



Governor's Public Health Commission

Commission Meeting Minutes

Indiana State Library
315 W. Ohio Street, History Reference Room
Indianapolis, Indiana

Thursday, November 18, 2021
1:00 – 3:00 pm

Members Present:

Judith A. Monroe (Co-Chair)
Luke Kenley (Co-Chair)
Kristina M. Box (Secretary)
Hannah Maxey
Virginia Caine
David J. Welsh

Mindy Waldron
Paul K. Halverson
Cara Veale
Kim Irwin
Mark Bardsley
Bob Courtney

Dennis Dawes

Non-voting Citizen Advisor
Susan Brooks

Members absent: Carl Ellison, Brian C. Tabor

Indiana Department of Health (IDOH) Staff Present:

Shane Hatchett
Pam Pontones
Micha Burkert

Amy Kent
Tami Barrett

I. Call to Order, Welcome, and Approval of Minutes

Co-Chair Judy Monroe called the meeting to order and noted the presence of a quorum after a roll call of Commission members by Shane Hatchett. She provided an overview of the meeting agenda and then recognized Co-Chair Luke Kenley for opening remarks.

Co-Chair Kenley expressed his enthusiasm for the quality and depth of experience of the Commission members and his appreciation for their willingness to serve on the Commission. He looked forward to their ongoing engagement and also encouraged them to continue to work with their organizations and other stakeholder groups to support the work of the Commission.

Co-Chair Monroe then called on Congresswoman Susan Brooks for opening comments. Congresswoman Brooks highlighted the other public health challenges we face beyond the

pandemic that the Commission needs to keep in mind as it does its work. In particular, she noted the recent surge in opioid overdose deaths. She noted that after focused attention on this issue in the past, we made significant progress, but we never conquered the problem and now deaths are rising again, likely exacerbated by pandemic-related isolation. She also noted the rise of syphilis that was highlighted in the article distributed in the Commission's meeting materials.

Co-Chair Monroe reported that the CDC Foundation, in collaboration with the Association of State and Territorial Health Officials (ASTHO) and the National Association of County and City Health Officials (NACCHO), is convening a series of monthly public health summit meetings on various topics. The first meeting will take place on December 6, 2021, and will focus on the public health workforce. She then called for approval of the minutes of the October 21, 2021, Commission meeting. Dr. Welsh made a motion to approve the minutes as presented, the motion was seconded by Commissioner Mark Bardsley, and the minutes were unanimously approved by consensus.

II. Public Comments Summary and Remarks from Selected Commissioners

Shane Hatchett presented a summary of the 14 comments received through the GPHC website between October 18 and November 4, 2021. He noted that the summary would be posted on the Commission website. He also invited members to provide any feedback they might have on the format and level of detail desired at future meetings.

Co-Chair Monroe then called on Dr. David Welsh and Dr. Cara Veale to share comments. Dr. Welsh reported on his service with the American Medical Association's (AMA's) Council on Science and Public Health, which just released a new report, "Full Commitment by Our AMA to the Betterment and Strengthening of Public Health Systems." ([Link](#)) The policy recommendations in this report formed the basis of a policy adopted at the AMA's House of Delegates meeting last week. The policy is aimed at strengthening the U.S. governmental public health infrastructure at the federal, state, territorial, local, and tribal levels and ensuring public health officials retain the authority to protect the public. Under the new policy, the AMA will develop an organization-wide strategy on public health including ways in which the AMA can strengthen health and public health infrastructure and report back regularly on its progress. Dr. Welsh indicated that he would make the report available to each Commission member and noted that it was the first in a planned series of reports. In addition to the AMA, Dr. Welsh also said that the American College of Surgeons (ACS) is actively engaged in this issue and offered to continue to share information from both the AMA Council and ACS with the Commission. In response to a question from Congresswoman Brooks, Dr. Welsh noted that the Indiana State Medical Association (ISMA) is aware of his work on the Commission and that the ISMA is also very

engaged, working with Secretary Box, local health officers, state legislators, and others on public health issues.

Dr. Veale expressed appreciation for the opportunity to share from a rural perspective. She commented on the need to explore ways to increase the focus on preventive health and healthy lifestyles and funding for this purpose. She noted that rural communities struggle greatly due to aging infrastructure and limited workforce and therefore lack the capacity to focus on all important public health initiatives. She cautioned that it would be important to ensure that small local departments do not end up losing all of their local resources. She also commented that often, a lot of folks work on the same issues, but do not work on them together. She emphasized the value of greater collaboration on key initiatives which could provide us "a bigger bang for our buck."

III. Governance Models Primer

Secretary Kristina Box provided a brief primer on public health services and the public health governance models used across the country. She emphasized the importance of better communicating what public health is and described examples of public health services, education, and focus areas (such as, infant car seats, infant mortality, and childhood immunizations). She also noted the particular importance of public health services for historically disenfranchised populations. Secretary Box referenced the list of statutory requirements for local health departments (LHDs) in Indiana prepared by Mindy Waldron and included in the Commission's meeting materials. She noted the unevenness of service delivery during the pandemic and that some LHDs had to prioritize the services they provided.

Nationally, some state departments of health are part of a larger umbrella agency, but a majority are free-standing agencies, as is the case in Indiana. Most states, including Indiana, follow a decentralized or largely decentralized model for the delivery of public health services, while fewer states (14) centralize or largely centralize public health at the state level. A few states operate "mixed" or "shared" governance models. In response to a question from Dr. Halverson, Dr. Box noted the last significant update to the state's public health laws was probably in 1992. Ms. Waldron concurred.

IV. Public Health Funding and Financing, Presentation by Shane Hatchett, MS, IDOH Chief of Staff

Co-Chair Monroe introduced Shane Hatchett, Chief of Staff for the Indiana Department of Health. Paraphrasing former Governor Mitch Daniels' 2008 State of the State address, Mr.

Hatchett noted that a time traveler from the 1800s would have no trouble recognizing the State of Indiana's public health system.

Mr. Hatchett noted that while the National Academy of Health estimated a \$24 billion public health funding gap in 2012, this paled in comparison to national health expenditures that totaled over \$2 trillion. He commented that, on a per capita basis, public health funding at both the state and local levels were low in Indiana (\$55) relative to the rest of the country (\$91).

He then presented information on the sources and amounts of IDOH funding, noting the heavy reliance on federal funding and the recent pandemic-related increases. Still, IDOH total funding accounts for just 1.42% of the overall state budget. Mr. Hatchett highlighted the IDOH appropriation for LHDs (about \$6.9 million in FY 2022), noting that while a small amount, it was perceived as a vital, flexible, and reliable funding source by LHDs. Dr. Welsh agreed that these appropriations were vital to helping LHDs meet their mission. In response to a question from Commissioner Dennis Dawes, Mr. Hatchett noted these appropriations were distributed based on a statutory formula based on population size. Commissioner Dawes noted that this approach could result in an amount that would not be material for a very small county.

Mayor Bob Courtney commented on the need for more consistent public health investments across the entire state. Mr. Hatchett then presented data on the local County Health Funds (CHF), including the share of CHF property tax draws as compared to CHF certified budgets (about 60%) and the significant variation in CHF property draws per capita across the state. Mr. Hatchett noted that Indiana's heavy reliance on property taxes to fund LHDs can have disadvantages. For example, if property tax collections decrease as a result of the loss of a major employer, that does not mean that public health needs have also decreased. Further, inability to increase local investments in public health to improve quality of life might cause that community to be unable to attract new investment. Mr. Hatchett noted that nationally, LHDs rely less on local funding and more on state and federal funding compared to Indiana.

In response to a question from Dr. Veale, Co-Chair Kenley noted that property assessment amounts are trended in accordance with rules issued by the Department of Local Government Finance in between reassessment years and that the state reviews local assessed values every four to five years and can conduct an audit when there are significant citizen complaints.

Dr. Paul Halverson commented that LHDs across the country usually receive their federal grants as pass-through funding from the state. So, in some cases, states may constrain the ability of LHDs to access federal funding. In response to a question from Dr. Hannah Maxey, Mr. Hatchett confirmed that local county councils are required to approve the expenditure of federal funds.

Mayor Courtney commented that many of these approval requirements are dictated at the state level, for example, by the State Board of Accounts. Mr. Hatchett then discussed other barriers or challenges that make it difficult for LHDs to maximize federal and state grant funding. Mr. Hatchett stated that where local funding works well, the county council, county auditor, and LHD work well together, although, as we learned at the last Commission meeting, LHD staff report the need for greater finance and budget skills.

Co-Chair Kenley observed that in addition to determining how much additional funding may be needed, it will be necessary to decide who will control expenditures. He noted that there are really only about 10 counties in the state with continuous local property tax growth, but the other 80 counties have limited ability to increase local funding. For example, the Local Option Income Tax is not really an option for a small community with no wealth. But the funding distribution would need to be perceived as fair/equitable, or the plan will be panned by advocates. Mr. Hatchett agreed that it is important to engage local officials – Indiana is, and is likely to remain, a home rule state.

Congresswoman Brooks asked about community health center (CHC) funding, which has seen significant federal funding increases in recent years, and whether some public health functions are carried out by CHCs. Dr. Caine noted that some small counties sometimes fall back on CHCs for some basic services (e.g., immunizations) but also noted that CHCs do not have the same level of expertise and sophistication on contact tracing, for example. Secretary Box commented that there is greater recognition now across clinical providers regarding “population health” and noted that if LHDs were better funded, they could be the liaison that brings healthcare providers together to work on population health issues. Dr. Maxey clarified the difference between federally funded FQHCs (Federally Qualified Health Centers) and CHCs that are state funded only. Co-Chair Kenley asked Mr. Hatchett for additional information regarding the funding and geographical location of CHCs and whether that needs to be part of the Commission’s deliberations. In response to a question from Commissioner Dawes, Mr. Hatchett noted that the CHC line item on slide 11 did not include federal clinic funding and pertained to only state CHC funding.

Mr. Hatchett reported that over the last 12 months, only about half of the LHDs had submitted a claim for Medicaid reimbursement and money is likely being left on the table that could be claimed if the various billing challenges could be overcome. For example, once an LHD staff person is trained to bill Medicaid, they are subject to being recruited away. Dr. Halverson noted, however, that there may be a misconception about leaving Medicaid money on the table, as the many services that LHDs provide are non-clinical.

Mr. Hatchett then turned to the experience of three case study states: Washington, Kentucky, and Ohio. He described their experiences supporting public health transformation, including funding reforms and expansions. Mr. Hatchett then briefly summarized, at a high level, the pros and cons of different potential funding sources to increase public health funding. He closed his presentation by emphasizing the value of upstream prevention and the return on investment of public health spending that exceeds \$14 per dollar invested.

V. Funding: Open Discussion

Several Commission members offered comments and observations.

Dr. Welsh advised sending the list of statutorily mandated public health services to all LHDs to begin to validate the need for greater funding. He also questioned whether the grants management function could be done at a regional level to relieve some of the burden on counties. Co-Chair Monroe commented that some states use Public Health Institutes as fiscal intermediaries.

Mayor Courtney recommended that the Commission collectively quantify LHD budgets across all counties.

Dr. Caine noted that local officials have a better pulse on what is going on in their communities but may not always have the expertise needed. She suggested, as an example, that perhaps one epidemiologist could serve 5 or 6 LHDs. She advised that the Commission identify the positions that are really needed; they could be based at the IDOH but shared.

In response to a question from Mayor Courtney, Mr. Hatchett and Secretary Box reported on ongoing efforts to survey LHDs about their needs and various other issues, but they do not always get a large response.

Mindy Waldron complimented Mr. Hatchett's presentation and noted that federal grant dollars are not discretionary, noting that if an LHD loses the clinical side of an issue (for example, diagnosing and treating an STD), it will also lose the investigative capabilities (i.e., contact tracing). She said it is important that we not create barriers to care that will prevent folks from seeking services especially for stigmatized services. For example, individuals with an STD may only seek care at an LHD rather than through a private provider. Dr. Halverson agreed that some clinical services are crucial, but it is a matter of finding the right balance. He also commented that in order to do a meaningful LHD survey regarding services, we must first determine what we want to have done with regard to public health in this state.

Congresswoman Brooks asked the county officials serving on the Commission whether there were other examples of services that are shared across counties. Commissioner Mark Bardsley cited mutual aid agreements (police, fire) and also the emergency response regions. Commissioner Dawes noted, however, that most of the sharing is within the county between the county and the towns or cities.

Dr. Caine noted the potential to leverage greater buying power through sharing arrangements and also cited examples (mosquito control and a lead poisoning outbreak) where Marion County had shared staff and resources with neighboring counties as a good neighbor.

Dr. Veale questioned whether continued reliance on property tax funding was the best method for evenness in funding. Co-Chair Kenley responded by citing the school funding reforms made some years ago to address a similar concern.

Ms. Waldron opined that there was merit in considering centralized positions, and Kim Irwin commented that next Monday, November 22 was "Public Health Thank You Day." She expressed her gratitude to Indiana's public health workforce and urged other Commission members to take time on Monday to say thank you as well.

VI. Final Thoughts and Adjourn

Co-Chair Judy Monroe noted the next Commission meeting is Thursday, December 16, 2021, and the main topic would be public health governance and infrastructure. She then adjourned the meeting at 3:02 p.m.