Flint water emergency. The FY2017 budget includes $7.2 million for Flint, as well as other one-time appropriations for drinking water safety and waterway cleanup.

Other Departments

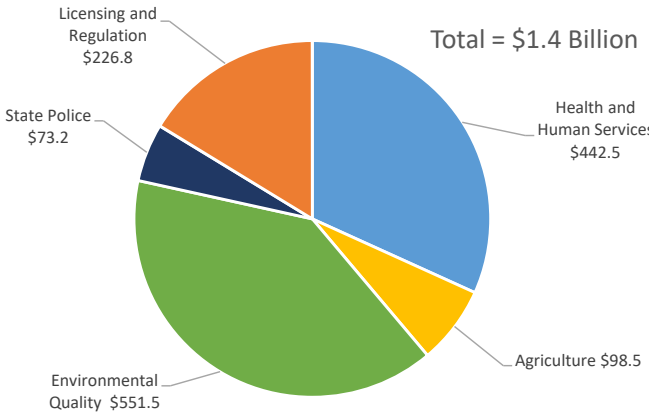
Other state departments also have public health responsibilities, most notably the Department of Licensing and Regulatory Affairs (LARA) and the State Police. LARA has responsibility for health professional and facility licensure, regulation of environmental health threats, and the Michigan Occupational Safety and Health Administration. State Police perform a critical role in hazardous material and disaster response, as well emergency management and planning. State Police functions geared towards preventing injury and harm (such as highway safety planning and sexual assault prevention) might also be considered public health.

Public Health Funding Across State Agencies

Assembling line item appropriations across departments helps to provide a more complete picture of public health funding flowing through the state budget in Michigan (see **Chart 9**). To accomplish this view, we combined public health-related line item appropriations found within budgets for a number of state departments. Taken together, these funds represent a total state investment of nearly $1.4 billion. This suggests that just 2.5 percent of Michigan's $55.8 billion state budget is dedicated to protecting the health and well-being of Michigan residents through safe foods, roads, workplaces, natural environments, promotion of wellness and prevention of diseases, and assurance of well-trained, high-quality health professionals and facilities.

Chart 9

Public Health Appropriations in Michigan, FY2018
(dollars in millions)



Source: CRC Analysis of State Line Item Appropriations

Social/Political Investment in Promoting Public Health

Protecting (and improving) the health of the public requires collaboration across governments and sectors. The effectiveness of such collaboration is predicated upon belief in the value of public health. Michigan will be unable to improve public health unless leaders in government (and in the private sector) make public health a priority. Those leaders, in turn, may not make public health a priority until members of the public demand it.

Protecting (and improving) the health of the public requires collaboration across governments and sectors.

One way to accomplish this broad integration of public health across various sectors is through a "Health in All Policies" approach to policymaking. Health in All Policies—a collaborative approach to public health advanced by the American Public Health Association and the Public Health Institute—provides guidance for reducing health disparities and inequities and addressing the diverse and complex factors that affect health of individuals and communities, such as educational attainment, employment, housing, transportation, and public safety.[78] By integrating a public health perspective into the formulation and implementation of other policy areas, policymakers can mitigate harm from unintended consequences of policy decisions and can work to maximize individual and community well-being.

Health in All Policies can only be realized by forging strategic partnerships across the public (and private) sector, and by increasing public understanding of the importance of public health. The Public Health 3.0 model proposes that public health leaders should embrace the role of a "Chief Health Strategist" to bring together relevant partners and collaborators and work to explicitly address "upstream" factors that determine health.

This model also suggests enhancing the accreditation process in public health and incorporating the training necessary for a future public health workforce that can build robust, well-structured partnerships.

While Michigan has a comprehensive public health code, a well-trained public health workforce, and nationally accredited university programs to train the next generation of public health professionals, it will be impossible to improve the future health of the public absent the public's support, consent, and buy-in. Public health 3.0 is hardly a panacea for all Michigan's problems, but the shift to a network-based, strategic public health delivery model to address the key factors that lead to poor health across the state could have a large and positive impact.

This paradigmatic shift in public health cannot be accomplished without improved state funding for public health, public health reorganization that empowers strong public health leadership at the state level (and in local communities), and greater understanding and support from the general public.

Public Health 3.0

Public Health 3.0 is a call to action from the U.S. Department of Health and Human Services.[i] The terms Public Health 1.0, 2.0, and 3.0 were created as ways to characterize the ongoing evolution of public health. These terms of art, coined by former U.S. Assistant Secretary for Health Dr. Karen DeSalvo, highlight three very different historically-situated conceptualizations of public health.

Public Health 1.0 began in the late 19th century. This was the period when public health became an essential function of government. Public health pursued systematic sanitation, improved food and water safety, expanded understanding of disease, developed disease prevention tools (like vaccines), and expanded epidemiology and laboratory science capabilities.[ii] With the benefit of scientific progress—from germ theory to public administration and scientific management—entire populations began to enjoy public health protection.

Public Health 2.0 began in the late 20th century, a period during which public health departments became increasingly professionalized. The Institute of Medicine's seminal 1988 report The Future of Public Health that established the three core functions of public health was also highly influential in shaping Public Health 2.0. The report asserted that "the nation has lost sight of its public health goals and has allowed the system of public health to fall into 'disarray'," and that public health was not prepared to address new epidemics like HIV/AIDS or the rising burden of chronic diseases.[iii] Public Health 2.0, therefore, was characterized by the move to define core public health functions, essential public health services, and performance standards for public health agencies at every level.[iv]

Public Health 3.0 proposes a newly broadened and enhanced public health practice characterized by cross-sectoral collaboration and a "Chief Health Strategist" role. It aims to overcome health inequities and disparities. Public Health 3.0 challenges public and private leaders to incorporate a "health in all policies" approach to leadership and governance across the public and private sectors.

This call to action recommends a remodeled approach to public health by expanding community partnerships, enhancing and repurposing funding, clarifying metrics to measure public health successes, enhancing public health accreditation, and creating a strategic approach to public health from the community level up.[v]

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The Ongoing Need for Public Health

Public health keeps communities safe from diseases, disasters, and unsafe environments. Strong public health investment (financially, culturally, and politically) also enables people to live healthier, more productive lives. Not surprisingly, there is also a corresponding cost to disinvestment in public health and dismissal of its core principals.

Health Indicators in Michigan

Communities throughout Michigan face serious, ongoing health challenges. While the U.S. tends to rank poorly compared to other peer nations in many measures of health, Michigan often fares even worse than the rest of the country. Measuring various indicators of population health can paint a clearer picture of the health status and needs of Michigan's population.

In 2016, Michigan had the 8th highest rate of deaths due to heart disease and the 15th highest rate of cancer deaths in the U.S. Michigan also exceeded the national average that year for the rates of death from chronic lower respiratory disease, accidental deaths, Alzheimer's disease, diabetes, kidney disease, and influenza/pneumonia.[79] The state likewise exceeded national averages for total firearm deaths, drug overdoses, and homicides.

> While the U.S. tends to rank poorly compared to peer nations in many measures of health, Michigan often fares even worse than the rest of the country.

Obesity is a condition associated with numerous chronic diseases that impair individual and community health, increase health care spending, and play a factor in many of the leading causes of preventable death.[80] In 2016, 32.5 percent of Michigan adults were obese; only nine states had higher proportions of obesity.[81] Obesity is strongly associated with social factors (like poverty, social norms, and the availability of healthy food). Obesity is also strongly associated with depression, another growing public health concern.[82] The relationship between these conditions is reciprocal, whereby each increases the likelihood of developing the other.

Tobacco use—the leading cause of preventable disease and death in the U.S.—continues to be a problem in Michigan. As of 2017, 20.4 percent of adults in Michigan smoke tobacco[c], a proportion in excess of the national average of 17.4 percent that gives Michigan a rank of 40th nationally.[83] Like obesity, tobacco use is related to various social factors.

When tobacco use is stratified by level of educational attainment, one finds that 41.1 percent of adults in Michigan who did not finish high school smoked tobacco, compared with 26.9 percent of adults who completed high school and 14.4 percent of adults with education beyond high school.[84] The proportion of tobacco use among individuals with a bachelor's degree or higher is further reduced to 7.5 percent. Tobacco use also varies when stratified by race, with the American Indian/Alaskan Native population in Michigan experiencing the greatest proportion of tobacco use (42.4 percent) and the Asian population the least (11.3 percent). As one might expect, low-income communities have a much greater prevalence of tobacco use when compared with higher income communities.

Infant mortality[d] is a common proxy (along with life expectancy at birth) that is used to assess the health of a population. The U.S. infant mortality rate is higher than average among Organisation for Economic Co-operation and Development (OECD) nations.[85] Yet again, Michigan fares still worse than the national average on this metric. In 2013, only eight states had a higher rate of infant mortality than Michigan (7.05 deaths per 1,000 live births).[86] By 2016, Michigan's infant mortality rate improved slightly to 6.4 deaths per 1,000 live births (730 deaths total); however, so did the U.S. rate of 5.9 deaths per 1,000 live births.[87] Michigan also exceeded national averages for the proportion of preterm births[e] (10.1 percent vs 9.9 percent), low birthweight[f] births (8.5 percent vs 8.2 percent), and the proportion of births to unmarried mothers (41.0 percent vs 39.8 percent).[88]

c Percentage of adults who report smoking some days or every day and who have smoked more than 100 cigarettes in their lifetime.

d The infant mortality rate is defined as the number of deaths of children aged less than one in a given year per 1000 live births

e Babies born prior to 37 weeks of pregnancy (gestation)

f Babies born weighing less than 2,500 grams or 5 lbs. 8oz

There is considerable variation of infant mortality across jurisdictions within the state. While Michigan's 2016 infant mortality rate was 6.4 deaths per 1,000 live births, the rate in Detroit was 12.7 (2012-2016 average: 13.7).[89] The average infant mortality rates in rural counties[g] such as Arenac (2012-2016 average: 11.2), Kalkaska (2012-2016 average: 12.5), and Presque Isle (2012-2016 average: 14.7) are all comparable to the rate in Detroit.[90] These glaring health disparities reinforce the importance of policies addressing health equity so that residents in small rural communities and in major cities all have the same opportunities to live a healthy life.

To further illustrate how morbidity and mortality can differ across populations, **Table 1** shows age-adjusted mortality rates in Detroit, Michigan, and the U.S. for the ten leading causes of death for Michigan residents in 2016.

Table 1

Age-Adjusted Mortality Rates* for the Ten Leading Causes of Death in Michigan, 2016

*Rates are per 100,000 persons

	U.S.	Michigan	Detroit
Heart Disease	165.5	200.8	322.9
Cancer	155.8	167.1	192.7
Chronic Lower Respiratory Diseases	40.6	44.7	33.9
Unintentional Injuries	47.4	50.8	71.9
Stroke	37.3	39.1	47.4
Alzheimer's Disease	30.3	33.8	20.1
Diabetes Mellitus	21	21.5	27.6
Kidney Disease	13.1	14.5	23.5
Pneumonia/Influenza	13.5	13.7	21
Intentional Self-harm	13.5	13.4	8.9
All Causes of Death	728.8	787.8	1,027.4

Source: Detroit Health Department

Some might assume that these differences in health outcomes throughout the state might be explained by differences in access to health care. Access to health care is an important determinant of health, and it is true that people of lower socioeconomic status tend to have less access to quality health care. Previous Citizens Research Council research has highlighted that many rural communities and urban core communities consistently have shortages of primary care health providers, restricting access to health care services when they are needed in these communities.[91] Yet, Michigan tends to rank better than the average among states with regard to healthcare access, cost, and the proportion of the population with health insurance. Many of Michigan's hospitals also rank among the best in the U.S. Why, then, aren't people in Michigan also healthier on average?

g Small sample sizes in rural counties lessen statistical power, leading to wider confidence intervals for rate estimates.

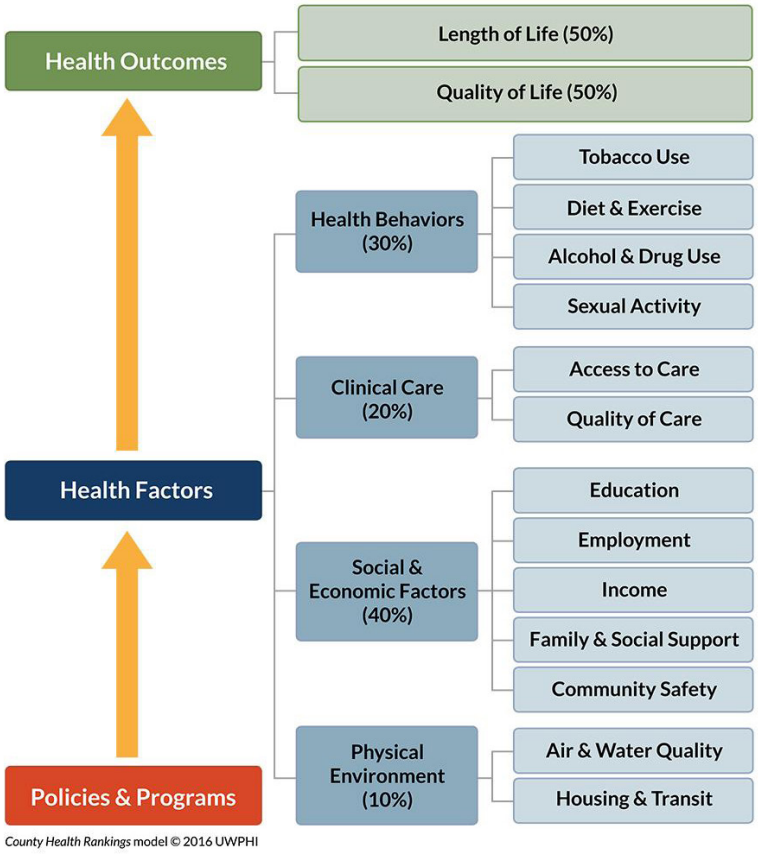
Among the changeable factors that affect health outcomes, medical care accounts for only 10-20 percent, while social determinants account for the other 80-90 percent (see the population health model in **Figure 2**).[92]

To understand Michigan's poor health outcomes, we must consider two things:

1. It is the social determinants of health—not differences in medical care—that account for the greatest proportion of disparities in the health of different communities. Michigan's economic struggles in the 21st century, below average educational achievement and degree attainment, and a litany of other social factors have contributed to poorer health outcomes
2. Lack of investment in public health has contributed to a variety of harmful exposures (from accumulated environmental toxins to increased viral load to chronic stress) that both cause immediate damage and erode health over time, worsening the health of Michigan citizens. This lack of investment has also left state and local health officials less equipped to intervene in ways that promote better health and to address the underlying societal factors that contribute to poor health and increase health inequities between communities.

Figure 2

Model of Population Health Emphasizing Modifiable Health Determinants



Source: University of Wisconsin Population Health Institute. County Health Rankings & Roadmaps 2018. www.countyhealthrankings.org

Infrastructure and Public Health

Just as natural and social environments affect the health of individuals and communities, so does the built environment. Infrastructure has a very strong effect on the health and well-being of the public; however, Michigan has fallen into an historic trend of remaining at the bottom nationally with regard to infrastructure investments in everything from water systems to highways and bridges.[i]

Poor drinking water infrastructure has led to very serious public health threats. Michigan faces $13.8 billion in drinking water infrastructure needs over the next two decades, as well as an additional $2.1 billion for wastewater infrastructure.[ii] The state's antiquated infrastructure inhibits cost-effective delivery, threatening both access and safety. Potable water, functional wastewater treatment systems, and drain infrastructure are important not only to human health, but to economic and industrial development as well as environmental conservation.

Vehicle and transportation safety is also an important public health concern, and the policy-driven reduction in traffic fatalities during the twentieth century was an important public health achievement. Road and bridge infrastructure is failing, and this is perhaps the most visible symbol of Michigan's infrastructure needs; more than one-fifth of the state's roads are categorized as in "poor condition" and 11 percent of bridges are structurally deficient. There is an estimated $540/year excess cost to Michigan motorists for driving on roads in states of disrepair.[iii]

Multimodal public transportation also enhances public health in a variety of ways, by reducing traffic fatalities, limiting emissions/pollution, encouraging physical activity and improving walkability, enhancing access to healthcare services and healthy foods, and reducing financial stress on lower-income households.[iv] [v] Yet, Southeast Michigan is the largest region in the U.S. without a comprehensive, regional public transportation system.

The internet plays a growing role in connecting individuals to, among other things, jobs, social support, health information, and mobile health technologies. For this reason, some have suggested that broadband access should be considered a social determinant of health.[vi] Rural areas and lower-income urban neighborhoods that tend to experience the worst health outcomes also tend to be areas lacking adequate broadband access.

Replacement of aging water infrastructure, prompt investment to clean up contamination sites, and incorporation and strict adherence to science-based environmental and drinking water standards will help Michigan promote and protect the health of the public. Energy waste reduction and pursuit of clean energy that minimizes negative environmental impacts is also an important ongoing consideration to safeguard the public's health. Safer roadways, modernized transportation infrastructure, and robust public transportation systems all likewise would improve health and safety. The Governor's 21st Century Infrastructure Commission identified "a healthy environment" as a key outcome the state should pursue, stating:

> "The state's infrastructure system is interconnected with the health of our people, environment, and communities. Investments in communications, energy, transportation, and water networks and technologies support a Pure Michigan that, in many ways, defines the character of our state."[vii]

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Conclusion

Public health is an important set of critical functions performed by state and local health departments, as well as national health agencies and partners inside and outside of government. These critical functions include preventing epidemics, containing environmental hazards, ensuring that food and water are safe, and promoting health and wellness. Despite the importance of public health, many are unaware of the role of public health and how it differs from medical care or social services.

Because of this lack of awareness, public health is rarely at the forefront of public policy discussions. These discussions tend to focus on infrastructure, schools, economic development, and medical care—the things on which governments spend the most money. Nonetheless, public health affects student achievement in schools, as well as the success of talent attraction and workforce development efforts. It also impacts outcomes and spending in the health care sector. Public health is interrelated with state and local infrastructure and is at the core of government's responsibility to provide for the public good.

The Governor's Public Health Advisory Commission identified a need for a comprehensive review of all state public health funding; the Citizens Research Council shares this assessment. Michigan would benefit from consistent, transparent, and flexible pathways to better invest in public health. Moreover, current funding levels are inadequate to respond to future crises or undertake the work necessary to address poor health across the state. Michigan cannot continue this subsistence approach to public health.

Michigan also has a fragmented public health delivery system that demands improvement. Further study is needed to determine the best way to maximize service efficiency and equity without sacrificing effectiveness of the services provided. On the surface, it appears that numerous unutilized opportunities for collaboration exist within government and with private and non-profit partners.

Each of Michigan's departments, agencies, and local governments should prioritize safeguarding the public health and adopt a "Health in All Policies" philosophy and approach to governance. Policy decisions in areas as disparate as road construction, education, city planning, and policing all impact the health of the public, and public health assessments and impact statements should accompany all state and local policymaking. On the one hand, programs or policies that create health risks should be reevaluated and risks should be minimized or eliminated. On the other hand, policies across government (e.g., education, agriculture, and arts grants) should be strategically leveraged to promote and improve health. Education programs might incorporate mechanisms for coping with stress, a greater focus on health literacy, or an expanded role for school-based nurses and social workers. Policies that support local agriculture might also promote better nutrition. Arts programs supported with state grants might work to facilitate social and cultural capital in communities. Strategic policymaking can maximize public benefit and enhance the value of each public dollar that is spent.

Michigan pays a price for not prioritizing and funding public health. That price is evident in Flint and other communities that experience health threats from their water, food, and environment. The insidious nature of this price is revealed in Northern Michigan's "disability belt" and in the communities struggling with opioid addiction. The unfair character of this price is paid especially by low-income communities and communities of color where people live much shorter, sicker lives and watch infants perish at more than twice the rate of other communities. Michigan cannot afford to continue to spend massive amounts on health insurance policies and costly medical interventions while failing to invest in population-level health promotion and disease prevention, or, more generally, in social well-being.[93] Moreover, Michigan cannot afford to be seen as a state that fails to protect the safety and well-being of its people.

Health inequities and health disparities experienced throughout Michigan are not inevitabilities, but rather may be addressed through various public health activities. The Michigan Department of Health and Human Services has declared that higher than average proportions of tobacco use, obesity, heart disease, stroke, vaccine preventable illnesses, and poor neonatal health are

all winnable battles.[94] Winning these battles, however, requires adequate funding. Winning will also require strategic partnerships and collaborations with a variety of public, private, non-governmental, and community-based organizations. Moreover, many differences in health that exist across the state are because of social factors over which people have little control; this leads to unfair health outcomes. Michigan will not be able to improve the well-being of its citizens without paying greater attention to the social determinants of health.

Health underpins every individual's ability to pursue their own happiness and to make productive contributions to their community. Michigan faces numerous health challenges and large numbers of people continue to experience notable health disparities. Greater attention to public health is needed to remove physical and social barriers to healthy, productive lives, and to safeguard the health and well-being of all citizens on this pair of pleasant peninsulas.

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Medical Director's Report to the Board of Health
H. Lauren Vogel, D.O., M.P.H.
April 2019 – Respiratory Protection

The use of a respirator (mask) can be protective for both a patient with potential exposure during a surgical procedure and for the protection of an individual with potential exposure to infectious or noxious agents. The selection of the appropriate respirator for the condition requiring protection and correct use of the respirator is important.

According to OSHA, over 5 millions workers are required to wear respiratory protection in some 1.3 million workplaces throughout the US.[1] Respirators are used to protect against dust, infectious agents, toxic vapors, smoke and reduced oxygen environments. Respirators work by removing contaminants from the air or can be used to provide clean air and oxygen for use in toxic environments. Selection of the appropriate respirator for the risk condition assures optimum protection.

For healthcare workers, OSHA requires that the employer provide, maintain and store appropriate respirators for all employees at risk. Initial and annual fit testing is required to assure that respirators function appropriately and that employees know how and when to use respiratory protection. [2] Use of respirators prevent disease and this is an important public health concept.

In the medical field, respirators are most often selected to reduce risk of exposure to infectious agents. Surgical masks and the N95 respirator are the most commonly used devices. The surgical mask is used for particulate protection and barrier protection against large respiratory particles. These devices do not effectively filter out small particles and do not prevent leakage around the edge of the mask during inhalation. [3] In the surgical suite, the mask provides effective protection against exhalation contamination and helps maintain the sterile environment. Used by patients with respiratory infection, these masks can reduce spread of large particulate matter by reducing exhalation contamination but are not effective in preventing individual exposure to infectious agents through inhalation.

The N95 respirator must be fitted to the individual and is designed to protect against inhalation of small particulate particles (95 percent effective). The unit must be exchanged when dirty, contaminated or after 8 hours of continuous use. The same N95 respirator should not be used in the care of multiple patients. This respirator comes in different styles and in different sizes. Fit testing must be completed by trained personnel to assure appropriate fit of the mask. Training the employee on the mask's use is an essential part of the fit testing. Fitting and testing of the N95 is an annual requirement.

Credentialed healthcare facilities are aware of the need for appropriate respiratory protection and provide respiratory protection and person training. However, many physician's offices and community episodic healthcare facilities with exposure risk to infectious agents do not offer respiratory protection as required by OSHA. The lack of necessary training and employee protection is a public health issue.

A program to inform and educate non compliant facilities is probably necessary. A program developed by the health department and offered to those in need of fit testing and access to the N95 masks would be a community benefit. Development of education programs for the public focusing on the importance of using masks in public places when sick could be another public health initiative.

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April 2019 – Respiratory Protection

H. Lauren Vogel, D.O., M.P.H.

BRANCH-HILLSDALE-ST. JOSEPH COMMUNITY HEALTH AGENCY | YOUR LOCAL HEALTH DEPARTMENT

Important Facts

- Over 5 millions workers are required to wear respiratory protection in US workplaces.[1]
- Respirators protect against dust, infectious agents, toxic vapors, smoke and reduced oxygen environments.
- Respirators remove contaminants from the air and/or provide clean air and oxygen for use in toxic environments.
- Appropriate use of respirators prevent disease

OSHA requires that the employer must:

- Provide, maintain and store appropriate respirators for all employees at risk.
- Provide initial and annual fit testing is required to assure that respirators function appropriately and that employees know how and when to use respiratory protection. [2]

Respirator Facts

- In healthcare, respirators are most often selected to reduce risk of exposure to infectious agents.
- Surgical masks and the N95 respirator are the most commonly used devices.
- The surgical mask offers exhalation protection for the environment.
- A surgical mark does not effectively prevent leakage around the edge of the mask during inhalation. [3]
- Used in a clean environment, a surgical mask can protect patient exposure from respiratory particulate matter from the surgical staff.
- Used by patients with respiratory infection, masks can reduce spread of large particulate matter but are not effective in preventing individual exposure to infectious agents.

Community Issues

- Physician's offices and community episodic healthcare facilities do not offer respiratory protection as required by OSHA.
- Public awareness of the benefit of using a mask when sick is lacking.

References

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Accident Fund	Workers Comp Quarterly Payment	2,843.00
ACD.Net	Telephones 3 offices	2,657.44
Action Quick Print Plus	Printing - AAA	68.00
Aetistry Technologies	Web Hosting 1 Yr.	600.00
AFLAC	Payroll Deduction	1,469.86
Alerus Financial (Retirement)	Payroll Deduction	590.00
Arcadia Health Services	Care Management	541.28
Armstrong Health Care	WIC / AAA Contractual Consultant	3,176.72
Blue Cross Blue Shield	Health Insurance	52,840.18
Branch Area Transit Authority	Elderly Transportation Service	2,576.64
Branch County Commission COA	Home & Community Based Services	7,298.08
Branch County Complex	Rent - Coldwater Office	5,694.28
CAA of South Central	Home & Community Based Services	19,936.79
Care-N-Assist	Care Management	725.92
CDW Government Inc.	Computer Supplies	1,318.44
Center For Information Mgmt..	Hardware/Software Maintenance AAA	450.00
Century Bank Basic Flex Health Plan	Payroll Deduction	1,658.48
Century Bank EFPTS	Federal & Fica Taxes	41,071.99
Century Bank Master Card	CSHCS Client - 2	212.34
Century Bank Mers	Forfeiture/Underfunded Pmt. **2 Months**	4,978.05
Century Bank Mers	MERS DB /Retirement 2 Months	59,124.66
Century Bank State	Michigan Tax	6,877.91
Charter Communications	Sturgis Internet & Phone Line 2 Months	229.94
Cintas	Rugs & Lab Coats - Cleaning	111.65
City of Coldwater	Water Lab Test	160.00
City Of Three Rivers	Water / Sewage & Lab Testing	246.64
Clia Laboratory Program	Certificate Fee	180.00
Coldwater Petty Cash	Petty Cash	22.91
Companion Life Insurance Co.	Life Insurance Premiums 2 Months	2,041.64
Connect America	Care Management	70.50
Control Solutions, Inc.	Data Loggers Supplies	475.78
Crossroads Health & Home Services	Care Management	1,390.04
Current Office Solutions	Office Supplies/Copier Charges -12 Invoices	2,865.20
David Wagoner	Reimbursement - Labels	15.36
Deanna Himebaugh	Reimbursement - Amazon, car seat covers, Bottles & Sleeves	113.03
Dr. Vogel	Medical Director - Contractual	4,495.23
Embrace Your Health	Care Management	398.00

FedEx	Bat Head Mailing	18.71
Frontier	Sensaphone & Fax Line Service 2 months	591.54
GDI	Building Cleaning Expense - HD 2 months	5,298.00
GDI	Building Cleaning Expense - TR 2 months	3,498.00
GDI	Building Supplies Expense - HD 2 months	248.45
GDI	Building Supplies Expense - TR	154.99
GlaxoSmithKline	Medical Supplies 6 **Invoices**	10,852.00
Hillsdale Board Of Utilities	Building Expense - HD 2 months	4,435.64
Hillsdale County Treasurer	Building Labor Expense - HD	416.06
Hillsdale County Treasurer	Building Refuse Expense - HD	150.00
Hillsdale County Treasurer	Building Snow/Mow Expense - HD	580.00
Hillsdale County Treasurer	Building Supplies Expense - HD	168.03
Hillsdale County Treasurer	Building Supplies Expense - HD - Gas 2 months	190.21
Hillsdale Public Health	Rent - Hillsdale Office	7,375.00
Home Care Wellness	Care Management	328.00
Hospital Network Health	Medical Waste Removal	55.00
Indiana Michigan Power	Building Expense - TR	1,241.92
James Cook	Training - Homeland Security	350.00
Jean Howatt	Contractual Hep A	1,146.54
Kensington Hotel	Training - Mapes	252.00
Lab Corp	Lab Fees	60.00
Legal Service Of South Central Mi.	Older Adult Legal Assistance	660.00
Macks Fire Protection	Fire Extinguisher Inspection Three Rivers	245.00
Maner Costerisan	Auditor 17/18	11,500.00
Maplecrest	Rent - Sturgis Office	567.00
Marana Group	Postage Pick Up Service 2 Months	284.00
McKesson	Medical Supplies 2 Invoices	1,415.79
MDHHS Bureau of Laboratories	Lead Testing	159.03
Merck & Company	Medical Supplies	4,857.40
Mers 5% Alerus Financial DC	Defined Contributions 5% EES 2 Months	2,986.85
Michigan Municipal Risk	Professional Liability - Agency	8,958.50
Michigan Public Health	Training - 3 Employees	3,196.58
Michigan State Disbursement Unit	Payroll Deduction	617.00
Nationwide	Payroll Deduction	4,700.00
Pfizer Pharmaceutical	Medical Supplies	3,529.24
POC Transact Rx	Billing Service	22.50
ProAssurance Casualty Company	Professional Liability - Physician	818.00

ProMedica	CRP Training	200.00
Prompt Care	Drug Testing - 3 Employees	207.00
Reserve Account	Postage	3,000.00
Richard Clark	Building Cleaning Expense - CW	1,800.00
Riley Pumpkin Farm	TR Building Expense - Snow Plowing	100.00
Rochelle Agar	Kick Butts Luncheon	103.34
Sandy's Interiors	Building Expense - TR Painting	50.00
Sanofi Pasture	Medical Supplies	823.15
SEMCO Energy	Building Expense - TR	94.07
Shaffmaster U-Stor	Storage 3 Months	150.00
Sherlock Homes	Refund - Well & Septic	365.00
Shred It	Document Destruction	90.00
Smile Makers	Hearing Test Stickers	82.89
St Joseph County COA	Home & Community Based Services	33,831.23
St Joseph Trans Authority	Older Adult Transportation	1,699.26
St. Joseph Community Co-op	Care Management	715.50
St. Joseph County Dept. Human Service	2019 FY Dues	2,000.00
Staples	Office Supplies	490.34
State Of Michigan	Approp. Match Dental Clinic	42,840.16
State Of Michigan	Food Licenses	15.00
State Of Michigan	Notary Renewal - Hough	10.00
State Of Michigan	Training - Clinic 2 Employee's	50.00
State Of Michigan	Water Lab Test	146.00
Three Rivers Health	Rent - Dental Clinic	2,775.00
Thurston Woods	Home & Community Based Services	2,176.96
Tobacco -Free Michigan	Training - Mapes	203.95
Verizon	Cell Phones	873.21
VRI Lifeline Of Michigan	Care Management	719.90
Wal Mart Misc.	AAA Aging Class Supplies	24.16
Wal Mart Misc.	Misc. Expense - Clinic Supplies	19.08
Wal Mart Misc.	Secretary Meeting	81.55
Xmission	Email Provider 2 Months	446.43
Total Of Invoice List		407,636.14

Balance Sheet: BHSJ-CHA
3/1/2019 - 3/31/2019

Assets	
Cash on Hand	3,842.94
Cash with County Treasurer	810,492.16
Community Foundation Grant	309,955.94
Accounts Receivable	24,131.35
Due from State	35,064.45
Due from Other Funding Sources	184,085.61
Prepaid Expenses	121,745.07
Biologic Inventory	110,099.60
Total Assets	1,599,417.12
Liabilities	
Accounts Payable	100,737.07
Payroll Liabilites	135,393.29
Capital Improvements	25,000.00
Deferred Revenue	56,208.52
Biologics	110,099.60
Total Liabilities	427,438.48
Net Assets	
Operation Fund Balance	352,772.48
Restricted Fund Balance	384,722.35
Designated Fund Balance	434,483.81
Total Net Assets	1,171,978.64
Total Liabilities and Net Assets	1,599,417.12
Designated Fund Balance	434,483.81
Total Net Assets	1,164,933.31

Prior Year Fund Balance Comparison at 3/31/2018:

Operation Fund Balance	$	280,194.09
Restricted Fund Balance	$	364,619.09
Designated Fund Balance	$	437,982.31
Total Fund Balance	**$**	**1,082,795.49**

Expense by Program - 3/1/2019 - 3/31/2019

	RU Code	RU Title	Current Month	Year to Date	Total Budget - Amend 1	Percent Expended Amend 1
*	10	Agency Support	3,180.45	63,140.78	58,013.00	108.83%
*	22	Coalition for Tobacco Control	3,841.24	17,852.81	26,004.00	68.65%
*	115	MCH Enabling Women	3,412.34	40,438.11	58,951.00	68.59%
**	326	Vision (ELPHS)	7,002.12	55,937.62	88,398.00	63.27%
*	345	Lead Testing	1,179.87	8,366.42	13,422.00	62.33%
*	8	Salary/Fringe Payoff	14,376.88	43,060.89	70,000.00	61.52%
**	32	Emergency Preparedness	12,088.75	68,996.31	112,710.00	61.21%
*	325	CSHCS	17,550.06	102,742.74	183,879.00	55.87%
*	338	Immunization Vaccine Handling	33,426.16	212,734.15	403,313.00	52.74%
*	745	Type II Water	6,577.26	39,954.81	78,025.00	51.20%
**	327	Hearing (ELPHS)	7,420.63	39,464.80	78,338.00	50.37%
	21	Dental Clinic - Three Rivers	2,775.00	16,650.00	33,300.00	50.00%
	321	CHC Tele-A-Health	3,643.51	19,308.03	38,685.00	49.91%
	12	Area Agency on Aging	94,128.53	612,423.16	1,233,813.00	49.63%
	335	MCH Public Health Functions & Infr	1,714.03	12,506.25	25,569.00	48.91%
	108	WIC Breastfeeding	6,146.32	40,468.02	84,999.00	47.60%
	109	WIC	74,588.38	433,069.52	910,907.00	47.54%
	605	General EH Services	5,662.12	31,478.54	66,465.00	47.36%
	714	Onsite Sewage Disposal	26,969.62	149,937.29	316,582.00	47.36%
	721	Drinking Water Supply	26,969.62	149,937.29	316,582.00	47.36%
	23	Capital Expenditures	3,215.58	20,873.54	44,440.00	46.97%
	341	Infectious Disease	19,350.52	118,351.90	256,265.00	46.18%
	331	STD	10,787.57	62,830.86	136,347.00	46.08%
	138	Immunization IAP	53,629.22	302,712.24	665,510.00	45.48%
	332	HIV Prevention	2,870.78	14,039.11	31,763.00	44.19%
	101	Workforce Development	2,934.45	21,572.39	50,257.00	42.92%
	329	MCH Enabling Children	2,996.06	14,726.32	34,976.00	42.10%
	14	VOCA	16,138.90	83,321.39	199,750.00	41.71%
	704	Food Service	31,866.53	199,486.54	494,016.00	40.38%
	29	Dental Clinic - Hillsdale	1,067.05	3,861.38	9,683.00	39.87%
	107	Medicaid Outreach	7,518.76	47,577.46	131,388.00	36.21%
+	34	Outbreak Investigation	630.21	4,202.90	25,127.00	16.72%
+	275	Medical Marijuana SJ	191.14	191.14	18,772.00	1.01%
+	212	Medical Marijuana BR	145.99	145.99	16,733.00	0.87%
+	230	Medical Marijuana HD	156.09	156.09	22,034.00	0.70%
+	36	Zika Virus Comm Support	0.00	0.00	24,390.00	0.00%
	112	CSHCS Medicaid Outreach	0.00	0.00	36,467.00	0.00%
	852	Forensic Fluids	266.01	1,019.58	0.00	0.00%
		Total Expense	**506,417.75**	**3,053,536.37**	**6,395,873.00**	**47.74%**

The Agency is currently 2.26% under budget.

*6/12 Months = 50.0%

**9-Month Program

Programs Over Budget as of 3/31/2019

RU 010: Professional Liablity quarterly payment hit in January. Audit expense has been at 71%. One time purchases of computer supplies. Program will end FY at 100% as final indirect rate is charged out to programs (based on salary/fringe).

RU 022: Increased activity in program at this time of year. Should fall in line with budget within the next few months.

RU 115: Purchased safe sleep materials in October (written into the grant), program will fall back in line with budget as FY progresses.

RU 326: Within budget - 9 Month program

RU 345: Increased activity in program. This budget will be amended at amendment #2.

RU 008: Over due to recent retirement. Should fall in line with budget as the year progresses.

RU 032: Within budget - 9 Month program

RU 325: Once program is 100% expended, will allocate additional costs to RU 112 to take advantage of federal matching funds.

RU 338: Meridian takeback payment (not in current budget). Will be added at amendment #2)

RU 745: Slightly over budget due to increased activity, will monitor program.

RU 327: Within budget - 9 Month program

Special Notes:

RU 034: We received an increase in funding after the current budget was completed. For management purposes, this report reflects the budget increase, not the current approved budget.

RU 036: We received this grant funding after the current budget was completed. For management purposes, this report reflects the proposed working budget for this grant.

RU 212: We received this grant funding after the current budget was completed. For management purposes, this report reflects the proposed working budget for this grant.

RU 230: We received this grant funding after the current budget was completed. For management purposes, this report reflects the proposed working budget for this grant.

RU 275: We received this grant funding after the current budget was completed. For management purposes, this report reflects the proposed working budget for this grant.

BHSJ Community Health Agency
Schedule of Cash Receipts and Disbursements
September 30th 2018 thru March 31st 2019

9/30/2018 Cash Balance	**$ 1,112,893.18**
Plus: Cash Receipts	$ 568,883.63
Less: Cash Disbursements For Payroll/AP	$ (577,984.60)
10/31/2018 Cash Balance	**$ 1,103,792.21**
Plus: Cash Receipts	$ 404,039.64
Less: Cash Disbursements For Payroll/AP	$ (552,656.00)
11/30/2018 Cash Balance	**$ 955,175.85**
Plus: Cash Receipts	$ 541,344.15
Less: Cash Disbursements For Payroll/AP	$ (517,013.68)
12/31/2018 Cash Balance	**$ 979,506.32**
Plus: Cash Receipts	$ 678,174.64
Less: Cash Disbursements For Payroll/AP	$ (469,114.45)
1/31/2019 Cash Balance	**$ 1,188,566.51**
Plus: Cash Receipts	$ 393,866.20
Less: Cash Disbursements For Payroll/AP	$ (425,183.21)
2/28/2019 Cash Balance	**$ 1,157,249.50**
Plus: Cash Receipts	$ 515,117.40
Less: Cash Disbursements For Payroll/AP	$ (551,918.80)
3/31/2019 Cash Balance	**$ 1,120,448.10**

Summary of Personnel Policy Manual Changes

- Work Related Travel Section – Pg. #9
  This section of the policy was updated to reflect changes suggested by the Agency's attorney to ensure that our policy was compliant with the law.

- Jury Service – Pg. # 13
  The wording in this part of the policy was updated to clarify that employees must surrender any compensation received from jury duty service if they want to be compensated by the agency at their usual rate of pay.

- Sick Leave – Pg. # 18
  Public Act 369 of 2018 went into effect on 3/29/2018, which requires some employers to provide Paid Medical Leave to a wider group of employees. This section of the policy was updated to ensure the agency's policy is in compliance with this new law.

- Extended Absences – Pg. # 19
  This section of the policy was confusing and contradicted itself. A small edit was made to clarify that missing three consecutive days is considered and extended absence and may require a physician's verification.

- Compensation for a Holiday Worked – Pg. # 25
  The statement, "in accordance with the additional time policy" was added to this section to clarify that staff must follow the additional time policy even when working on a Holiday.

- Bad Weather Policy – Pg. # 31
  This section was updated to specify that if the agency is closed for bad weather, employees who have already been granted approved leave time, either sick or vacation time, will be required to utilize their paid time off.

- Changed "Handicapped People" to "People with disabilities" throughout the document.

PURPOSE OF THE PERSONNEL POLICY MANUAL

This manual was developed to describe some of the expectations of our employees and to outline the policies, benefits, and procedures available to eligible employees. Employees should familiarize themselves with the contents of the Personnel Policy Manual as soon as possible, for it will answer many questions about employment with Branch-Hillsdale-St. Joseph Community Health Agency.

No personnel policy manual can anticipate every circumstance or question about policy. As time goes on, the need may arise and the Branch-Hillsdale-St. Joseph Community Health Agency Board of Health reserves the right to revise, supplement, or rescind any policy or portion of the manual from time to time as it deems appropriate, in its sole and absolute discretion.

This Personnel Policy Manual supersedes any and all previous personnel policies created separately and collectively by the Branch-Hillsdale-St. Joseph Community Health Agency Board of Health.

This Personnel Policy Manual shall be distributed to appropriate agency personnel at the time of hire. Copies of subsequent updates of this manual shall be provided to appropriate agency personnel as soon as possible after the adoption of such updates.

Board of Health
Branch-Hillsdale-St. Joseph
Community Health Agency

SECTION 1: DEVELOPMENT OF PERSONNEL POLICIES

A. COMPOSITION OF THE PERSONNEL POLICY MANUAL COMMITTEE

There shall be a committee composed of the Health Officer, a designee of the Health Officer, a representative and alternate from each of three counties - Branch, Hillsdale, and St. Joseph.

B. SELECTION OF OFFICE REPRESENTATIVES AND ALTERNATES

A request for volunteers as representatives shall be conducted at the beginning of each calendar year. Representatives shall serve for a two-year term from their respective offices. Employees elected shall serve the first year as the alternate representative and the second year as the representative. In the event the office of representative or alternate representative is vacated during the elected term, a request for a volunteer to replace the alternate will be conducted in the office involved. If the representative vacates, the current alternate representative shall move into that position. These names will be posted annually in the mail room of each office.

C. MEETING SCHEDULE OF THE COMMITTEE

The committee shall meet at least once a year to provide suggestions to the Health Officer regarding the personnel policies. Each office shall have one vote. If both the alternate representative and representative from an office are present, they will be allowed one vote. In the event of a tie vote, the issue is to be tabled until the next scheduled meeting, at which time if the issue still results in a tie then it is considered defeated. The chair of the committee will be elected by the representatives and alternates during the first meeting. The Health Officer will not have voting privileges.

A secretary shall be selected from the committee and will arrange for minutes of each committee meeting to be distributed to each committee member. The committee members are responsible for posting the minutes in each office. The announcement of personnel policy committee meetings and the minutes from the meetings will be sent to 'everyone@bhsj.org' through the Agency's employee's email system and in the Personnel Policy folder on the Coldwater shared drive. Each employee shall be responsible for reading the minutes and providing input to a member of the committee.

D. IMPLEMENTATION AND INTERPRETATION OF THE PERSONNEL POLICIES

The Health Officer shall be responsible for the implementation of the approved personnel policies within this manual. The Administrative Services Director shall be available to the employees and management regarding the interpretation of the personnel policies.

SECTION 2: EMPLOYMENT POLICIES, PROCEDURES AND REQUIREMENTS

A. EMPLOYMENT POLICIES

1. Employment Relations. The Board of Health believes that the work conditions, wages, and benefits it offers to its employees are competitive with those offered by other employers in this area and in this industry. If employees have concerns about work conditions or compensation, they are strongly encouraged to voice these concerns openly and directly with their immediate supervisors.

2. Equal Opportunity Employer. In order to provide equal employment and advancement opportunities to all individuals, employment decision at the agency will be based on merit, qualifications, and abilities. The agency does not discriminate in employment opportunities or practices on the basis of race, color, religion, gender, national origin, age, disability, or any other characteristic protected by law. The agency will make reasonable accommodations for qualified individuals with known disabilities. This policy governs all aspects of employment, including selection, job assignment, compensation, discipline, termination, and access to benefits and training.

3. Job Posting. The agency provides employees an opportunity to indicate their interest in open positions and advancement according to their skills and experience. Job openings will be posted and normally remain open for five (5) workdays. Each job posting will include the dates of the posting period, job title, department, grade level, essential duties and qualifications.

4. Immigration Law Compliance. In compliance with the Immigration Reform and Control Act of 1986, each new employee, as a condition of employment, must complete the Employment Eligibility Verification Form I-9 and present documentation establishing identity and eligibility.

5. Hiring of Relatives. Employment of more than one member of the family may be permitted, providing each individual possesses the necessary qualifications and competed in the usual manner with other qualified applicants.

6. Conflict of Interest. An actual or potential conflict of interest occurs when an employee is in the position to influence a decision that may result in personal gain for that employee or for a relative as a result of the agency's business dealings. If employees have any influence on transactions involving purchases, contracts, or leases, it is imperative that they disclose to their immediate supervisor as soon as possible the existence of any or potential conflict of interest so that safeguards can be established to protect all parties. For the purposes of this policy a relative is any person related by blood or marriage.

7. Outside Employment. Employees may hold outside employment as long as such employment does not present a conflict of interest or in any way interfere with the efficient discharge of duties required to satisfactorily function in the position held with the agency.

8. Pre-Employment Medical Exam and Drug Test. After an offer has been made to an applicant entering agency employment, the new hire shall undergo a medical examination and drug test at the agency's expense. The offer and assignment to duties is contingent upon satisfactory completion of these exams. Information on employees' medical condition or history will be kept separate from other employee information and will be maintained confidentially.

9. Background Check. When an offer has been made to an applicant entering agency employment, the new hire shall undergo a background check. The offer and assignment to duties is contingent upon satisfactory completion of this background check. The Agency reserves the right to conduct annual background checks on all employees.

10. Hire Date. The date an employee was hired. In the event that an employee had been employed and left employment and subsequently rehired, the Hire Date will be the most recent date of hire.

11. Anniversary Date. The Anniversary Date is the Hire Date or if an employee moves into a new job classification the Anniversary Date will change to the date that the new job classification becomes effective.

12. Continuous Length of Service. Continuous Length of Service is defined as the period of time in which an employee continues in agency employment without interruption subject to the conditions described in other sections of this manual.

13. Orientation. The immediate supervisor will provide each new employee an introduction to their co-worker, work environment, job responsibilities, procedures, and policies. All necessary employment forms and paperwork must be completed on the first day of work with the Administration division.

14. Probationary Period. All new and rehired employees will be on a six-month probationary period following their date of hire or rehire. At any time during the six-month probationary period, the agency or the employee for any reason may terminate employment.

15. Work Schedule. Work schedules may vary throughout the agency. Immediate supervisors will advise employees of their individual work schedules. Staffing needs and operational demands may necessitate variations in starting and ending times, as well as variations in the total hours that may be scheduled each day and week.

16. Performance Evaluations. Immediate supervisors and employees are encouraged to discuss job performance and goals on an informal, day-to-day basis. The immediate supervisor shall prepare the formal evaluations at three months and at the six-month probationary period and then every subsequent year following the hire or reassignment of employees.

17. Residency Requirement. There shall be no residency requirement that employees live within the boundaries of the areas served by the agency.

18. Approval for Hiring. Final approval of the hiring of all agency employees shall rest with the Health Officer.

19. Removal from Payroll. An employee who is defined as "casual" and does not work in three (3) consecutive months shall be removed from payroll.

20. Reporting of Accidents/Incidents. The employee must report any & all accidents/injuries within 24 hours to the Administrative Services Director.

21. Reporting of Neglect/Abuse/Exploitation. Employees must report any and all suspected case/cases of abuse, neglect, and exploitation immediately by calling State of Michigan Centralized Intake at 855-444-3911. Employee must also notify immediate supervisor.

22. Identification Badges**.** All employees are issued an identification badge and are required to wear it during the performance of their job duties. In the event the badge is lost, stolen, or damaged the employee must notify the Administrative Division for a replacement immediately.

23. Sign In/Sign Out Policy. All employees shall sign in when they arrive at work and sign out at the time of leaving the building at any time during the day. This is required so we know who is in the building and who isn't in the event of an emergency. Sign out sheets are in the mail room. Each staff member will be responsible for their own time in and out.

24. Drivers Licenses and Car Insurance**.** Every employee must possess a valid driver's license and car insurance—you will be asked to present copies of these to the Administrative Division at hire and upon renewal.

B. PERSONNEL FILE PROCEDURE

1. Contents of the Personnel File. The agency maintains a personnel file on each employee. The personnel file includes such information as the employee's job application, resume, performance evaluations, documentation of reassignments and salary increases, and other employment records.

2. Review of the Personnel File. Personnel Files are the property of the agency and access to the information they contain is restricted. Generally, only the immediate supervisor, division director, and other agency personnel who have a legitimate reason, as determined by the Health Officer to review the information in a personnel file, are allowed to do so. Employees are entitled to inspect the contents of their personnel files. Employees who wish to inspect their own personnel file should contact the Administrative Services Director. With reasonable advance notice, employees can review the content of their personnel files in the presence of the Administrative Services Director.

3. Personnel Data Changes. Employees are responsible for promptly notifying the Administrative Division of any changes in personnel data. Changes relating to personal information such as mailing addresses, telephone numbers, individuals to be contacted in the event of an emergency, dependents covered by agency provided insurance, or marital status must be accurate and up to date.

4. Verification of Employment Requests. No information will be shared on an employee until verified with that employee. Verification needs to be made before giving any institutions any information on any employees. No information will be shared PERIOD until validated by the Administrative Services Director.

C. PERSONAL CONDUCT REQUIREMENTS

1. General Statement of Policy. It is not possible to list all the forms of behavior that are considered unacceptable in the workplace. The agency expects employees to perform their job in a manner that will protect the interests and safety of all employees and the agency. Violation of the following Personal Conduct Requirements may lead to progressive disciplinary action, up to and including termination of employment.

2. Personal Appearance. Employees are expected to present a clean and neat appearance and to dress according to the requirements of their position. Employees who appear for work inappropriately dressed will be sent home and directed to return to work in proper attire. Under such circumstances, employees will not be compensated for the time away from work.

3. Agency Phone, Cell Phone, E-mail and Fax Usage. Employees should practice discretion when making personal phone calls and sending e-mail or faxes. Employees shall be required to reimburse the agency for any charges resulting from their personal use of the telephone, fax machine, or copier. Any employee, who has misplaced, lost, or damaged agency property must report such to their supervisor or the Administrative Services Director as soon as possible. The employee may be asked to reimburse the agency for the replacement/repair of said item or items if the loss or damage was a result of negligence by the employee.

4. Smoking Policy. In keeping with the agency's intent to provide a safe and healthful workplace, smoking or the use of E-cigarettes is prohibited in any agency facility or within 50 feet of the building.

5. Breaks and Lunch Periods. Employees will be granted two (2) paid fifteen-minute breaks during the full workday. Employees will have a ½ hour unpaid lunch period for each full workday. The timing of the breaks and lunch periods will be at the discretion of the department head and in compliance with labor law. It is the supervisor's responsibility to have staff coverage during all service hours, allowing for uninterrupted breaks and lunches.

6. Drugs and Alcohol in the Workplace. It is the agency's desire to provide a drug-free, safe and healthful workplace. Employees may not use, possess, distribute, sell, or be under the influence of illegal drugs or alcohol while on agency premises or while conducting agency business-related activities off agency premises. Please refer to the Agency's Substance Abuse Policy.

7. Harassment in the Workplace. The agency is committed to providing a workplace that is free of discrimination and unlawful verbal and physical harassment. Sexual harassment is defined as unwelcome sexual advances, requests for sexual favors, and other verbal, non-verbal, or physical conduct of a sexual nature. All allegations of harassment should be reported, in writing, to the Administrative Services Director's office as soon as possible. In the event the Administrative Services Director is the alleged harasser, the allegations of harassment should be reported, in writing, to the Health Officer.

8. Attendance and Punctuality at Work. To maintain a safe and productive work environment, the agency expects employees to be reliable and punctual in reporting for scheduled work. Absenteeism and tardiness place a burden on other employees and on the agency. When employees cannot avoid being late to work or unable to work as scheduled, they must notify their immediate supervisor as soon as possible in advance of anticipated tardiness or absence.

9. Solicitation. In an effort to ensure a productive and harmonious work environment, persons not employed by the agency may not solicit or distribute literature or products in the workplace at any time for any purpose without the permission of the Health Officer. Employees may not solicit or distribute literature or products concerning outside event and organizations during working time without the permission of the Health Officer.

10. Contributions. Contributions by employees to community organization fund drives shall be entirely voluntary. Agency management personnel or Board of Health shall at no time estimate or determine what amount such contributions shall be.

11. Use of Agency Equipment. Equipment essential in accomplishing job duties is expensive and may be difficult to replace. When using agency property, employees are expected to exercise care, and follow operating and safety standards and guidelines. Employees shall not engage in the improper, careless, negligent, destructive, or unsafe use or operation of agency equipment. In the event that any Agency owned or leased equipment is misplaced, stolen, lost, or damaged you must report it to the Administrative Services Director immediately. Employees may be asked to reimburse the Agency for the repair/replacement of said item or items if it is deemed the employee was careless and negligent. For legal liability reasons, employees are not to transport non-employees during work time unless special authorization is given.

12. Political Activity. Employees are subject to the rights and limitations of the Hatch Act.

13. Gifts and Favors. Employees or their immediate family shall not be permitted to accept loans, gifts of money or goods, services or other preferred arrangements for personal benefit under any circumstances directly or indirectly involving possible influence or appearance of influence upon the manner in which they perform work, make decisions to otherwise discharge their duties as an employee.

14. Confidentiality of Information. The agency shall be in compliance with the Health Insurance Portability and Accountability Act (HIPAA). Protected information contained in reports, records or communications of the agency shall be considered confidential. Unauthorized disclosure of such information by staff members shall be considered sufficient grounds for dismissal.

D. EMPLOYEE CLASSIFICATIONS

1. Full Time. An employee who is regularly scheduled to work at least 37.5 hours per workweek.

2. Minimum Full Time. An employee who is regularly scheduled to work less than 37.5 hour per workweek but a minimum of 30 hours per workweek.

3. Part Time. An employee who is regularly scheduled to work at least 20 hours per workweek.

4. Casual. An employee who works irregular hours.

5. Contractual Employees. An individual performing a service, job or duty as outlined in the terms of a contract are not subject to the Agency's travel reimbursement, pay schedule, vacation or sick time schedule or other benefits unless stated in their contract, but are subject to portions of the Personnel Policy that relate to personal conduct.

6. Seasonal Employees. An employee that has been hired to work in a specific program which is suspended each year and the program is scheduled to begin again within 12 months. Employee on seasonal layoff will not earn vacation, sick time, or cash-in-lieu while on layoff. The employee while on seasonal layoff will not be covered by the Health Insurance Policy offered by the Agency and will be transferred to COBRA. The Agency will not issue payments for any benefits which come due while the employee is on seasonal layoff. Such benefits include cash-in-lieu or longevity payments. Any longevity payments normally paid or the cash-in-lieu benefit earned by the employee prior to being placed on seasonal payoff will be paid once the employee returns to work or at the end of our current fiscal year or if the employment is terminated during the seasonal layoff period.

E. EMPLOYEE PROMOTION OR RECLASSIFICATION

The rate of pay, for employees who have been promoted to a higher level position, will be adjusted to the minimum rate of pay of the higher level or to that salary step on the higher level above their current rate of pay, whichever is higher.

The rate of pay, for employees who have been reclassified to a position in a lower level, will be paid at their current level or adjusted to their salary step rate of pay, whichever is lower.

The health officer shall authorize all reclassifications.

F. EMPLOYEE TRANSFER

The rate of pay, for employees who have transferred to a position in the same classification, the rate of pay shall be determined by the Health Officer and the division Director based on employee knowledge and training needed.

G. WORK RELATED TRAVEL

Employees who use their own personal vehicles for agency business will be reimbursed at the rate established by the Board of Health. The Board of Health set travel reimbursement at the standard mileage rate as set by the IRS each year. However, if the Health Officer determines that there are budgetary concerns of the agency, any increase in the agency's Travel Reimbursement must be postponed until the budgetary concerns have been addressed.

1. Agency Travel Policy. Travel expense reimbursement is based upon the following:
   - Every employee is assigned a home base office
   - Any employee or contractual employee of this Agency who drives a vehicle for business related activities or receives mileage reimbursement from this Agency must possess at all times, a valid driver's license that does not restrict their driving for Agency related business.
   - Within the health district, employees are paid mileage from their home base to the place of work assignment and back to their home base. If an employee leaves from their residence to a work assignment other than their home base, the mileage is paid from their residence if the distance is less than from their home base.
   - Employees who request to work at an agency office that is not their home base shall not be reimbursed for travel time and mileage from the home base to the office where they have chosen to work.
   - Employees assigned by their immediate supervisor to job responsibilities at an agency office that is not their home base shall be reimbursed for mileage.
   - Meal expenses incurred within a work day are reimbursed only if they are pre-approved by an immediate supervisor. Supervisors shall use discretion approving meal expenses for offsite training, hosting visiting officials, etc.

- Reimbursement for travel outside the health district must be pre-approved by the division director.
- ~~Travel time outside the health district shall be reimbursable only if travel occurs during assigned business hours.~~
- Travel time that occurs ~~within the health district and~~ outside of assigned business hours will ~~only~~ be reimbursed in accordance with the adjusted time policy.~~if the employee is required to attend training or perform a job duty by their supervisor.~~
- Reimbursement for training and related expenses (tuition, meals, etc.) must be pre-approved by the division director ~~and the health officer~~. To begin the pre-approval process, employees shall submit an agency Training form, detailing the anticipated training expenses, to their supervisors.
- Travel mileage between offices shall be calculated as follows:
    - Coldwater to Hillsdale, 25 miles
    - Coldwater to Three Rivers, 40 miles
    - Coldwater to Sturgis, 26 miles
    - Three Rivers to Sturgis, 23 miles

H.. STAFF DEVELOPMENT

The Board of Health encourages employees to develop professionally through training and continuing education. Subject to management approval and agency budgetary constraints, employees will be assisted to attend identified training and education events. Attendance at approved conferences, training, or exams shall be treated as a special work assignment. The agency will require an employee to sign a payback agreement to protect the agency from a premature departure of the employee once high-investment specialty training is concluded.

1. Staff Development Procedure. Pursuant to Section 2, Part H of the Branch-Hillsdale-St. Joseph Community Health Agency's Personnel Policies the following procedure has been developed and approved for implementation regarding employee requested training.

    - All regular full-time, minimum full-time, and regular part-time employees are eligible to apply in writing for staff development assistance.
    - Applications for staff development assistance shall be endorsed by the appropriate division director, then reviewed and approved by the health officer for being in the "best interest of the agency".
    - Approved applicants must maintain employment throughout the training period.
    - Approved applicants are eligible for reimbursement of courses taken, not to exceed $3,000 in four consecutive quarters, three consecutive trimesters, or two consecutive semesters.
    - Pre-approval of expenses must be obtained prior to the beginning of the school term.
    - Covered course expenses are tuition and books.
    - All courses must be through an accredited institution.

- All courses must be part of an educational program that relates to the employee's current position or a future position with the agency.
- An employee may request reimbursement for the course or training by submitting a copy of the receipt showing that the fee had been paid by the employee along with the following:
    - An employee must obtain a grade of "C" or better at the undergraduate level and "B" or better at the graduate level.
    - Upon the completion of the course(s) and the posting of grades the employee must present the grades to the health officer.
- Employees who leave before one year's time after the last staff development reimbursement payment must reimburse the agency a pro-rate share of that last payment. This requirement may be waived by the health officer upon appeal.

SECTION 3: COMPENSATION POLICIES

A. MONETARY COMPENSATION

1. Rate Determination. The Board of Health shall approve an employee salary scale that seeks to assure that covered salaries are externally competitive and are internally comparable in terms of job difficulty and responsibility. A copy of the approved salary scale shall be available in each office.

2. Starting Wage. A newly hired employee will start at the minimum of the approved salary range for the position for which they were hired. The Health Officer may approve that an employee be started above the starting wage but not at a wage exceeding the maximum of the salary range. The Health Officer shall seek approval from the Board of Health of any new hire that is started above the first-year step on the employee salary scale.

3. Credit Transfer. A division director may recommend to the Health Officer that an employee transferring from a full time or minimum full-time position to another full-time position or minimum full-time position at the same salary range be credited with their prior service for salary.

B. PAY PERIODS

1. Schedule. All employees are paid on two-week cycles beginning on Saturday at 0:01 a.m. and ending on Friday at midnight. Payday is on the Friday one week following the close of the pay period. If the regular payday falls on a federal banking holiday, employees can receive their paychecks the last day of work prior to the federal banking holiday.

2. Payroll Reporting Responsibility. All employees are responsible for submitting a completed time sheet to their immediate supervisor for approval and processing no later than 9 a.m. of the first work day following the end of the payroll period. The immediate supervisors are responsible for seeing that all submitted and approved time sheets are electronically processed to the agency accounting office no later than 10 a.m. of the first work day following the end of the payroll period.

C. ADDITIONAL TIME POLICY

The additional time policy applies to staff that are required to work on Saturday, Sunday or in excess of normal business hours or on Agency observed Holiday to conduct Agency work at

scheduled venues. Staff will receive a minimum of two (2) hours for reporting on the weekend and if the time worked exceeds two (2) hours they will receive an additional ½ hour for each ½ hour worked. The agency recognizes two types of additional time; adjusted-time and overtime.

1. Adjusted Time Schedule

Policy: Full time staff members are limited to a 75 hour per pay period work schedule. Minimum full-time staff members are limited to a 60 hour per pay period work schedule. Part-time staff members are limited to less than 60 hours per pay period work schedule, as specified by their supervisor.

For most staff, their work schedule coincides with the Agency's regular work hours: 7.5 hours per day, Monday through Friday. (Note: While normal business hours are 8 a.m. to 4 p.m., clinic staff, working a late clinic which starts later than 8 a.m. and ends after 4 p.m., should consider a late clinic normal business hours).

Certain positions within the agency (i.e., communicable disease nurse, health educator, sanitarian, outreach worker, etc.) may have work assignments as part of their job duties/responsibilities which require work that can only be done outside of the Agency's normal work schedule. Due to these requirements, the work schedule for these employees can be adjusted, with prior written approval from their division's director, to accommodate these specific duties and responsibilities. (During the affected pay period, the employee will work to accommodate any overages in hours on one day by taking time off on one or more subsequent days. Days selected to adjust for time overages shall be low volume work days or days with limited work commitments.)

Staff members are instructed that, without prior written authorization of the health officer and their director, they are not allowed to work more than their budgeted hours as identified on their Payroll Status Wage Form and are not eligible for overtime payments.

Procedure:

A. Employees who have work commitments which fall outside of the Agency's regular work hours of Monday through Friday, will submit an adjusted time schedule form to their director for the pay period prior to the time being adjusted.

B. The form will indicate the Employee's name, Employee Number, and the pay period being adjusted.

C. Employees will identify the number of hours they are working each day, and include the start and end times for each day.

D. Employees will identify the reason for the adjustment for those days where they are working outside their normal 7.5 hours per day.

E. Employees will document that for those days in which they are working more than 7.5 hours, they have made an appropriate adjustment on a subsequent day. Employees will do their best to work with their directors to assure that these adjustments are not

made on days which will result in unnecessary work assignment shifts or undue hardship for their co-workers or to the Agency. Scheduled adjustments to offset time in excess of a 7.5-hour day should occur on days that are low volume or with limited commitments.

F. Employees will certify that they will not deviate from the schedule or work in excess to the schedule by signature without prior notification and approval. In addition, they will also certify they will not work in excess of budgeted hours without written approval of their director and the health officer. An employee cannot use paid time off to exceed their budgeted hours.

G. Once received, the director will provide written approval in a timely manner, but no later than 24 hours prior to the start of the adjustment.

H. Written requests and approvals can be submitted in-paper form, fax or electronically, as the director prefers.

I. The director will keep documentation of adjusted work schedules as required by document retention policies.

J. Failure to submit adjusted work schedule forms and to comply with the adjusted policy and procedures will result in progressive disciplinary action.

2. Compensation for Overtime. Hourly/Professional/Technical – When the Agency's budget permits, staff that work in excess of eighty (80) hours in a single pay period may be compensated at one and one-half their regular rate of pay for the time in excess of 80 hours. Staff may only work in excess of their budgeted schedule with prior division Director and Health Officer written approval.

D. LONGEVITY COMPENSATION

1. Purpose and Eligibility. Longevity Compensation is granted to full time and minimum full-time employees based on their consecutive years of full time and/or minimum full-time service. Part time and casual employees are not granted longevity compensation.

2. Amount Granted. The amount of longevity compensation granted to eligible employees varies with the number of consecutive years of service from their anniversary date as shown in the following schedule:

5-9 Years of Service	=	$150
10-14 Years of Service	=	$300
15-19 Years of Service	=	$450
20 Years Plus of Service	=	$600

3. Payment Schedule. Longevity compensation payments will be paid out to eligible employees during the first payday following the employee's anniversary date. Seasonal employees receive longevity as outlined under the seasonal employee definition.

E. JURY SERVICE

1. Purpose and Eligibility. Jury Service Compensation is available to eligible employees to encourage employees to fulfill their civic responsibility by serving jury duty when required. If an employee of the Branch-Hillsdale-St. Joseph Community Health Agency has been called to serve, notification to the employee's immediate supervisor and the Administrative Services Director is required for jury service compensation.

2. Amount Compensated. Employees will be compensated at their normal rate of pay, provided they surrender all compensation received from other sources associated with their jury duty services. ~~shall provide a statement indicating the total amount of compensation received for jury duty. If jury duty compensation does not equal the usual salary, the agency shall reimburse the employee the difference. If jury duty compensation equals or exceeds the usual salary, there shall be no additional reimbursement by the agency to the employee.~~

3. Giving Notice. Employees must give reasonable advance notice to their immediate supervisor and the Administrative Services Director of their summons to serve as a possible juror. Employees must also give periodic updates in respect to anticipated jury service completion time.

4. Maintenance of Benefits. All paid leave benefits: vacation leave, sick leave, and holidays will continue to accrue during jury service. All insurance plans the employee participated in prior to the jury service will continue during the jury service.

F. 457 DEFERRED COMPENSATION ACCOUNTS

The agency offers two "457" or deferred compensation plans that allow employees to put pre-tax or post-tax dollars away for future retirement needs. All employees are eligible for benefits that are subject to state and federal regulations. Employee participation is voluntary.

G. MERS RETIREMENT PROGRAM

The agency provides a compulsory retirement plan through the Municipal Employees Retirement System (MERS) for its employees classified as full time and minimum full time. In 2015, the Agency's MERS plan changed from defined benefit to defined contribution. Eligible employees contribute 3% of their gross wages to MERS. The agency contributes an amount determined by MERS as the employer match contribution for those employees under the defined benefit plan. The agency contributes 5% of an employee's gross wages to MERS for those employees on the defined contribution plan. A 55/25 waiver for all participating employees is in effect.

H. HEALTH CARE SAVINGS PLAN (MERS)

A post-employment Health Care Savings Program (HCSP) is an employer-sponsored program that allows employees to save money by getting reimbursed for medical expenses and or health insurance premiums after termination of service from their employer. All contributions made to the program are tax free, will accumulate tax free, and since payouts are used for reimbursing medical expenses they will remain tax free. The Health Care Savings Plan was suspended effective January 1, 2018.

I. BASIC FLEX

The Agency offers staff the opportunity to transfer a portion of their gross pay to a flexible spending plan. The employee determines a dollar amount to be set aside in a special account that can be used to pay for qualifying expenses as they occur. Only full-time and minimum full-time employees qualify to use Basic Flex. See the Accounting department for additional detail regarding this plan.

IRS regulations state that if an employee or an employee's spouse is enrolled in a General Purpose Flex plan, the employee would be disqualified from establishing a Health Savings Account (HSA)

J. AFLAC

The Agency offers AFLAC as part of a flexible spending plan.

K. REIMBURSEMENT FROM SOURCES OTHER THAN THE AGENCY

In the case where some other organization reimburses an employee for job-related expenses, employees shall be allowed reimbursement from one source only for job-related expenses. If reimbursement from a non-agency source is sufficient to cover expenses incurred by an employee, the employee shall submit an expense voucher to the agency, and the reimbursement from the non-agency source shall be turned into the agency.

SECTION 4: INSURANCE BENEFITS

1. HEALTH INSURANCE

1. Purpose and Eligibility. The agency provides access to health (medical, dental, and vision) insurance for eligible employees and their families. Full time and minimum full-time employees and their dependents until age 26 are eligible for access to health insurance coverage under the agency's plan. Part time and casual employees are not eligible for access to health insurance coverage through the agency's plan.

2. Start of Coverage. Application for health insurance coverage must be made with the Administrative Division upon hiring. Coverage for eligible employees should become effective the first day of employment.

3. Cash-in-Lieu of Health Insurance. Those employees that meet the following eligibility requirements:

a. are full time or minimum full time as outlined in (1.) above, and
b. provide proof of health insurance from another provider on an annual basis to the Agency,

Eligible employees may elect to receive a cash-in-lieu payment. This payment is made after the conclusion of each fiscal quarter. An eligible employee as defined above, may elect to take the dental and vision plan and receive a cash-in-lieu payment that is reduced.

4. Insurance Benefit During an Unpaid Leave.

a. FMLA qualifying event: Employees on an unpaid leave who are eligible for FMLA are charged their regular cost of the health care plan premium during the qualifying FMLA period. Employees are asked to write a check for this cost while on FMLA.
b. Non-qualifying FMLA leave: If an employee is taking unpaid leave, the employee is responsible for the entire cost of the health care plan premium. This rate will be figured on a daily basis of the monthly premium. Contact the Administration Division regarding what the daily charge would be based on the health care plan selected. Any cost owed to the Agency by the employee will be subtracted from the next pay check issued to the employee.

2. LIFE INSURANCE

1. Purpose and Eligibility. The Agency provides term life insurance in the amount of $15,000 for eligible employees. Full time and minimum full-time employees are eligible for life insurance coverage. Part time and casual employees are not eligible for life insurance. Group life insurance coverage will decrease to $11,000.00 on the first day of the month after an employee's 65th birthday and further shall decrease to $8,000.00 on the first day of the month after an employee's 70th birthday.

2. Accidental Death and Dismemberment Coverage. As part of the agency's life insurance plan, each full time and minimum full-time employee is also covered up to $15,000 for accidental death and dismemberment. Employees who are on layoff may purchase continuation life insurance coverage.

3. SHORT TERM DISABILITY INSURANCE

1. Purpose and Eligibility. The agency provides short-term (up to twenty-six weeks) disability insurance for eligible employees who are unable to work because of a qualifying disability due to injury or illness. Full time and minimum full-time employees are eligible under the agency's short-term disability plan. Part time and casual employees are not eligible for short-term disability insurance.

2. Scope of the Plan. Eligible employees are provided with disability insurance that becomes effective 30 days after the disability and pays 70% of an employee's weekly earnings up $400.00 during the eligibility period.

3. Restrictions. Eligible employees may not collect disability payments in addition to accrued leave time. Only one source of payment either from disability insurance payments or accrued leave time can be collected during any one-time period. Employees who are on layoff are not covered by the short-term disability insurance.

4. Relationship to Worker's Compensation. Disabilities covered by worker's compensation are excluded from agency's short-term disability plan coverage. The employee is responsible for their bi-weekly payment of the health care plan they have selected.

4. UNEMPLOYMENT INSURANCE

The agency participates in the state/federal unemployment insurance program. All employees are eligible for benefits that are subject to state and federal regulations.

5. WORKER'S COMPENSATION

The agency provides a comprehensive worker's compensation program that covers employee injuries or illnesses sustained in the course of employment that requires medical, surgical, or hospital treatment. All employees are eligible for benefits that are subject to applicable legal requirements. All work-related injuries or illnesses are to be promptly reported within 24 hours to the Administrative Services Director.

F. PROFESSIONAL LIABILITY INSURANCE

The agency provides liability insurance coverage for all employees engaged in the day-to-day operations of the agency. The agency shall include surety bond coverage.

G. SOCIAL SECURITY

The agency participates in the Federal Social Security Plan. All employees shall supply the payroll department with the necessary information for reporting.

H. COBRA REQUIREMENT

1. Purpose and Eligibility. The federal Consolidated Omnibus Budget Reconciliation Act (COBRA) gives regular full-time employees and minimum full-time employees (who have participated in the health insurance plan) the opportunity to continue health insurance coverage when a "qualifying event" would normally result in the loss of health insurance eligibility.

2. Qualifying Event Defined. Under COBRA, qualifying event is defined as resignation, termination of employment, or death of an employee; reduction of employee's work hours or a leave of absence; an employee's divorce or legal separation; and a dependent child no longer meeting eligibility requirements.

3. Payment of Costs. Under COBRA, the employee or beneficiary pays the full cost of coverage at the agency's health insurance premium rates plus an administration fee.

SECTION 5: EMPLOYEE LEAVE POLICIES

A. VACATION LEAVE

1. Purpose & Eligibility. Vacation Leave with pay is available to eligible employees. Full time employees are eligible for vacation leave and minimum full-time employees are eligible for vacation leave on a pro-rata basis. Part time and casual employees do not accrue vacation leave.

2. Amount Accrued. The amount of vacation leave employees accrue each year varies with the length of consecutive years of employment. The following accrual schedule assumes a thirty-seven and one-half hour workweek:

First 5 years of service = Sixteen (16) days or 4.61 hours per pay period
After 5 years of service = Twenty-Two (22) days or 6.34 hours per pay period
After 10 years of service = Twenty-Eight (28) days or 8.07 hours per pay period

The following accrual schedule assumes a thirty-hour workweek:

First 5 years of service = 3.68 hours per pay period
After 5 years of service = 5.06 hours per pay period
After 10 years of service = 6.456 hours per pay period

3. Start of Accrual. Employees begin to accrue vacation leave from the date of employment. Earned vacation leave is available for use at the end of the 6-month probationary period.

4. Vacation Leave and Leaves without Pay. Employees who are on a leave without pay do not accrue any additional vacation leave until their return to service.

5. Requesting a Vacation Leave. Employees must request advanced approval from their immediate supervisor to utilize accrued vacation leave. Requests will be reviewed based on a number of factors, including department operational needs and staffing requirements.

6. Rate of Payout. Vacation leave will be paid out at the employee's pay rate at the time of vacation leave.

7. Maximum Accrual. Employee may accrue vacation leave up to twice the maximum annual accrual allowance schedule. Once an employee has accrued the maximum, no additional vacation leave will be accrued until the employee has used vacation leave to reduce their total below the maximum. The following accrual is for full-time employees:

First 5 years of service = 240.00 hours maximum
After 5 years of service = 330.00 hours maximum
After 10 years of service = 420.00 hours maximum

Minimum full-time maximum accrual is:
First 5 years of service = 210 hours maximum
After 5 years of service = 270 hours maximum
After 10 years of service = 360 hours maximum

8. Upon Termination. Upon termination of employment, employees will be paid for all unused accrued vacation leave that has been earned through the last day of work. Payment can be received by two methods: (1) Lump sum pay off of the accrued vacation leave. (2) With a two-week notice to the payroll department, the employee may elect to contribute part or all of your remaining vacation hours into the MERS HCSP.

9. Bi-annually on January 1st and July 1st, any eligible vacation days can be deposited into the MERS Health Care Savings Plan (HCSP) up to 75 hours (10 days) in one calendar year.
(The eligibility description of the HCSP also is stated in Section 3: Compensation Policies)

B. SICK LEAVE

1. Purpose & Eligibility. Sick Leave with pay is available to eligible employees for periods of temporary absences for the following purposes:

a. a personal mental or physical illness or injury or to seek treatment for such illness or injury, including a Medical/Dental or preventative care appointment;
b. a mental or physical illness or injury or to seek treatment for such illness or injury of a family member or any person that the employee is designated as the primary caregiver in accordance with FMLA. A family member includes any child, stepchild, foster child, parent, spouse, grandparent, grandchild, sibling, or any other individual included in the definition of "family member" under Sec. 2(g) of Paid Medical Leave Act (PMLA), MCL 408.962(g).
c. to permit an employee to work less than their regularly scheduled work hours until full recovery following a prolonged illness, injury or surgery;
d. for purposes of bereavement for events not covered under the bereavement policy;
e. due to the closure of the Health Department, the primary Health Department worksite the employee, or to care for the child of the employee due to the closure of the child's place of care, if such closure is by order of a public official due to a public health emergency;
f. if the employee or a family member of the employee is the victim of domestic violence or sexual assault, for medical care or counseling, the receipt of victim services, relocation or legal services, or participation in level proceedings related to or resulting from the domestic violence or sexual assault;
g. for any other purpose not listed above but identified in Section 4 of the PMLA, MCL408.964(1)(a) – (b).

2. Amount Accrued. Each full-time employee shall accrue sick leave at the rate of 3.46 hours per pay period and each minimum full-time employee shall accrue sick leave at the rate of 2.76 hours per pay period. Each employee that works a minimum of 25 hours per week on average, but less than 30 hours per week and does not otherwise qualify as a minimum full-time employee, shall accrue sick leave at the rate of 2.31 hours per pay period. Part time and casual employees who work less than 25 hours per week on average do not accrue sick leave~~Purpose & Eligibility. Sick Leave with pay is available to eligible employees for periods of temporary absences for the following reasons: (1) Sick leave may be used in the event of personal illness or injury, or a Medical/Dental appointment. (2) Sick leave may be used in the event of illness, injury of an immediate family member. Immediate family shall be defined as spouse, son, daughter, parent, brother, or sister or any person that the employee is designated as the primary caregiver in accordance with FMLA. (3) Sick leave may be used following a prolonged illness, injury or surgery, to permit an employee to work less than their regularly scheduled work hours until full recovery. (4) Sick leave may be used for purposes of bereavement for events not covered under the bereavement policy.2. Amount Accrued. Each full-time employee shall accrue sick leave at the rate of 3.46 hours per pay period and each minimum full-time employee shall accrue sick leave at the rate of 2.76 hours per pay period. Part time and casual employees do not accrue sick leave.~~

3. Start of Accrual. Employees begin to accrue sick leave from the date of employment. Earned sick leave is available for use at the beginning of the third month of employment.

4. Sick Leave and Leaves without Pay. Employees who are on a leave without pay do not accrue any additional sick leave until their return to service.

5. Notification of Supervisor. An employee requesting to use sick leave must notify their immediate supervisor as soon as possible, preferably before the scheduled start of their next workday. The immediate supervisor must also be contacted on each additional day of absence.

6. Extended Absences ~~from Work Longer than Three Days~~. An employee who is off on sick leave three or more consecutive workdays may be required by their immediate supervisor to submit a physician's verification of illness prior to returning to service. Such verification must include the reason for the absence and any job restrictions that may exist prior to returning to work.

7. Rate of Payout. Sick leave is paid at the employee's pay rate at the time of illness or injury.

8. Maximum Accrual. Employees will be allowed to accrue sick leave up to a maximum of 263 hours. Once an employee has accrued the maximum, no additional sick leave will be accrued until the employee has used sick leave to reduce their total below the maximum. Once a year in December, an employee that has accrued sick leave over 200 hours may request that their sick time over 200 hours be paid to them and/or placed in their Health Care Saving Plan (HCSP). If the employee does not request payment of their sick hours over 200 into their HCSP, then those hours will automatically be paid to them. All such payments will be made in the last payroll of the calendar year.

9. Limitation on Payment of Accrued Sick Time. Upon resignation of employment, in good standing, employees who have accrued sick leave on the date that they tender their resignation will be paid their accrued and unused hours of their sick leave up to, but not to exceed, a total of 200 hours. Payment may be made either: (1) in a lump sum, (2) in the form of a contribution to the employees MERS Health Care Savings Plan. The employee must elect one of these two options at least two-weeks prior to their last scheduled work day. The purpose of this payment is to encourage employee who intend to resign their employment to continue working through the effective date of their resignation.

In all other cases where the conditions of this policy are not met, an employee forfeits payment for sick time that has accrued, but remains unused, on the date their employment is terminated. Resignation in good standing is defined in Section 7 (G) below.

C. BEREAVEMENT LEAVE

1. Purpose & Eligibility. Bereavement Leave with pay is available to eligible employees who need immediate time off to deal with a death in the immediate family. Immediate family shall be defined as spouse, son, daughter, parent, brother, or sister. Full time and minimum full-time employees are eligible for bereavement leave. Part time and casual employees are not eligible for paid bereavement leave.

2. Amount Available. Eligible employees may utilize up to three (3) days of bereavement leave per event.

3. Requesting Bereavement Leave. Employees should request approval from their immediate supervisor for needed bereavement leave.

4. Rate of Payout. Bereavement leave is paid at the employee's rate of pay at the time of the emergency leave.

5. Use of Bereavement Leave. Bereavement leave is set up to assist employees with the death of an immediate family member. Bereavement leave cannot be carried from one calendar year to the next.

6. Upon Termination. There is no accrued bereavement leave for employees upon termination.

D. FAMILY AND MEDICAL LEAVE

Family and Medical Leave , as specified in federal law (Family and Medical Leave Act of 1993), is available to eligible employees who wish to take time off from work duties to attend to the personal circumstances as outlined in the law. A detailed policy has been approved by the Board of Health

FAMILY AND MEDICAL LEAVE POLICY

In compliance with the Family Medical Leave Act of 1993 and the Branch-Hillsdale-St. Joseph Community Health Agency Personnel Policies:

It is the Branch-Hillsdale-St. Joseph Community Health Agency's policy to grant unpaid family and medical leaves of absence to all full-time and regular part-time employees who worked 1,250 hours or more during the 12 months prior to the request for family and medical leave. You are entitled a maximum of 12 work weeks of leave during any calendar year for one or more of the following purposes:

X To care for your child after birth, adoption or placement of a child in your home for fosters care. Such leave may be taken only in the first year after the birth, adoption or placement of the child.

We shall require medical certification (or rectification on a reasonable basis) of the existence of a "serious health condition" of you or your eligible family member, which certification shall contain the date the health condition commenced, the probable duration of the condition, the appropriate medical facts within the health care providers knowledge regarding the condition. Medical Certification Forms may be obtained from Director of Human Resources.

In certain cases, the following additional information may be required in the Medical Certification:

If the leave is required because of the serious health condition of an employee's child, parent or spouse, a statement that the eligible employee is needed to care for the covered individual and the amount of time necessary for such care.

If the leave is needed because of the employee's own serious health condition, a statement that the employee is unable to perform the function of his/her position.

For an intermittent leave or a reduced leave schedule for planned medical treatment for the employee, the dates that such treatment is expected to be given and the duration of such treatment; or if not for planned treatment but for rehabilitation, a statement of the medical necessity for and duration of such intermittent leave or reduced leave schedule.

For an intermittent leave or leave on a reduced schedule for a child, spouse or parent, a statement that the employee's leave is necessary for the care of such individual or will assist in their recovery, and the expected duration and schedule of the intermittent leave or reduced leave schedule.

We may obtain a second opinion of another physician to verify the health condition certified by your physician.

In the event a conflict exists between the medical opinion of the employee's or covered family member's health care provider and that of the Company in the second opinion examination, a third examination will be required to be performed by a health care provider selected and paid for by the Company. In such instances, the opinion of the third health care provider will be final and binding on the Company and the employee.

Leave may be taken intermittently, when medically necessary, provided that if such leave is recurring, we may require you to transfer temporarily to an available position (at the same pay and benefits) which better accommodates recurring periods of leave.

As part of the leave granted under this policy, you must first use all accrued and unused vacation, sick or earned time off days during a period of family or medical leave.

If you are taking a family and medical leave because of a serious health condition, which makes you unable to perform the functions of your position; you may also be eligible for short or long term medical disability benefits. You may not elect to discontinue your family and medical leave at the time you begin receiving medical disability benefits.

All employment benefits that are calculated on an accrual basis, such as vacation, sick time or paid time off, will not accrue during a leave under this policy.

All current group medical insurance benefits will continue during periods leave under this policy, subject to continued payment of your employee premium contribution, if any, which was in effect before your leave.

Participation in pension or retirement plans will continue, subject to the terms and conditions of the plan.

An expected date of return will be determined at the beginning of the leave. If you fail to return within three (3) working days of the expected date of return, you will be considered as having voluntarily resigned employment, without further notice from the employer.

You will be required to report to your supervisor at least every four (4) weeks to report on your status and the possibility that you will be able to return to work at the end of the leave period. You must give the Director of Human Resources five (5) days' notice of the date you expect to return from such leave.

You may not accept nor seek any other employment while on such leave or your employment will be terminated.

When you are released for work by your attending physician, you may be required to make an appointment with our designated physician in order to return to work. The designated physician has the authority to delay or deny your return to work if it is determined that your ability to meet the physical requirements of your position are in question or if it is determined that your condition presents a health hazard to other employees.

X To care for a spouse, child or parent who has a serious health condition.

X To allow you to recover from or receive treatment for a serious health condition which makes you unable to perform the functions of your position.

DEFINITIONS

For purposes of this policy the following definitions apply:

Calendar Year–the employer has elected to use the "rolling year" method for determining the "12-month period" in which the 12 weeks of leave entitlement occurs. The calendar year is measured backward from the date an employee uses any FMLA leave. Each time an employee takes leave under this policy the remaining leave entitlement would be any balance of the 12 weeks, which has not been used during the immediately preceding 12 months.

Child--includes a biological, adopted, foster child, stepchild, legal ward who is under 18 or older than 18 if incapable of self-care because of a mental or physical disability.

Parent--biological parent or individual legally recognized as a parent to an employee when the employee was a child.

Serious health condition--an illness, injury, impairment, or physical or mental condition that involves inpatient care in a hospital, hospice, or residential medical care facility, or continuing treatment by a health care provider (i.e., a doctor of medicine or osteopathy who is licensed to practice medicine or surgery by the state in which he/she practices).

PROCEDURES FOR REQUESTING AND MAINTAINING LEAVE

If the leave is based upon the expected adoption or placement of a child, or for planned medical treatment of you or your child, spouse or parent, you must provide not less than thirty (30) days' notice of the time your leave is to commence.

If you need to take Family or Medical leave, you must provide us with enough information to determine whether or not you are entitled to such leave as soon as you are able, preferably, before the leave commences.

REINSTATEMENT AFTER LEAVE

Eligible employees taking leave under this policy will be reinstated to their former position, or to an equivalent position, with equivalent benefits and other terms and

conditions of employment. However, no employee is entitled under this policy to any right, benefit, or position other than that to which the employee would have been entitled had he/she not taken leave. Thus, for example, if a layoff or some other extenuating circumstances or business condition arises which affects the employee's position, reinstatement may not be possible. Additionally, employees on a leave extension are not guaranteed reinstatement.

The Branch-Hillsdale-St. Joseph Community Health Agency also reserves the right, however, to deny leave reinstatement to "key employees," where such denial is necessary to prevent substantial economic injury to the Agency's operations. Key employees will be notified of the Agency's intention as soon as a determination is made. In the event such notice is given to a key employee already on leave, the employee will be offered the opportunity to terminate his/her leave and immediately return to work. Key employees notified while on leave, who decide not to return to work, will remain on leave. Key employees are defined as the highest paid 10 percent of the employees employed by the Agency, within 75 miles of the facility at which the employee is employed.

E. EDUCATIONAL LEAVE

1. Purpose & Eligibility. Educational Leave without pay is available to eligible employees who wish to take time off from work duties to pursue professional educational goals. The department head determines eligibility for educational leave with concurrence from the Health Officer.

2. Amount Received. Eligible employees may request educational leave for a defined period of length. Requests will be evaluated based on a number of factors, including department operational needs and staffing requirements.

3. Requesting an Educational Leave. Employees must request an educational leave from their immediate supervisor. Each request for educational leave must be in writing.

4. Rate of Payout. Educational leave will be unpaid unless the employee has accrued vacation leave to utilize.

5. Suspension of Benefits. All paid leave benefits: vacation leave and sick leave will be suspended during the unpaid educational leave. Health insurance benefits may continue during the unpaid educational leave. If an employee is taking unpaid leave, the employee is responsible for the entire cost of the Health Insurance premium. This rate will be figured on a daily basis of the monthly premium.

F. MILITARY LEAVE

1. Purpose & Eligibility. Military Leave without pay is granted to employees who are absent from work because of short term and long-term service in U.S. uniformed services in accordance with the Uniformed Services Employment and Reemployment Rights Act (USERRA) and applicable state laws.

2. Amount Received. Employees may request up to ten (10) days per calendar year for use as short term military leave. Employees may request an indefinite period of time for use as long term military leave.

3. Requesting Military Leave. Employee must give advance notice to their immediate supervisor, unless military necessity prevents such notice or it is otherwise impossible or unreasonable.

4. Rate of Payout. Military Leave will be unpaid unless the employee has accrued vacation leave time to utilize.

5. Continuation of Benefits. Continuation of health insurance is available as required by USERRA based on the length of the leave and subject to the terms, conditions and limitations of the health insurance plan for which the employee is eligible.

6. Termination of Benefits. The military leave and the right to restoration of his/her former position shall automatically terminate if the employee voluntarily remains in the military service beyond the requirement of minimum service.

G. LIFE ENRICHMENT LEAVE

1. Purpose & Eligibility. Life Enrichment Leave without pay is available to employees wishing to take time off from work duties to pursue personal enrichment activities. Full time and minimum full-time employees are eligible for sabbatical leave. Part time and casual employees are not eligible for sabbatical leave.

2. Amount Received. Eligible employees may request to take up to two months of life enrichment leave each calendar year. Requests will be evaluated based in a number of factors, including department operational needs and staffing requirements.

3. Requesting Life Enrichment Leave. Employees must request life enrichment leave from their immediate supervisor. Each request for life enrichment leave shall be in writing.

4. Rate of Payout: Life enrichment leave will be unpaid unless the employee has accrued vacation leave time to utilize.

5. Suspension of Benefits: All paid leave benefits: vacation and sick leave will be suspended during the unpaid life enrichment leave. Employees will be responsible for the cost of health insurance benefits.

SECTION 6: HOLIDAY POLICY

HOLIDAY PAY

1. Purpose & Eligibility. The agency has designated 11 days for observance of holidays. These holidays are granted with pay for eligible employees. Full time employees are eligible for holiday pay at a rate of 7.5 hours per holiday. Minimum full time employees are eligible for holiday pay only if the holiday falls on a day that they are scheduled to work. Part time & casual employees are not eligible for holiday pay.

2. Designated Holidays. The following days are designated as holidays:

New Year's Day
Martin Luther King, Jr. Day
President's Day
Memorial Day

Independence Day
Labor Day
Thanksgiving
Day after Thanksgiving
Christmas Eve Day
Christmas Day
New Year's Eve Day

3. Scheduling. In the event Christmas Eve, Christmas Day, New Year's Eve Day, New Year's Day and/or Independence Day fall on Sunday the following Monday is recognized as an agency holiday. If an aforementioned holiday falls on Saturday, the preceding Friday is recognized as an agency holiday.

4. Rate of Payout. Holiday days will be paid out at the employee's pay rate at the time of the holiday.

5. Compensation for a Holiday Worked: Employees required to work during an agency designated holiday shall be compensated at one and one-half times the current rate of pay for the time worked in accordance with the additional time policy. Eligible employees will also receive holiday pay. Employees must receive prior approval from their division director before working on a holiday.

SECTION 7: TERMINATION PROCEDURES

A. RESIGNATION

Resignation is a voluntary act initiated by the employee to discontinue employment with the agency. All employees should give at least ten (10) working days but where possible twenty (20) working days written notice of their intention to terminate employment with the agency. All employees that are ending their employment with this Agency must inform the Administration division so that all necessary paper work can be completed prior to their resignation.

B. DISCHARGE

Discharge is a non-voluntary act initiated by the employer to discontinue the employment of the employee with the agency. Any employee may be discharged by the immediate supervisor, provided notification is given to the Health Officer and provided the steps of progressive discipline have been followed.

C. LAYOFF

Layoff is a non-voluntary act initiated by the employer to discontinue the employment of the employee with the agency for non-disciplinary reasons. Employees may be laid off for the lack of sufficient work or funds. Employees shall be laid off and recalled according to seniority within their service division. Employees on layoff may bump into a position for which they are qualified and trained that is held by a person with less seniority within their service division.

Employees who are notified of a layoff may appeal the decision of layoff utilizing the Grievance Procedure outlined in Section 8 of this manual.

D. FURLOUGH DAYS

As a result of unforeseen or unplanned budgetary deficiencies, the Health Officer may order that furlough days be taken by employees. An employee required to take a furlough day does not report to work that day and does not receive any payment for that day. When an employee is taking a required furlough day they will accrue the same benefits and seniority as when they are on a paid leave. The employee will not be able to use sick leave when taking a required furlough day.

E. JOB ELIMINATION

Job elimination is a management action taken to address a chronic and seeming permanent situation of lack of sufficient work or funds. Employees whose jobs are eliminated are not entitled to bumping rights. Employees who are notified of a job elimination may appeal the decision of job elimination utilizing the Grievance Procedure outlined in Section 8 of this manual.

F. RETURN OF AGENCY PROPERTY

Employees are responsible for all agency property and materials issued to them or in their possession or control. Employees must return all agency property and materials immediately upon request or termination. Where permitted by applicable laws, the agency may withhold from the employee's check or final paycheck the cost of any items that are not returned when required.

G. RESIGNATION IN GOOD STANDING

To resign in good standing an employee must meet all of the conditions listed below:

(1) Meet with their immediate supervisor and agree to a written plan, acceptable to the Agency for transitional staffing of their position.

(2) Submit a letter of resignation in accordance with "A" above

(3) Be eligible for re-hire, or retirement, and have no pending or unresolved disciplinary or grievance issues.

SECTION 8: PROGRESSIVE DISCIPLINE, AND GRIEVANCE AND APPEAL PROCEDURES

A. PROBLEM RESOLUTION STATEMENT

The Branch-Hillsdale-St. Joseph Board of Health is committed to providing the best possible working conditions for its employees. Part of this commitment is encouraging an open and frank atmosphere in which any work-related problem, complaint, suggestion, or question receives a timely response from management.

Not every problem, complaint, suggestion, or question can be addressed to everyone's total satisfaction, but through understanding and discussion, employees and management can develop confidence and trust in each other.

A pre-disciplinary meeting may be used when the Administrative Services Director has been made aware of a situation, action or behavior of an employee that could result in disciplinary action against an employee. The immediate supervisor shall notify the Administrative Services Director as soon as possible when they become aware of a situation that may result in disciplinary action against an employee. The Administrative Services Director shall request, in writing, and within five (5) days of the alleged situation, that a pre-disciplinary meeting be scheduled with the immediate supervisor and employee. Within the request, the Administrative Service Director shall

schedule the date, time, and location of the meeting and state the nature of the allegation(s). The employee may bring a personal representative to the meeting. The Administrative Services Director will act as the mediator of the meeting. If the situation is not resolved, the supervisor will continue with the steps listed in the next section (Progressive Discipline). In the event the Administrative Services Director is also the Supervisor; the Health Officer will appoint another director as mediator.

Where appropriate, the following progressive discipline policy and grievance and appeal procedures are superseded by applicable state laws and rules as further outlined in B(4).

B. PROGESSIVE DISCIPLINE

1. Purpose. The purpose of this policy is to promote the equitable and consistent administration of discipline for unsatisfactory work performance and behavior in the workplace.

2. Types of Disciplinary Action. Disciplinary action may call for any five steps – oral reprimand, written warning, suspension without pay, demotion or dismissal. Disciplinary action taken will be dependent on the severity of the problem and the number of occurrences.

Oral Reprimand – This is an action taken by the immediate supervisor in which he/she tells an employee about an action or behavior of the employee which he/she as the immediate supervisor find objectionable and/or wishes corrected. This action must be done in a private setting. The Oral Reprimand is an informal action only for the employee's benefit and is not relevant to Group I, II, or III Offenses as defined below.

Written Warning – This is an action taken by the immediate supervisor in which the supervisor writes out the action or behavior which the supervisor wishes the employee to change, cease, or begin. The written warning must describe in detail the behavior to be corrected, and must give direct and concrete orders for the future, and must point out the consequences of non-compliance with the Written Warning.

Suspension Without Pay – This is an action taken by the immediate supervisor which removes the employee from the workplace and payroll for a definite period of time. The reason(s) for the suspension must be in writing. The employee does not accrue salary, vacation or sick leave credit during the time of suspension, nor can the employee use such leave time while on suspension. At the end of suspension, the employee returns to the same salary and benefit conditions that existed prior to the suspension.

Demotion – This is an action taken by the immediate supervisor which reduces an employee's classification to a classification with a lower minimum salary. The reason(s) for the demotion must be in writing. The employee's salary must be reduced to fall within the range of the new, lower classification, but no lower annual step designation than the one held in the higher classification. The employee's job duties and responsibilities must be reduced to those of the new, lower classification.

Dismissal – This is an action taken by the immediate supervisor which permanently removes an employee from agency employment. The reason(s) for the dismissal must be in writing. Dismissed employees shall leave the premises at the time of dismissal and will be reimbursed for time remaining in the day. Dismissed employees shall be paid for all unused vacation leave that has been earned through the last day of work through a lump sum pay off. Dismissed employees shall not be entitled to any form of 'severance pay'.

3. Group Offenses. Examples of behavior that would be cause for disciplinary action are provided below. These examples are divided into three groups of offenses. Guidelines for administering discipline are set forth within each of these groups and the immediate supervisor shall follow these guidelines when dealing with the types of behavior described.

GROUP I OFFENSES include,

- Habitual tardiness at the beginning of a work day or after lunch (Habitual shall be interpreted to mean two instances in one month without sufficient reason, as determined by the immediate supervisor.)
- Absenteeism without sufficient reason or proper notification
- Disregard of safety rules or common safety practices
- Abuse of break time
- Use of profanity or obscene language in the presence of fellow employees or the public
- Quarreling with fellow staff members on the premises.
- Inefficient use of work time
- Any other offenses of like consequences

The disciplinary procedure in this group shall be: 1st offense, written warning; 2nd offense, one-day suspension without pay, 3rd offense, three-day suspension without pay; 4th offense, seven-day suspension without pay, 5th offense, dismissal. The violations shall be cumulative for a period of not more than one year.

GROUP II OFFENSES, include

- Injurious or dangerous pranks
- Physical fighting on the premises
- Faulty work and/or covering up faulty work
- Making or publishing of false and vicious and/or malicious statements concerning a fellow employee
- Abuse of the public, either verbal or physical
- Sexual harassment
- Willful disobedience to the proper directive of a supervisor, or other acts of insubordination
- Consumption of any alcoholic beverages during work hours
- Any other offenses of like consequences

The disciplinary procedure in this group shall be: 1st offense, three-day suspension without pay, 2nd offense, seven-day suspension without pay, 3rd offense, dismissal. The violations shall be cumulative for a period of not more than two years.

GROUP III OFFENSES, include

- The misuse or removal from the premises, without prior authorization, of any agency records, confidential information, or of any agency property, except as necessary in the performance of the employee's job duties and responsibilities
- Theft of any property belonging to a fellow employee, a customer, or the agency

- Knowingly falsifying any time slip or other payment voucher, or intentionally giving false information to anyone whose duty it is to make such records
- Absence of three consecutive work days without notice and without justifiable reason for the failure to report
- Using delegated job responsibilities in an unlawful manner to gain unfair advantage against a fellow employee or the public
- Any other offenses of like consequences.

The disciplinary procedure in this group shall be up to and including immediate dismissal.

4. Exceptions for Severity. There are certain types of employment problems that are serious enough to justify either a three-day suspension, or, in extreme situations, dismissal from employment, without going through the normal progressive discipline steps.

5. Suspension with Pay. It may be necessary to separate an employee from the workplace while an investigation of an allegation against the employee is taking place. At such times, the employee will be placed on suspension with pay pending the investigation. The employee will retain all other fringe benefits during this time.

C. GRIEVANCE AND APPEAL PROCEDURES

1. Purpose. The purpose of this procedure is to provide a method for complaints to be voiced in an orderly manner such that the proper authorities can resolve such matters fairly and in a timely manner.

   This procedure outlines for employees and management the proper steps involved when employees believe that there has been:

   Alleged violations or misinterpretation of agency policies but not limited to such matters as conditions of employment, promotion, demotions, dismissals, and layoffs, and a claim of discipline without just cause; and

   Alleged discrimination due to political opinion or affiliation, religious opinion or affiliation, gender, race, color, national origin, age, or physical disability.

2. Content of the Grievance. The content of the grievance shall include the following:

   - Who is the grievant?
   - What specific event occurred?
   - When did it happen?
   - Where did it happen?
   - What sections(s) of the Personnel Policies have allegedly been violated?
   - What adjustments or corrections are requested for each alleged violation?

3. Representation. The grievant may elect to have one representative of their choice at any step in the grievance and appeal procedure. The name of the representative attending the grievance or appeal proceeding shall be submitted to the agency's Administrative Services Director at least two (2) working days prior to the hearing date. The grievant and one representative, if that representative is a fellow employee, shall be granted the necessary and reasonable absence

from work for the scheduled proceeding under this procedure without loss of pay or leave credits.

4. Steps of a Grievance. All grievances and appeals shall be initiated and processed in the following manner:

   Step 1. Employee presents the issue in writing to their immediate supervisor within ten (10) workdays after the occurrence of the alleged incident. The immediate supervisor shall respond in writing, to the employee within five (5) workdays of the initial written presentation of the issue.

   Step 2. If the grievance cannot be resolved in Step 1, the employee has the option of submitting a written appeal to the Health Officer within five (5) workdays of receiving written notification from their immediate supervisor. The Health Officer shall confer orally with the employee within five (5) days of receiving the written appeal. The Health Officer shall respond back in writing within ten (10) workdays of receiving the written appeal.

   Step 3. If the grievance cannot be resolved in Step 2, the employee has the option of submitting the written grievance to the Board of Health within five (5) workdays of receiving the Health Officer's written response. The Board of Health's Program, Policy and Appeals Committee shall schedule a hearing with the employee at their next regularly scheduled meeting in order to review the grievance. The Program, Policy and Appeals Committee shall respond back in writing within five (5) days of hearing the grievance.

5. Time Limitations. Time for this grievance and appeal procedure shall be computed in terms of workdays, which are defined as Monday through Friday, excluding holidays. In the absence of a timely appeal by a grievant, the last decision at any step of the procedure becomes final. In the absence of a timely answer by any level of management, the grievant may appeal to the next step of the procedure within ten (10) workdays from the expiration of management's time for a decision. Time limits may be extended by mutual agreement in writing. Late appeals at any step may be filed upon showing a good cause for the delay.

6. Appeal Hearing Procedure. The appeal hearing is conducted so that the Board of Health's Program, Policy, and Appeals Committee can review pertinent facts and documents. Some guiding principles apply to the appeal hearing, including:

   - Prior to the appeal hearing, the entire appeal file shall be made available to the Committee and the grievant. The appeal file shall include the initial written grievance and all subsequent management written decisions.
   - Attendance at an appeal hearing is limited to persons determined by the Committee to have a direct connection with the grievance. When requested by the grievant, and the Committee does not object, the hearing may be open to the public.
   - As far as it is operationally possible, the agency must make its employees available as witnesses when requested.
   - The order in which the parties are heard is at the discretion of the Committee.
   - Testimony shall be under oath or by affirmation; both the grievant and their representatives shall be given the opportunity to cross-examine all witnesses who appear to testify.
   - A written record of the hearing shall be kept.

- Each member of the Committee shall have an equal vote. Decision shall be by majority vote.

7. Freedom from Reprisal. This procedure shall be available to employees and their representatives without restraint, interference, coercion, discrimination or reprisal. No employee of the agency, whether acting in an official capacity for the agency or any other basis, shall interfere with another employee's exercise of their rights under this procedure. No employee of the agency, whether acting in an official capacity employee or any other basis, shall take or threaten to take, any act of reprisal against another staff member because they have exercised, or expressed an intention to exercise any of these rights under this procedure.

8. Group Grievances. Employees having a common complaint may file a group grievance. The grievance shall be filed at the lowest step of the procedure involving a common level of supervision. Employees must choose one spokesperson and one representative of their choice.

9. Appeal by External Applicant for Employment. An external applicant for employment who is not selected may appeal the selection decision if they believe they were discriminated against because of political opinion or affiliation, religious opinion or affiliation, gender, race, color, national origin, age, or physical disability.

   Such appeals shall be made in writing and directed to the health officer within fifteen (15) workdays following notification of non-selection. The health officer shall render a written decision within five (5) workdays of receiving an appeal. If the applicant is not satisfied with the written decision of the health officer, he/she may make a written appeal to the Board of Health's Program, Policy, and Appeals Committee. All appeal-hearing procedures outlined previously would then apply.

Section 8: Emergency-Weather-Disaster Policies

A. Bad Weather Policy

The Branch-Hillsdale-St. Joseph Community Health Agency offices shall remain open to provide services to consumers unless one of the following occurs:

1. It is announced on the Coldwater, Hillsdale, Sturgis, or Three Rivers local radio station that an office is closed. This should occur by 7:30 A.M.
2. The immediate supervisor informs employees that the local agency office is closed for the day due to weather.

The Administrative Services Director is responsible for conferring with the Health Officer prior to 7 a.m. to determine whether an office shall be closed. When a determination is made to close an office, the Health Officer and Administrative Services Director utilize the Emergency Call List to notify staff of the decision. In the event an agency office is closed due to the weather, ~~all scheduled~~ staff will be compensated at their normal pay rate unless they have already been granted approved leave time, either calling in sick or approved vacation time. Staff that have approved time off will be required to utilize their paid time off.

If an agency office is open, employees who are unable to report due to weather conditions may use annual vacation ~~or personal time~~ to be compensated. Employees must inform their immediate supervisor that they are unable to report due to weather conditions as soon as possible. Scheduled staff members are expected to use common sense and good judgment in determining their ability to report to work in bad weather.

B. Bomb Threat Procedure

When a bomb threat call comes in, the person receiving the call should remain calm and should cause no undue alarm.
The person receiving the call should do the following:
1. Write down the time the call was received and make notations, if possible, while still listening carefully.
2. If another person is available, notify them by passing a note that you have a bomb threat on the phone.
   The second person should then do the following:
   a. Notify local law enforcement authorities by calling 911.
   b. Notify the person in charge:
      Health Officer, Administrative Services Director, or immediate supervisor
3. Keep the caller talking as long as possible. Do not hang up on the caller.
4. Try to find out where the bomb is supposed to be located. Try to pinpoint the area and time it is set to go off.
5. Try to find out something about the bomb, (size, type of explosives).
6. Record the time that the caller hangs up.
7. Try to write down or communicate as many specifics and facts that you can immediately after the call.
8. If you are alone when the call is received, follow the procedure outlined in 2 above as soon as possible after the caller hangs up. If evacuation becomes necessary, this will be a joint decision of the Health Officer, Administrative Services Director, and other Administrative staff present.

C. Dr. Strong Policy

Any employee who feels that he/she is being threatened or is in harm's way shall page on the overhead paging system: Example: "Dr. Strong to Environmental Health" Employees hearing this page should immediately pick up the phone and dial 911. Employees hearing this page should **not** report to that specific location.

D. Emergency Contact List Procedures

In the event of an emergency or bio-terrorism event the contact tree is in place so that each director and supervisor know who they are in charge of contacting. Contacts may be made by voice or text. Documentation of contacts is made on the Emergency Contact List Documentation Log by the supervisor and forwarded to the Administrative Services Director. The log sheets are filed by the Emergency Preparedness Coordinator. Instructions will be given and employees are to follow them in the case of any emergency situation.

E. Fire Alarm Emergency Plan

When the fire alarm is activated by pulling the fire alarm box everyone will leave the building and go at least 100 feet from the building. ~~Handicapped persons~~ People with disabilities will be assisted by staff. If there is an elevator located in the office, no one will be authorized to use it.

The clinic personnel will be responsible for seeing that all clients have left the clinic.
No one will re-enter the building until they are notified to enter. All cars parked near the entrance should be moved as soon as possible.

F. .**Lock Down Policy**

The Branch-Hillsdale-St. Joseph Community Health Agency takes the safety and security of our staff and clients very seriously. Circumstances may present themselves whereby the Agency must secure its doors and verify the identity of all those who enter. These circumstances may be related to incidents that happen within the Agency or possibly influenced by incidents (such as a prison escape) from outside the Agency. As it is our aim to serve our clients whenever possible we have developed a series of policies that will detail the Agency's actions during such emergencies

Lock Down Initiation

The decision to lock down a clinic or building will rest with the Health Officer or any other management level staff person. Any employee who notices an incident or is aware of a threat to another employee or client shall immediately make that information available to one of the above persons. Appropriate action will be taken and the doors to the building will be secured with staff posted to monitor the doors. If the decision is made by the Clinic Coordinator it shall be reported as soon as possible to the Health Officer or Administrative Services Director. These actions will be in effect until such time as the Health Officer or Administrative Services Director shall determine they are no longer appropriate. Circumstances that may initiate a lock down may consist of:

- Domestic violence threat to a client or staff member
- Workplace violence issue or threat
- Civil unrest within the community including protests and picketing of the Agency
- Prison or Jail escapes (mainly Coldwater or Hillsdale)

Lock Down Procedure (during business hours)

1. Deal immediately with whatever issue has prompted the lock down and call the appropriate authorities as necessary.
2. The staff member directing the lock down should remain calm as to dissuade panic among the staff or clients
3. Secure all entry points into the buildings.
4. Staff and clients may be moved to an interior or more secure area of the building should the situation require it
5. Post a staff member to monitor the entry points even if these points are not to be used to gain entry into the Agency
6. All entry points to the Agency will be posted with a sign directing inquiries to a single entry point these signs will be available in the mail room of each office.
7. If client service can continue, that person monitoring the designated entry point shall verify the identification and purpose of the person seeking admittance prior to their gaining entry.
8. If we are unable to continue client service a sign shall be posted at all entry points indicating that the Agency is closed and will re-open as soon as possible; we apologize for any inconvenience; please direct them to call the Agency phone number or consult our web site for further information.
9. Regardless of which service state we are in Public Safety personnel will be admitted.

After Business Hours Lock Down

Our Agency is normally secured during our non-service hours; however, circumstances may present themselves which necessitate the Health Officer or Administrative Services Director to designate the building "locked down" until further notice. The normal procedure will be to initiate use of the

Emergency Call List process as soon as practical. In the event that staff are already en route to work or did not receive their call they may find that one of the above lock down conditions exists. Either the Health Officer or Administrative Services Director (or their designee – possibly Public Safety) should already be present and will direct the staff accordingly. It is important that staff maintain their Agency identification badge with them at all times so that they may be positively identified by whoever may be monitoring the entrance. If admitted to the building staff will be directed to a conference room where a briefing will take place to advise them of the situation

G. .**Master Disaster Checklist -** Approved 1/31/07

Notification

- Receive notification of situation from HAN; Phone; or other
- If you have interagency call list responsibilities – call those on your list and report back to your designated person as to the success of those calls
- Advise family members of situation and make any arrangements necessary to cover the time you may be absent
- Advise family members of the Family Emergency Contact number which is 517-279-9561 pick option #7 (this extension will be manned by an employee or a recorded message will be available advising the family member where to go for further information) **Remember:** This number is for Health Department staff and families only, do not disseminate this to the general public.
- Report for assignment to your designated location

Assignment

- Report to the Incident Commander or their designee to sign in for duty
- Receive assignment and Job Action Guidelines for that assignment
- Receive the appropriate Identification badge, vest, or other such to designate your duty or position
- Read and understand the guidelines; ask any questions prior to reporting to your station
- Upon arrival at your station identify yourself to your supervisor; any further questions regarding your assignment may be answered at this time; be sure to understand the chain of command structure related to your assignment
- Upon reporting to your station, inventory and assess the condition of any equipment you will be responsible for operating, maintaining, or using during the incident – If you require further equipment or items are missing from inventory report this immediately to your supervisor for re-stocking or re-supply.

H. Office Closure Procedure

In the event of circumstances that shall warrant closure of any Agency office(s), the employees assigned to that office will be notified. All other agency offices shall be notified of the situation as well.

I. Robbery Policy

When a robbery threat is evident, remain calm and do the following:

1. If another staff person is nearby, notify them by the "code" established within the agency that an emergency is happening and they should immediately contact 911 and the immediate supervisor within the building.
2. Follow the instructions of the robber and do not try to intervene. Give them whatever they demand.
3. Stay calm, and listen carefully and try to remember everything about the individual for future use.

J. Tornado Emergency Plan

In the event of a Tornado Warning the entire staff will evacuate to the inner corridor or the restrooms. Avoiding the West and South walls. All persons will remain there until the warning is over. ~~Handicappers~~ People with disabilities will be assisted by assigned staff. The Clinic Clerk/Manager or EH Clerk/Manager will collect the sign-in/sign-out log and bring it to the evacuation location.

In the event of a Tornado Watch the radio will be monitored and regular routine will be maintained until a warning is issued. We have an alert system with the Sheriff's Department to notify of a warning.

The sign-in/sign-out sheet will be evaluated to determine which staff are out working in the field. These staff will be called to inform them of the Warning.

A Tornado drill will be held once a year on a randomly selected day and time

K. Utility Shut Off Procedures

Any employee who is notified that any utility in the area is going to shut down their services at any time of the work day at the Agency, must contact the Administrative Services Director so that a judgment of necessity will be taken into consideration before the shutdown occurs. We do not want services interrupted if it is not necessary and the utility company cannot fix the problem after Agency hours.

L. Burglary or Vandalism to the Agency

It is possible that an early arriving employee shall discover that a window is broken, door ajar, or other condition which may mean that building has been entered or is unsecured. This staff member shall report this immediately to 9-1-1 for action by Public Safety officials. Under no circumstances should a staff member or client be allowed to enter the building until it is cleared and secured by Public Safety officials.

If this condition is found after entering the building the staff member should immediately exit the building and call 9-1-1. The staff member should then notify the Health Officer or Administrative Services Director. Until the building has been cleared by Public Safety no staff or client should be allowed to enter.

Section 9: Information Technology Policies

A. Electronic Mail Policy

The purpose of this policy is to assure that the Branch-Hillsdale-St. Joseph Community Health Agency electronic mail (E-Mail) users are aware of the Agency's policies and laws concerning E-Mail services and that these services are used in compliance with these policies and laws.

Any e-mail address or account associated with the Branch-Hillsdale-St. Joseph Community Health Agency or assigned by the Agency to individuals, is the property of the Branch-Hillsdale-St. Joseph Community Health Agency. As property of the Agency, E-mail accounts can and will be monitored for content by the IT staff. Individuals that use the Agency's E-mail systems are expected to do so

responsibly. (i.e. To comply with the state and federal laws and other policies and procedures of the Agency.)

Access to E-mail services, when provided, is a privilege that may be wholly or partially restricted by the Agency when there is substantial reason to believe that violations of policy or law have taken place.

Use of free e-mail services including, but not limited to the following is strictly prohibited while using the Agency's property: Hot mail, Excite mail, Bigfoot mail.

No staff member shall use E-mail for the personal amusement if it (1) directly or indirectly interferes with the Agency's operation of computing facilities or electronic mail services; (2) burdens the Agency with incremental cost, or (3) interferes with the individual's employment or other obligations to the Agency. Furthermore, no employee shall use the Agency's E-mail systems or services for the purpose of transmitting copyright infringement, libel, fraudulent, defamatory, harassing, obscene, or threatening messages, or any other communications that are prohibited by law.

No staff member shall use e-mail to (1) disclose confidential information, (2) promote personal political beliefs, (3) promote personal business interests, (4) promote discrimination, (5) promote sexual harassment, (6) view or download obscenities, (7) or any other communication prohibited by law.

Since E-mail is not a totally secure medium, employees should consider E-mail as an inappropriate vehicle for the transmission of extremely personal and/or confidential medical records.

Failure to comply with this policy may result in suspension of e-mail privileges and/or commencement of disciplinary actions against the employee.

B. Computer Usage Policy

Legal Use of Computer Systems

These guidelines apply to all users of computing resources and computing equipment owned, leased or rented by the Branch-Hillsdale-St. Joseph Community Health Agency (hereinafter BHSJCHA). Computing equipment includes, but is not limited to, modems, printers, microcomputers, fileservers, and networking equipment used to link these components and to the Internet. The user is responsible for the content of any material the user prepares, receives or transmits. It is the user's responsibility to make sure they comply with all Local, State, Federal and International laws governing computer usage, including but not limited to, the following:

- Destruction or damage to equipment, software, or data belonging to BHSJCHA
- Harassment of others
- Unauthorized copying of copyright-protected material

Ethical Use of Computer Systems

Computing resources should be used in accordance with the ethical standards of the BHSJCHA. Examples of unacceptable use (some of which may also have legal consequences) include, but are not limited to, the following:

- Violation of computer system security, including but not limited to: Use of computer accounts, access codes, or network identification numbers not assigned to you
- Use of computing facilities for private business purposes unrelated to the mission of the BHSJCHA.
- Screen savers/desktop wallpaper that does not reflect the mission and ethics of the BHSJCHA.
- Violation of software license agreements (Installation of any software that is not owned by the BHSJCHA, including files downloaded from the internet or brought from the users home.)

Cooperative Use of Computer Systems

Day to day operation of BHSJCHA demands the practice of cooperative computing. It includes, but not limited to, the following examples:

- Regular deletion of unneeded files from one's accounts on shared computing resources
- Refraining from unnecessary connect time, information storage space, printing facilities or processing capacity
- Refraining from use of sounds and visuals which might be disruptive to others
- Refraining from unauthorized use of departmental or individual computing resources

Sanctions

Violators of the computer usage policy will be subject to the normal disciplinary procedures of the BHSJCHA. Violations of the policies described above for legal and ethical use of computing resources will be dealt with in a serious and appropriate manner. Illegal acts involving BHSJCHA computing resources may also be subject to prosecution by local, state, and/or federal authorities.

C. **Internet Policy**

The purpose of this policy is to assure that the Branch-Hillsdale-St. Joseph Community Health Agency (hereinafter BHSJCHA) internet users are aware of the BHSJCHA's policies and laws concerning internet services and to ensure that this access does not impair network security or result in inappropriate use.

The BHSJCHA's internal network is connected to the Internet and utilizes the same data lines we use for our CMHC system. While the Internet is a great resource for our organization, it is the responsibility of each employee to use this resource responsibly and respectfully. Since use of the Internet will slow down the entire network including CMHC, no staff member shall use the Internet for personal amusement.

Access to internet services, when provided, is a privilege that may be wholly or partially restricted by the BHSJCHA when there is substantial reason to believe that violations of policy or law have taken place.

It is against federal law and the BHSJCHA's policy to violate the copyrights or patents of others on or through the Internet. Staff may not download or use copyrighted material without obtaining written authorization.

No file should be downloaded from the Internet without permission. Such files may contain viruses that could infect one PC or the entire network. Please check with the MIS department if you need any software or files from the Internet.

Every connection made on the Internet can be traced back to the originator, leaving a trail or log easily tracked by others. The MIS staff can and will be monitoring these logs. Do not use the Internet for tasks that you would not want logged. Internet access is provided for business purposes only.

No staff member shall use the internet to (1) disclose confidential information, (2) promote personal political beliefs, (3) promote personal business interests, (4) promote discrimination, (5) promote sexual harassment, (6) view or download obscenities, (7) or any other communication prohibited by law.

The truth or accuracy of information on the Internet should be considered suspect unless it is from an official government site. Make sure you confirm information from the Internet from a separate and reliable source.

Failure to comply with this policy may result in suspension of Internet privileges and/or commencement of disciplinary actions against the employee.

Section 10: Information Requests-HIPAA-Confidentiality

A. **Freedom Of Information Request Procedure**

Any employee or department who receives a letter requesting information on medical records or environmental issues, must forward this request on to the Administrative Services Director who in turns okays the information to be given out or denied to that particular client. A copy is given back to the employee and one copy kept in central file for future referencing.

B. Medical Release Procedure

Any questions regarding who a Medical Release form goes to, should always be directed to the Administrative Services Director. He/she will then send it on to have copies made and sent to the proper place and a copy of the release form will be made and put in to the clients file for future reference.

Level 1 Disciplinary Sanctions shall be administered in a progressive manner. Disciplinary sanctions shall be reported to the applicable professional licensing board as appropriate.

Level 2 Curiosity or Concern (no personal gain) - This level of violation occurs when an employee intentionally accesses or discusses patient information for purposes other than the care of the patient or other authorized purposes but for reasons unrelated to personal gain. Examples include, but are not limited to: an employee looks up birth dates, address of friends or relatives; an employee accesses and reviews a record of a patient out of concern or curiosity; an employee reviews a public personality's record.

Disciplinary Sanctions:

First offense: Depending upon the facts, oral or written warning documented and maintained in the employee's personnel record.

Second offense: Depending upon the facts, a final written warning and suspension for 3-30 days without pay, documented and maintained in the employee's personnel record, or termination.

Third Offense: Termination

Except in the case of termination, the employee shall be required to review the Confidentiality Policy and sign a new Confidentiality Agreement. Disciplinary sanctions shall be reported to the applicable professional licensing board as appropriate.

Level 3: Personal Gain or Malice—This level of violation occurs when an employee accesses, reviews or discusses patient information for personal gain or with malicious intent. Examples include but are not limited to: an employee reviews a patient record to use information in a personal relationship; an employee compiles a mailing list for personal use or to be sold.

Disciplinary Sanctions: Termination. Report to applicable professional licensing board. Reporting and filing requirements:

For all levels of violation, all written documentation relating to the violation and subsequent actions will be kept on file in appropriate administrative files for no less than six years after the date of the final resolution of the violation, or for a period of time specified by our practices document retention policies or applicable state or federal laws, whichever is longer. The disciplinary action and appropriate documentation shall also be placed in the employee's personnel file.

Mitigation:

Our practice is required to mitigate to the extent practicable, any harmful effect that is known by our practice of a use or disclosure of Protected Health Information that is in violation of its policies and procedures or the requirements of HIPAA or its business associate.

Refraining from Intimidating or Retaliatory Acts

Our practice may not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any individual for the exercise of any right under granted under HIPAA, or for participation by the individual in any process established by HIPAA this includes:

Any individual or other person for:

Filing of a complaint with the Secretary;

Testifying, assisting, or participating in an investigation, compliance review, proceeding, or hearing; or

Opposing any act or practice made unlawful by HIPAA, provided the individual or person has a good faith belief that the practice opposed is unlawful, and the manner of the opposition is reasonable and does not involve a disclosure of Protected Health Information in violation of HIPAA.

Disclosures by Whistleblowers and Workforce Member Crime Victims

Disclosures by Whistleblowers: A covered entity is not considered to be violation of the HIPAA requirements if a member of your workforce or a business associate discloses Protected Health Information, provided that:The workforce member or business associate who believes in good faith that your practice has engaged in conduct that is unlawful or otherwise violates professional or clinical standards, or that the care, services, or conditions provided potentially endangers one or more patients, workers, or the public; and

The disclosure is to:

I. A health oversight agency or public health authority authorized by law to investigate or otherwise oversee the relevant conduct or conditions of a practice or to an appropriate health care accreditation organization for the purpose of reporting the allegation of failure to meet professional standards or misconduct by the covered entity; or

II. An attorney retained by or on behalf of the workforce member or business associate for the purpose of determining the legal options of the workforce member or business associate with regard to the conduct that is unlawful or violates professional or clinical standards, or that the core services or conditions provided by your entity potentially endangers one or more patients, workers, or the public.

Disclosures by workforce members who are victims of a crime:

A covered entity is not considered to be a violation of HIPAA if a member of your workforce who is the victim of a criminal act discloses Protected Health Information to a law enforcement official, provided:

A. The Protected Health Information disclosed is about the suspected perpetrator of the criminal act; and

B. The individual agrees to the disclosure The Protected Health Information disclosed is limited to the Following Information:

Name and Address

Date and place of birth

Social Security Number

ABO Blood types and rh factor

Type of Injury

Date and time of treatment

Date and time of death, if applicable

Description of distinguishing characteristics, including height

weight, gender, race,

Hair and eye color, presence or absence of facial hair, scars

And tattoos.

C. **Subpoena Procedure**

Any subpoenas sent to any employee of the Agency must present this to the Administrative Services Director so that he/she may go over them and make sure that all rules are followed in complying with the subpoena. They will be in turn given back to the employee and a copy kept in central file for future referencing.

D. **Sanctions for Violations of Confidentiality**

POLICY:

Our practice must have and apply appropriate sanctions against members of the workforce who fail to comply with the appropriate laws protecting the privacy and confidentiality of Protected Health Information. This statement does not apply to disclosures made by Whistleblowers and workforce member crime victims or individuals filing a complaint with the secretary; testifying, assisting or participating in an investigation, compliance review, or hearing under Part C or Title 11: or opposing a practice or act made unlawful, provided the individual has a good faith belief that the practice is unlawful and the manner of opposition is reasonable and does not involve a disclosure of Protected Health Information in violation of HIPAA.

PROCEDURE:

Violations of patient confidentiality have been divided into the following three levels with the corresponding disciplinary action for each level of violation.

Level 1. Carelessness—This level of violation occurs when an employee unintentionally or carelessly accesses, reviews or reveals patient information to him/herself or others without a legitimate need to know the patient information. Examples include, but are not limited to: employees discuss patient information in a public area; employee leaves a copy of patient medical information in a public area; employee leaves a computer unattended in an accessible area with a medical record unsecured.

Disciplinary Sanctions:

Depending upon the facts, counseling, oral warning, written warning, final written warning or suspension, documented in writing and maintained in the employee's personnel record, or termination. Except in the case of termination, the employee shall be required to review the Confidentiality Policy and sign a new Confidentiality Agreement.

Section 11: **SUBSTANCE ABUSE POLICY**

The Branch-Hillsdale-St. Joseph Community Health Agency (the Employer) takes seriously the problem of drug and alcohol abuse. We are committed to provide a substance abuse free work place for our patients, clients, and employees. This policy applies to all employees of the Agency, without exception, including part-time, temporary, and on call employees, and volunteers.

POLICY:

1. No employee is allowed to consume any alcoholic beverage or unauthorized drugs while performing his/her job duties for this Agency.

2. No employee may possess, sell or give to another any alcohol, or drug, whether authorized or unauthorized, during assigned work time or while performing any services for the employer. This section shall not apply to employees who are authorized by law or job description to prescribe or dispense medication.

3. An employee may consume or possess authorized medications in the manner prescribed by the employee's physician or directed by the manufacturer.

4. The Employer will not tolerate employees who report for duty while impaired or under the influence of alcoholic beverages or unauthorized drugs.

5. All employees should report evidence of alcohol or drug abuse to a supervisor or a personnel representative immediately. In cases where the use of alcohol or drugs pose an imminent threat to the safety of persons or property, an employee must report the violation. Failure to do so could result in disciplinary action for the non-reporting employee.

DEFINITIONS:

1. Unauthorized Drug- Any drug that cannot be obtained legally or has been illegally obtained, including prescription drugs obtained without a prescription, prescribed or over the counter drugs used other than as properly instructed and drugs sold or represented as being illegal. This definition includes, but is not limited to Amphetamines, Marijuana or Cannabinoids, Cocaine, Opiates, Phencyclidine, or any of their derivatives or metabolites.

2. Authorized Drug – Prescribed drugs that are used as prescribed by a medical professional or over the counter drugs used as intended by the manufacturer.

3. Under the Influence – For the purpose of this Policy, that the employee is either visibly affected by alcohol or an unauthorized drug, or a testing device or medical test or examination demonstrates any detectable amount of an unauthorized drug, alcohol or a metabolite of either, in the employee, blood, breath, urine or body.

VIOLATION OF THE POLICY:

1. Employees who violate the Anti-Substance Abuse Policy will be subject to disciplinary action, including termination.

2. After a positive drug test, or upon reasonable suspicion that an employee has violated this policy, a pre-disciplinary hearing will be scheduled, in accordance with the Employer's Personnel Policies.

3. Any employees who suffer from drug or alcohol abuse, may request employer assistance, before the occurrence of any misconduct or the commencement of disciplinary action. You may be eligible for referral to the Employee Assistance Program (EAP) or for a medical leave of absence. We encourage any employee with a problem to contact the Human Resources Representative for details. Such requests are considered confidential. An employee referred to the EAP is not relieved from job expectation requirements.

DRUG TESTING:

As a part of our policy to ensure a substance abuse free workplace, employees may be asked to submit to a medical examination and/or tested for the presence of alcohol and/or drugs. The Employer reserve the right, at our discretion, to examine and test for drugs and alcohol. Some such situations where testing may be requested may include, but not be limited, to the following circumstances.

1. All employees who are offered employment;

2. Where there are reasonable grounds for believing an employee is under the influence of alcohol or drugs;

3. As part of an investigation of any accident in the workplace in which there are reasonable grounds to suspect alcohol and/or drugs contributed to the accident;

4. As a follow-up to a rehabilitation program:

5. As necessary for the safety of employees, patients, clients or the public at large, where allowed by statute;

6. When an employee returns to duty after an absence other than from accrued time off such as vacation or sick leave.

It is a condition of your continued employment that you comply with this Substance Abuse Policy.

Branch-Hillsdale-St. Joseph Community Health Agency
Environmental Public Health Services
Report for the April 25, 2019 Board of Health Meeting
Prepared by Paul Andriacchi R.E.H.S, Director of Environmental Health

Food Service Sanitation

We have another retirement on the horizon for our EH Clerk manager in the Branch County office. Marcia Ledyard has been with our agency for almost 18 years and has worked in her capacity as EH Clerk Manager in both the Hillsdale and Branch County offices. Marcia has been an outstanding employee who has been very dedicated to her work and she will be missed greatly. Marcia last day with us will be May 24, we have posted that vacancy and will be interviewing for her replacement in the very near future.

Well & On-Site Sewage

Work in the field programs has really begun to pick up over the past few weeks with many applications for well and septic permits. Our staff has been working hard keeping up with the increase in service demands as well as providing training for our newest sanitarian Ben Aalberts. As I reported last month, Ben has taken over the field position vacated in St. Joseph County by Cody Johnson who transferred to Branch County to fill the vacancy created by the retirement of Tony Headley. Ben has been doing an excellent job so far and has picked up on our policy and procedures very quickly.

General Programs

We participated in the MDEQ Medical Waste Inspection pilot once again this year. We get compensated for the inspections we complete and the dollar amount varies from $100 for each small operation to $250 for larger facilities. The grant allows a maximum reimbursement of $5000 per year. We completed 20 small facility inspections and 12 large facility inspection to fulfill the requirements for the entire $5000 grant maximum. This program fits in well with our workload for the field staff because the inspections can be done in the winter months when the field work slows down significantly.

Our staff assisted a team from MDHHS with follow-up sampling at the health care facility in St. Joseph County that had legionella bacteria identified in their water system. The facility has contracted with a remediation firm to address the deficiencies in the water system that were identified on the initial investigation and water sample collection. There has been extensive progress in addressing those deficiencies and the MDHHS consultants were please with the corrections and progress with the water system. There will be continued monitoring of the water supply for the next 6 months and our agency will be assisting with any further investigation activities.

BRANCH - HILLSDALE - ST. JOSEPH COMMUNITY HEALTH AGENCY

ENVIRONMENTAL HEALTH SERVICE REPORT 2018/2019

	MARCH				YTD 2018/2019				YTD 2017/2018			
	BR	**HD**	**SJ**	**TOTAL**	**BR**	**HD**	**SJ**	**TOTAL**	**BR**	**HD**	**SJ**	**TOTAL**
WELL/SEWAGE SYSTEM EVAL.	1	-	3	4	9	3	10	22	3	1	3	7
CHANGE OF USE EVALUATIONS - FIELD	1	5	3	9	4	16	19	39	8	8	24	40
CHANGE OF USE EVALUATIONS - OFFICE	4	-	5	9	9	4	25	38	16	-	16	32
ON-SITE SEWAGE DISPOSAL												
PERMITS NEW CONSTRUCTION	1	2	7	10	26	19	30	75	16	18	32	66
REPAIR/REPLACEMENT	4	1	8	13	18	21	52	91	26	19	27	72
VACANT LAND EVALUATION	2	2	-	4	4	4	4	12	2	2	12	16
PERMITS DENIED	-	-	1	1	-	-	1	1	-	-	-	-
TOTAL	7	5	16	28	48	44	87	179	44	39	71	154
SEWAGE PERMITS INSPECTED	2	2	7	11	25	38	66	128	30	42	54	124
WELL PERMITS ISSUED	12	8	12	32	45	52	74	171	65	58	97	220
WELL PERMITS INSPECTED	34	9	16	59	70	56	77	203	66	57	89	212
FOOD SERVICE INSPECTION												
PERMANENT	24	22	23	69	109	104	154	367	129	144	160	433
NEW OWNER / NEW ESTABLISHMENT	1	-	-	1	1	5	8	14	7	4	4	15
FOLLOW-UP INSPECTION	-	2	1	3	11	22	10	43	8	14	16	38
TEMPORARY	-	1	3	4	4	9	18	31	7	13	14	34
MOBILE/STFU	-	-	-	-	-	2	4	6	2	10	1	13
PLAN REVIEW APPLICATIONS	3	-	1	4	5	3	2	10	1	3	6	10
FOOD RELATED COMPLAINTS	-	2	-	2	3	7	3	13	6	3	2	11
FOODBORNE ILLNESS INVESTIGATED	-	-	-	-	-	-	-	-	-	-	1	1
FOOD CLASSES												
MANAGEMENT CERTIFICATION CLASS	n/a	n/a	n/a	20	n/a	n/a	n/a	83	n/a	n/a	n/a	108
FOOD HANDLERS CLASS	n/a	n/a	n/a	-	n/a	n/a	n/a	-	n/a	n/a	n/a	-
METH LAB REFERRALS	-	-	-	-	-	-	-	-	-	1	1	2
METH LAB LETTERS SENT	-	-	-	-	-	-	-	-	-	1	-	1
CAMPGROUND INSPECTION	-	-	-	-	-	-	-	-	-	-	-	-
NON-COMM WATER SUPPLY INSP.	3	4	1	8	3	10	20	33	-	1	2	3
SWIMMING POOL INSPECTION	-	-	-	-	10	4	-	14	10	4	-	14
PROPOSED SUBDIVISION REVIEW	-	-	-	-	-	-	-	-	-	-	-	-
SEPTIC TANK CLEANER	-	-	-	-	-	-	-	-	1	-	1	2
DHS LICENSED FACILITY INSP.	4	5	3	12	14	17	18	49	14	28	32	74
COMPLAINT INVESTIGATIONS	9	5	-	14	24	10	7	41	6	10	13	29
LONG TERM MONITORING	-	-	-	-	-	-	5	5	-	-	4	4
BODY ART FACILITY INSPECTIONS	-	-	3	3	-	3	5	8	2	3	1	7

Branch-Hillsdale-St Joseph
Food Establishment Inspection Report

For Date Range: 03/01/2019 - 03/31/2019

Name	Location	Date	Inspection Type	# P / Pf		# P/Pf Fixed During Inspection	# Core
ARBY'S	COLDWATER	03/21/19	COMPLAINTS			0	
LITTLE CAESARS PIZZA	HILLSDALE	03/15/19	COMPLAINTS			0	
HILLSDALE COUNTY JAIL/SHERIFF OFFIC	HILLSDALE	03/01/19	COMPLAINTS	0	0	0	0
VENUE 45	THREE RIVERS	03/19/19	CONSULT	0	0	0	0
LITTLE CAESARS/ EAST CONCORD PIZZA	COLDWATER	03/26/19	PREOPENING/NEV	0	0	0	5
BAILEY ELEMENTARY SCHOOL	HILLSDALE	03/11/19	ROUTINE/FULL	0	0	0	0
BIGGBY COFFEE #494	WHITE PIGEON	03/15/19	ROUTINE/FULL	0	0	0	0
BILL'S STEAKHOUSE	BRONSON	03/28/19	ROUTINE/FULL	0	0	0	1
BRANCH AREA CAREERS CENTER	COLDWATER	03/19/19	ROUTINE/FULL	0	0	0	1
BRANCH INTER. SCHOOL DISTRICR	COLDWATER	03/18/19	ROUTINE/FULL	0	0	0	0
CAMDEN MISSIONARY CHURCH OUTREA	CAMDEN	03/18/19	ROUTINE/FULL	0	0	0	0
CAVONI'S	THREE RIVERS	03/05/19	ROUTINE/FULL	0	0	0	0
CHICAGO ROAD CAFE	STURGIS	03/06/19	ROUTINE/FULL	0	0	0	0
COLDWATER FREE METHODIST CHURCH	COLDWATER	03/12/19	ROUTINE/FULL	0	0	0	0
COMMERICAL SPORTS BAR	COLDWATER	03/05/19	ROUTINE/FULL	0	0	0	1
COUNTRY TABLE RESTAURANT	WHITE PIGEON	03/15/19	ROUTINE/FULL	0	0	0	1
DAVINCI'S	STURGIS	03/27/19	ROUTINE/FULL	0	0	0	2
DOMINO'S / K C PIZZA LLC	HILLSDALE	03/11/19	ROUTINE/FULL	0	0	0	0
EDDY & LOUANN'S WHITE TAIL SALOON	WHITE PIGEON	03/15/19	ROUTINE/FULL	0	0	0	0
GIER ELEMENTARY SCHOOL	HILLSDALE	03/27/19	ROUTINE/FULL	0	0	0	3
GREENFIELD SCHOOL	HILLSDALE	03/11/19	ROUTINE/FULL	0	0	0	0
HARVEY HOUSE	CONSTANTINE	03/13/19	ROUTINE/FULL	0	0	0	2
JEFFERSON ELEMENTARY SCHOOL	COLDWATER	03/15/19	ROUTINE/FULL	0	0	0	4
JENNINGS ELEMENTARY SCHOOL	QUINCY	03/19/19	ROUTINE/FULL	0	0	0	1
LA COFFEE CAFE	THREE RIVERS	03/26/19	ROUTINE/FULL	0	0	0	0
LAKE AREA CHRISTIAN SCHOOL	STURGIS	03/29/19	ROUTINE/FULL	0	0	0	0
LAKELAND ELEMENTARY SCHOOL	COLDWATER	03/15/19	ROUTINE/FULL	0	0	0	0
LITCHFIELD COMMUNITY SCHOOL	LITCHFIELD	03/04/19	ROUTINE/FULL	0	0	0	0
LITCHFIELD CONGREGATIONAL CHURCH	LITCHFIELD	03/04/19	ROUTINE/FULL	0	0	0	0
MARIA'S	STURGIS	03/21/19	ROUTINE/FULL	0	0	0	1
MAX LARSEN ELEM SCHOOL	COLDWATER	03/15/19	ROUTINE/FULL	0	0	0	1
MIKE'S PIZZA-SUB	STURGIS	03/27/19	ROUTINE/FULL	0	0	0	0

Branch-Hillsdale-St Joseph
Food Establishment Inspection Report

For Date Range: 03/01/2019 - 03/31/2019

Name	Location	Date	Inspection Type	# P / Pf		# P/Pf Fixed During Inspection	# Core
NEW BEGINNING CHURCH	MONTGOMERY	03/18/19	ROUTINE/FULL	0	0	0	0
NEW DRAGON EXPRESS	STURGIS	03/21/19	ROUTINE/FULL	0	0	0	0
NEW JERUSALEM CHRISTIAN FELLOWSH	CEMENT CITY	03/01/19	ROUTINE/FULL	0	0	0	0
QUINCY BASEBALL & SOFTBALL ASSOCIA	QUINCY	03/19/19	ROUTINE/FULL	0	0	0	0
QUINCY DINER	QUINCY	03/19/19	ROUTINE/FULL	0	0	0	1
QUINCY JR SR HIGH SCHOOL	QUINCY	03/19/19	ROUTINE/FULL	0	0	0	1
READING HIGH SCHOOL	READING	03/15/19	ROUTINE/FULL	0	0	0	2
REYNOLDS ELEMENTARY SCHOOL	READING	03/15/19	ROUTINE/FULL	0	0	0	1
RYAN ELEMENTARY SCHOOL	BRONSON	03/21/19	ROUTINE/FULL	0	0	0	0
STOUT-NESBIT AMERICAN LEGION	MONTGOMERY	03/18/19	ROUTINE/FULL	0	0	0	0
THE FINISH LINE	HILLSDALE	03/26/19	ROUTINE/FULL	0	0	0	0
YOUTH FOR CHRIST	STURGIS	03/20/19	ROUTINE/FULL	0	0	0	1
BIG KING BUFFET OF DONG INC	THREE RIVERS	03/14/19	ROUTINE/FULL	0	1	0	0
BON APPETIT MGT CO.	HILLSDALE	03/25/19	ROUTINE/FULL	0	1	0	1
EAGLES LODGE 1314	STURGIS	03/21/19	ROUTINE/FULL	0	1	0	1
HILLSDALE COUNTY JAIL/SHERIFF OFFIC	HILLSDALE	03/01/19	ROUTINE/FULL	0	1	0	1
PIZZA HUT	HILLSDALE	03/13/19	ROUTINE/FULL	0	1	0	2
ST. CHARLES SCHOOL	COLDWATER	03/25/19	ROUTINE/FULL	0	1	0	0
THREE RIVERS PIZZA HUT	THREE RIVERS	03/04/19	ROUTINE/FULL	0	1	0	1
ANDERSON ELEMENTARY SCHOOL	BRONSON	03/21/19	ROUTINE/FULL	1	0	0	0
ARBY'S	COLDWATER	03/12/19	ROUTINE/FULL	1	0	1	0
BRONSON HIGH SCHOOL	BRONSON	03/21/19	ROUTINE/FULL	1	0	0	1
COLDWATER HIGH SCHOOL	COLDWATER	03/18/19	ROUTINE/FULL	1	0	1	0
GIRARD HEAD START BISD	COLDWATER	03/20/19	ROUTINE/FULL	1	0	0	0
JILLY BEANS	HILLSDALE	03/11/19	ROUTINE/FULL	1	0	1	1
KENTUCKY FRIED CHICKEN-STURGIS	STURGIS	03/13/19	ROUTINE/FULL	1	0	0	2
MCDONALD'S JLMAC, LLC	CENTREVILLE	03/13/19	ROUTINE/FULL	1	0	1	1
PANSOPHIA ACADEMY	COLDWATER	03/11/19	ROUTINE/FULL	1	0	1	0
WENDY'S	THREE RIVERS	03/04/19	ROUTINE/FULL	1	0	1	0
ARBY'S #7394	HILLSDALE	03/12/19	ROUTINE/FULL	0	1	0	2
BON APPETIT MGT. CO.	HILLSDALE	03/25/19	ROUTINE/FULL	1	0	1	4
COLDWATER WINGS ETC	COLDWATER	03/19/19	ROUTINE/FULL	1	1	1	4
DAIRY QUEEN	STURGIS	03/20/19	ROUTINE/FULL	1	1	1	0
SHORT'S LAMPLIGHTER, LLC	COLDWATER	03/12/19	ROUTINE/FULL	1	1	1	4
THE OAK'S TAVERN LLC	MOSCOW	03/26/19	ROUTINE/FULL	1	1	1	2

Branch-Hillsdale-St Joseph
Food Establishment Inspection Report

For Date Range: 03/01/2019 - 03/31/2019

Name	Location	Date	Inspection Type	# P / Pf		# P/Pf Fixed During Inspection	# Core
LAS DOS MARIAS	WHITE PIGEON	03/13/19	ROUTINE/FULL	2	0	2	3
PANSOPHIA ACADEMY	COLDWATER	03/11/19	ROUTINE/FULL	2	0	0	0
MCDONALD'S-JONESVILLE	JONESVILLE	03/13/19	ROUTINE/FULL	1	1	1	2
CAMDEN-FRONTIER SCHOOL	CAMDEN	03/18/19	ROUTINE/FULL	1	2	1	0
TACO BELL #33023	THREE RIVERS	03/22/19	ROUTINE/FULL	1	2	1	1
FIESTA MEXICANA	STURGIS	03/13/19	ROUTINE/FULL	1	3	1	3
BROADWAY GRILLE	UNION CITY	03/14/19	ROUTINE/FULL	3	1	0	8
D & S LOUNGE	PITTSFORD	03/12/19	FOLLOW UP			0	
EL CERRITO	HILLSDALE	03/11/19	FOLLOW UP			0	
ELKS LODGE	COLDWATER	03/26/19	FOLLOW UP			4	
ZHENG'S SUPER GRAND BUFFET	COLDWATER	03/26/19	FOLLOW UP			4	
EL SEMBRADOR LLC	STURGIS	03/27/19	FOLLOW UP			6	

COMPLAINTS 3
CONSULT 1
PREOPENING/NEW 1
ROUTINE/FULL 69
FOLLOW UP 5
TOTAL NUMBER OF INSPECTIONS: 79

Food Inspection Codes:

P-This indicates a priority violation which is a violation which includes a quantifiable measure to show control of hazards such as cooking, cooling, reheating and handwashing. It is in general terms a violation that can potentially lead directly to an illness.

Pf-This is a priority foundation violation which is a violation that supports a priority violation. For example, the lack of soap or towels at a handwash sink is a Pf. This supports the priority violation of not washing hands.

C-This is a core violation-This is an item the usually relates to general sanitation, operational controls and maintenance of facilities and equipment.

Area Agency on Aging (IIIC)
Branch-St. Joseph

April 25, 2019

Director's Report

Enclosures:

1. Services to Victims of Elder Abuse 2nd Quarter FY2019 Program Report
2. FY2020-2022 Multi Year Area Plan/FY2020 Annual Implementation Plan and 2019 Request for Proposals Timeline (to be distributed at meeting)
3. Older Michiganians Day 2019 – Platform for Legislative Action (to be distributed at meeting)

Updates:

1. Services to Victims of Elder Abuse Grant Updates
   The SVEA grant program is moving right along, with the 2nd quarter just completed. Enclosed in our 2nd quarter report with a new level of detail – by county! Staff are busy with coordinating multiple meetings, visits with local officials/agencies, and of course serving victims. We also submitted a budget amendment to the Division of Victim Services which re-allocates some of the awarded funds and amends our matching contribution.

2. Because dates were still technically "tentative" at the time this report is written, I was not able to include the "Multi-Year/Area Implementation Plan and RFP Timeline" document with the board packet. It will be distributed at the BOH meeting. Thank you in advance for your input and participation in the upcoming Community Needs Assessment process, Public Hearings and RFP proposal review committee! It's going to be an extremely busy couple of months of "AAA business"!

3. I met with our newly elected Senator, Kim LaSata, on Wednesday, April 16th. We had a very productive & detailed conversation. Sharing how our office is uniquely housed within public health to assure efficiency and transparency were talking points in our discussion and she seemed very intrigued by Region 3C. She is familiar with the network as a whole and our goals for independence and dignity, and aging in place. We will be coordinating schedules to have Senator LaSata visit us in St. Joseph County sometime in May or June.

4. REMINDER: OLDER MICHIGANIAN'S DAY 2019 is WEDNESDAY MAY 15th!
   We will leave Coldwater at 8:30am('ish) that morning. If you are interested to join us, please let me know! The printed "Platform for Legislative Action" will also be available at the BOH meeting. Our main messages this year include:
   - Rebalance Medicaid Long Term Care
   - Support the Direct Care Workforce
   - Support AASA In-Home Services
   - Promote Dementia Capable Michigan

Area Agency on Aging (IIIC) Branch-St. Joseph

Services to Victims of Elder Abuse Grant
FY18-19 Quarter 2 Report (Both Counties)

*Information below is based on number of occurences

**Quarter 2 runs from 01/01/2019-03/31/2019

Demographics	
New Clients Total	15
Black/African-American	0
Hispanic/Latino	0
White Non-latino/Caucasian	15
Male	3
Female	12
Age 25-59	7
Age 60 and Older	8
Special Classification	
Homeless	5
LGBTQ	1
Veteran	2
Disability	11
Types of Victimization	
Physical Assault	5
Sexual Assault	2
Domestic or Family Violence	10
Survivors of Homicide	2
Elder Abuse or Neglect	16
Identity Theft/Fraud/Financial Crime	8
Robbery/Burglary	5
Multiple Victimizations	16

Direct Services	
Information about Criminal Justice	6
Victim Notification	7
Referral to Other Victim Services	7
Referral to Other Services	22

Personal Advocacy	
Law Enforcement Interview	5
Emergency Medical Care	1
Individual Advocacy	8
Intervention with Person or Institutions	16
Transportation	28

Emotional Support or Safety Services	
Crisis Intervention	25

Shelter/Housing Services	
Relocation Assistance	5
Tranistional Housing	1
Criminal Justice Assistance	
Notification of Criminal Justice Event	7
Personal Protective Order	3
Prosecution Interview	5

For additional information or questions please contact:

Abigail Reardon Ph: (517) 462-0889 Email: reardona@bhsj.org

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Area Agency on Aging (IIIC) Branch-St. Joseph

Services to Victims of Elder Abuse Grant
FY18-19 Quarter 2 Report (Branch County)

*Information below is based on number of occurences

**Quarter 2 runs from 01/01/2019-03/31/2019

Demographics	
New Clients Total	5
Black/African-American	0
Hispanic/Latino	0
White Non-latino/Caucasian	5
Male	0
Female	5
Age 25-59	3
Age 60 and Older	2
Special Classification	
Homeless	2
LGBTQ	0
Veteran	0
Disability	3
Types of Victimization	
Physical Assault	0
Sexual Assault	0
Domestic or Family Violence	3
Survivors of Homicide	0
Elder Abuse or Neglect	3
Identity Theft/Fraud/Financial Crime	0
Robbery/Burglary	1
Multiple Victimizations	2

Direct Services	
Information about Criminal Justice	0
Victim Notification	0
Referral to Other Victim Services	2
Referral to Other Services	5

Personal Advocacy	
Law Enforcement Interview	0
Emergency Medical Care	0
Individual Advocacy	5
Intervention with Person or Institutions	11
Transportation	5

Emotional Support or Safety Services	
Crisis Intervention	6

Shelter/Housing Services	
Relocation Assistance	2
Tranistional Housing	0
Criminal Justice Assistance	
Notification of Criminal Justice Event	0
Personal Protective Order	0
Prosecution Interview	0

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Area Agency on Aging (IIIC) Branch-St. Joseph

Services to Victims of Elder Abuse Grant
FY18-19 Quarter 2 Report (St. Joseph County)

*Information below is based on number of occurences

**Quarter 2 runs from 01/01/2019-03/31/2019

Demographics	
New Clients Total	10
Black/African-American	0
Hispanic/Latino	0
White Non-latino/Caucasian	10
Male	3
Female	7
Age 25-59	4
Age 60 and Older	6
Special Classification	
Homeless	3
LGBTQ	1
Veteran	2
Disability	8
Types of Victimization	
Physical Assault	5
Sexual Assault	2
Domestic or Family Violence	7
Survivors of Homicide	2
Elder Abuse or Neglect	13
Identity Theft/Fraud/Financial Crime	8
Robbery/Burglary	4
Multiple Victimizations	14

Direct Services	
Information about Criminal Justice	6
Victim Notification	7
Referral to Other Victim Services	5
Referral to Other Services	17

Personal Advocacy	
Law Enforcement Interview	5
Emergency Medical Care	1
Individual Advocacy	3
Intervention with Person or Institutions	5
Transportation	23

Emotional Support or Safety Services	
Crisis Intervention	19

Shelter/Housing Services	
Relocation Assistance	3
Tranistional Housing	1
Criminal Justice Assistance	
Notification of Criminal Justice Event	7
Personal Protective Order	3
Prosecution Interview	5

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Personal Health & Disease Prevention March Update for April Meeting 2019

Communicable Disease: (CD-TB-HIV-STD):

- Flu reports have slowed down since Spring Break. I have changed the way Influenza is reported. The reports of tested individuals were going in the "Influenza like illness" category. They are now being reported under "Influenza".
- An Indiana Measles Case exposed three Sturgis sites. Special clinics were held at our Sturgis WIC site and at Holy Angel's Church in Sturgis. We administered around 30 MMR vaccines. We are taking walk-ins at all four clinics. This Sunday will be the 21st day following the exposure. We have had two suspect measles cases since then. One in Sturgis and one in Branch County. Both have been ruled out as measles cases. Indiana has only the 1 confirmed case. Currently Michigan has 42 cases and there are 555 in 20 of the United States.

Immunizations:

Hepatitis A: Jean continues to schedule Hepatitis A clinics.
We ordered a lot more MMR doses to have on hand in the event this outbreak continues to spread.

Women, Infants, and Children's Nutrition Program (WIC):

- WIC numbers went up in March. We are hoping to continue on this path. We did however, lose our WIC Coordinator this month.

Children's Special Health Care Services (CSHCS), Lead, and Hearing and Vision:

Hearing and Vision Technicians have been very busy attending all of the Kindergarten Round Ups in all three counties. Soon they will be off for the summer and return when school starts back up in the fall.

CSHCS recently applied for the Family Center's annual $10,000 grant to help with advertising the program. They will find out if they will receive the funds sometime in July. They use this money to do radio commercials, billboards, incentives, and fun fairs so they can tell people about the program and how it can help them.

Y. Atwood R.N., B.S.N. Director of Personal Health & Disease Prevention

Branch - Hillsdale - St. Joseph Community Health Agency
Personal Health and Disease Prevention

March-19	2018-2019				FYTD				2017-18 FYTD			
	BR	HD	TR	Total	BR	HD	TR	Total	BR	HD	TR	Total
Amebiasis				-	-	-	-	-	-	-	-	-
Animal Bite	1	5		**6**	11	33	1	**45**	10	17	5	**32**
Babesiosis				-	-	-	-	-	-	-	-	-
Blastomycosis				-	-	1	-	**1**	-	-	-	-
Brucellosis				-	-	-	-	-	-	-	-	-
Campylobacter			1	**1**	4	4	3	**11**	5	3	12	**20**
Chicken Pox				-	-	4	5	**9**	-	3	-	**3**
Chlamydia	6	6	22	**34**	66	49	117	**232**	77	56	91	**224**
Coccidioidomycosis				-	-	-	1	**1**	-	-	-	-
Colds W/O Fever	315	189	321	**825**	1,004	697	1,238	**2,939**	1,090	765	1,281	**3,136**
CRE Carbapenem Resistant Enterobac.				-	-	3	-	**3**	1	-	-	**1**
Creutzfeldt-Jakob Disease				-	-	-	-	-	-	-	-	-
Cryptococcosis				-	-	-	-	-	-	-	-	-
Cryptosporidiosis	2			**2**	4	1	1	**6**	-	1	3	**4**
Cyclosporiasis				-	-	-	-	-	-	-	-	-
Dengue Fever				-	-	-	-	-	-	-	-	-
E Coli 0157				-	-	-	-	-	-	-	-	-
Encephalitis - Primary				-	-	-	-	-	-	-	-	-
Encephalitis - St. Louis				-	-	-	-	-	-	-	-	-
Flu Like Disease	560	675	468	**1,703**	1,373	1,115	1,766	**4,254**	1,484	1,320	3,213	**6,017**
GI Illness	761	572	457	**1,790**	3,583	1,996	2,056	**7,635**	3,553	1,451	2,339	**7,343**
Giardiasis				-	-	1	2	**3**	2	-	-	**2**
Gonorrhea	1	2	12	**15**	13	15	48	**76**	5	4	22	**31**
Granuloma Inguinale				-	-	-	-	-	-	-	-	-
Guillian-Barre Syndrome				-	-	-	-	-	-	-	-	-
H. Influenzae Disease - Inv.				-	-	-	-	-	1	-	2	**3**
Head Lice	27	14	76	**117**	206	133	410	**749**	269	133	375	**777**
Hemolytic Uremic Syndrome				-	-	-	-	-	-	-	-	-
Hepatitis A				-	1	-	-	**1**	-	-	-	-
Hepatitis B - Acute				-	-	1	-	**1**	-	-	1	**1**
Hepatitis B - Chronic				-	-	1	3	**4**	1	1	2	**4**
Hepatitis C - Acute				-	-	-	-	-	-	-	-	-
Hepatitis C - Chronic		2	5	**7**	16	18	23	**57**	21	19	28	**68**
Hepatitis C Unknown				-	-	-	-	-	-	-	-	-
Histoplasmosis				-	-	-	2	**2**	-	-	2	**2**
HIV Infection				-	-	-	-	-	-	-	-	-
HIV/AIDS				-	-	-	-	-	-	-	2	**2**
Impetigo	6	12	5	**23**	25	16	30	**71**	16	9	17	**42**
Influenza	68	98	25	**191**	74	111	52	**237**	21	46	97	**164**
Influenza, Novel				-	-	-	-	-	-	-	-	-
Kawasaki				-	-	-	-	-	-	-	-	-

Branch - Hillsdale - St. Joseph Community Health Agency
Personal Health and Disease Prevention

March-19	2018-2019				FYTD				2017-18 FYTD			
	BR	HD	TR	Total	BR	HD	TR	Total	BR	HD	TR	Total
Legionellosis				-	-	-	-	-	-	1	-	**1**
Listeriosis				-	-	-	-	-	-	-	-	-
Lyme Disease		1		**1**	-	1	2	**3**	-	-	-	-
Measles				-	-	-	-	-	-	-	-	-
Malaria				-	-	-	-	-	-	-	-	-
Menengitis - Aseptic				-	-	1	1	**2**	-	-	2	**2**
Menengitis - Bacterial				-	-	-	-	-	-	-	-	-
Meningococcal Disease				-	-	-	-	-	-	-	-	-
Mononucleosis	23	8	-	**31**	63	15	7	**85**	46	14	13	**73**
Mumps				-	-	-	-	-	-	-	-	-
Mycobacterium - Other	1		1	**2**	3	1	2	**6**	1	2	1	**4**
Norovirus		3		**3**	-	8	-	**8**	-	-	25	**25**
Pertussis				-	3	1	-	**4**	-	-	1	**1**
Pink Eye	26	64	63	**153**	115	125	174	**414**	115	123	197	**435**
Q Fever				-	-	-	-	-	-	1	-	**1**
Rabies - Animal				-	-	-	-	-	-	-	-	-
Rickettsial Disease				-	-	-	-	-	-	-	-	-
Rubella				-	-	-	-	-	-	-	-	-
Salmonellosis	1			**1**	5	2	1	**8**	1	2	5	**8**
Scabies	3	-	1	**4**	7	5	19	**31**	3	9	7	**19**
Shiga Toxin-prod. (STEC)		1		**1**	1	2	-	**3**	-	-	-	-
Shigellosis				-	-	-	-	-	-	-	-	-
Shingles				-	-	-	-	-	-	1	-	**1**
Strep Invasive Gp A			1	**1**	1	1	2	**4**	1	1	1	**3**
Strep Pneumonia Inv Ds.				-	1	5	2	**8**	1	6	6	**13**
Strep Pneumoniae, Drug Res.				-	-	-	-	-	-	-	-	-
Strep Throat	201	40	137	**378**	591	269	382	**1,242**	599	351	589	**1,539**
Syphilis - Primary				-	-	-	-	-	-	1	1	**2**
Syphilis - Secondary				-	-	-	-	-	-	-	1	**1**
Syphilis To Be Determined				-	-	-	1	**1**	-	-	-	-
Tetanus				-	-	-	-	-	-	-	-	-
Trachoma				-	-	-	-	-	-	-	-	-
Trichinosis				-	-	-	-	-	-	-	-	-
Tuberculosis				-	-	-	-	-	-	-	-	-
Unusual Outbreak/Occurrence				-	-	-	-	-	-	1	29	**30**
Vibriosis				-	-	-	-	-	-	-	-	-
VZ Infection, Unspecified				-	-	-	1	**1**	-	-	2	**2**
West Nile Virus				-	-	-	-	-	-	1	-	**1**
Yersinia Enteritis				-	-	-	-	-	-	-	1	**1**
Zika				-	-	-	-	-	-	-	-	-

Branch - Hillsdale - St. Joseph Community Health Agency
Personal Health and Disease Prevention

March-19	2018/19					YTD 2018/2019					YTD 2017/2018				
	BR	**HD**	**ST**	**TR**	**Total**	**BR**	**HD**	**ST**	**TR**	**Total**	**BR**	**HD**	**ST**	**TR**	**Total**
						AVERAGE FOR WIC 18/19					AVERAGE FOR WIC 17/18				
WIC Participation/*Ave.*	1,194	945	745	947	**3,831**	*1,237*	*969*	*752*	*967*	***3,924***	*1,318*	*1,149*	*766*	*1,065*	***4,297***
CHILD IMMUNIZATIONS															
# Vaccines Given CHA	176	112		73	**361**	1,023	961	-	661	**2,645**	1,124	891	-	613	**2,628**
All VFC Doses Given	768	441		869	**2,078**	4,828	3,578	-	6,902	**15,308**	4,391	3,560	-	6,507	**14,458**
Waivers	1	-		4	**5**	35	39	-	38	**112**					
ADULT IMMUNIZATIONS															
# Vaccines Given	117	110		41	**268**	1,117	589	-	808	**2,514**	1,278	350	-	507	**2,135**
All VRP Doses Given	38	66		11	**115**	260	240	-	95	**595**	333	95	-	168	**596**
TRAVEL VACCINATIONS															
Branch Office	-				**-**	23	-	-	-	**23**	217	-	-	-	**217**
COMMUNICABLE DISEASE															
STD treatments	1	1		15	**17**	11	12	-	76	**99**	18	18	-	24	**60**
New STD Investigations	7	8		34	**49**	79	64	-	158	**301**	79	66	-	115	**260**
TB Tests Done	8	7		6	**21**	62	98	-	20	**180**	61	67	-	14	**142**
LTBI on Rx	-	-		-	**-**	-	-	-	1	**1**	1	-	-	-	**1**
HIV Testing	2	1		8	**11**	6	9	-	51	**66**	4	12	-	13	**29**
ENROLLMENTS															
Medicaid & Michild	-	-	-	1	**1**	3	-	-	17	**20**	14	-	-	27	**41**
REFERRAL SERVICE															
MCDC Referrals	22	35	5	1	**63**	81	141	12	18	**252**					
MIHP referrals	20	-	29	42	**91**	85	-	73	120	**278**	76	-	105	148	**329**
Hearing Screens															
Pre-school	55	28	-	233	**316**	111	163	-	502	**776**	113	203	-	394	**710**
School Age	364	337	-	80	**781**	1,078	1,056	-	1,876	**4,010**	1,117	957	-	2,079	**4,153**
Vision Screens															
Pre-school	59	30	-	242	**331**	107	148	-	515	**770**	109	170	-	442	**721**
School Age	333	341	-	437	**1,111**	2,724	2,322	-	4,786	**9,832**	2,859	2,511	-	4,656	**10,026**
Children's Special Health Care Services															
Diagnostics	1	13	-	-	**14**	16	40	-	-	**56**	2	-	-	3	**5**
Assessments-Renewal	17	18	-	13	**48**	108	113	-	174	**395**	104	104	-	170	**378**
Assessments-New	26	20	-	3	**49**	48	80	-	30	**158**	34	33	-	41	**108**