



Governor's Public Health Commission

Commission Meeting Minutes

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

Thursday, October 21, 2021
1:00 – 3:00 pm

Members Present:

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

Paul K. Halverson
Brian C. Tabor
Carl Ellison
Cara Veale
Kim Irwin
Mark Bardsley

Bob Courtney
Dennis Dawes

Non-voting Citizen Advisor
Susan Brooks

Members absent: Hannah Maxey

Indiana Department of Health (IDOH) Staff Present:

Shane Hatchett
Pam Pontones
Micha Burkert

Amy Kent
Tami Barrett

I. Call to Order and Welcome

Co-Chair Judy Monroe called the meeting to order and noted the presence of a quorum. She provided an overview of the meeting agenda, noting that the workforce topic is timely given the current retention issues across the state and country. She then called for approval of the minutes of the September 16, 2021, meeting. Brian Tabor made a motion to approve the minutes as presented, the motion was seconded by Dennis Dawes, and the minutes were unanimously approved by consensus. In his opening remarks, Co-Chair Luke Kenley encouraged Commission members to keep members of their organizations and other contacts posted on the Commission's activities, especially local government officials and state legislators.

II. Communications Plan and Public Engagement

Dr. Kristina Box provided an overview of the Governor's Public Health Commission Engagement Plan handout, which summarizes the various approaches that IDOH and the Commission will be using to educate and gain support for the Commission's work and obtain feedback from stakeholder groups and the general public. The plan will continue to be updated as needed and includes a dedicated Commission website with links to all relevant meeting materials. The public can visit the website and complete a form to leave a comment. All comments received will be summarized and shared at upcoming Commission meetings.

Dr. Box encouraged each Commission member to raise awareness about Commission activities and help get the message out that public health is about more than just mask mandates and pandemics. She also encouraged members to bring to the Commission feedback they receive from their organizations. Co-Chair Kenley also encouraged members to reach out to their county commissioners, with the goal of having them endorse the Commission's work to state legislators. Mr. Tabor recommended that the Department keep a list of all the groups they have been in contact with regarding the Commission's work, and Ms. Waldron stressed the importance of reaching out to county and city councilors who control funding decisions at the local level. Ms. Irwin commented that the Indiana Public Health Association (IPHA) has convened a new IPHA Action Team to monitor, discuss, and provide input to the Commission. Commissioner Dawes reported that he had already been contacted by individuals wanting to provide information to the Commission and that he would pass that information along to Mr. Hatchett.

III. Presentation by Courtney Medlock and Dr. Valerie Yeager: Indiana's Public Health Workforce, Gaps, and Insights

Co-Chair Monroe introduced Ms. Courtney Medlock of the Bowen Center for Health Workforce Research and Policy, Indiana University School of Medicine, and Dr. Valerie Yeager, from the Department of Health Policy and Management, Indiana University Richard M. Fairbanks School of Public Health.

Ms. Medlock indicated that she was presenting on behalf of Dr. Hannah Maxey (a Commission member), who could not attend the Commission meeting due to a pre-existing commitment.

Ms. Medlock described Indiana's healthcare workforce, its public health workforce, and areas of overlap between the two (i.e., public health nurses and physicians). She also described the governance structure for local health departments and local boards of health, noting that this

was a topic that the Commission might wish to revisit when it is considering governance and infrastructure issues.

Dr. Valerie Yeager then described three sources of data regarding the public health workforce: the Public Health Workforce Interests and Needs Survey (PH WINS), the Region V 2020 Public Health Training Center Survey, and IDOH's statewide annual survey of local health departments (LHDs). While these surveys provide a variety of workforce data (e.g., workforce numbers, roles, education levels, training needs, etc.), Dr. Yeager noted that Indiana-specific data and information are limited.

Dr. Yeager noted that about one-third of Indiana LHDs (32%) serve populations of 25,000 or less with an average of six employees. Another one-third of LHDs (37%) serve populations of between 25,000 and 50,000 with an average of nine employees. In both cases, however, a significant number of these employees work part-time. She noted that some LHDs, in fact, have no full-time employees. She also noted that 55 of Indiana's 94 local health officers were part-time, while 39 have full-time roles in their agencies. Dr. Yeager summarized the training needs that can be gleaned from the three survey sources, but noted that the data are too limited to be actionable for policymaking purposes. Across LHD employees, however, the most common training need cited was related to financial analysis methods applicable to program and service delivery. Training needs reported by IDOH employees were aligned, to a large extent, with the needs reported by LHD employees.

While state-level data do not exist, Dr. Yeager noted that nationally, four out of five public health employees have no public health training. She then highlighted the statewide variation in the workforce capacity of Indiana LHDs, noting that many LHDs do not have epidemiology expertise, informatics and data analytics expertise, emergency preparedness expertise and capabilities, or information technology infrastructure, and that Indiana's local public health system is not providing the essential public health services consistently across communities. Dr. Yeager then summarized the data on the challenges associated with recruitment and retention within the public health workforce (including an expected wave of retirements and losses on the horizon) but noted the lack of state-specific data for Indiana. She noted that, nationally, lack of a career pathway is an issue and that work experience requirements and salary considerations can be barriers for new master's graduates.

Dr. Caine asked about the collection of epidemiology and informatics workforce information and Ms. Waldron noted that it was technically captured under "other" in the IDOH annual survey. Dr. Box asked whether Indiana could use already developed national surveys to collect additional state-level data. Mr. Ellison asked whether the three workforce surveys collected race and

ethnicity demographic data: Dr. Yeager responded that PH WINS has this data but not the other surveys. Dr. Box also offered to reach out to the 12 LHDs that are part of PH WINS that is currently in the field to encourage completion. In response to a question from Commissioner Dawes, Dr. Yeager said that the PH WINS occurs every three years, but the current survey underway was delayed due to the pandemic.

Congresswoman Brooks asked about the talent pipeline of public health and how many are from Indiana. Dr. Halverson indicated that the IU Fairbanks School of Public Health had about 1,000 students and over 90% were Indiana residents. He noted, however, that most of these students do not go into government positions because they either do not meet the experience requirement for management positions or the salaries are too low. Dr. Yeager then highlighted the successful tuition reimbursement program at the Marion County Public Health Department.

Dr. Halverson then asked what is known about the public health education requirements for persons working at either the local or state levels. Dr. Yeager noted that local health officers must be physicians, but few have public health-specific training. While public health training for medical students is becoming more common, most surveyed reported not having training on the public health policy structure, workforce management, and how to navigate the governance structure.

Dr. Caine indicated salary issues are a big barrier, causing some smaller counties to lose a lot of public health employees, especially to hospitals that offer higher salaries for nurses. She noted that there is a lack of understanding of the skillsets required and that these skills are not accounted for in the budgets set by city and county councils. Ms. Waldron agreed and noted that county councils use a position classification system to set salaries that does not account for current wages in the market and is not reviewed often enough. Dr. Caine also noted that when LHDs receive new grant funding, the budget is often subject to offsetting local resources, a phenomenon known as "supplanting." Dr. Yeager then cited a recent example of a city council turning down a \$3 million federal grant that its LHD had secured to enhance its workforce. Dr. Veale asked about the recruitment and retention data available for IDOH staff as compared to LHD staff. Dr. Yeager responded that the service expectations at the state and local levels are different, so it is not possible to generalize the IDOH data to local LHDs.

Ms. Irwin commented that it was her understanding that the PH WINS survey was open to all 94 LHDs but only 12 chose to participate.

Dr. Caine commented that some are hesitant to rely on federal funding, fearing it may become unavailable in the future. She stated that she believed it was important, however, for Indiana to

take full advantage of the federal revenues to which it has access. Dr. Yeager noted that, on a national level, LHDs are typically funded with one-third federal funds, one-third state funds, and one-third local funds. In Indiana, however, LHDs rely primarily on local funds.

Mr. Tabor commented on the need to change incentives. He noted that applying for grants could be more trouble than it is worth for an LHD that already has capacity issues. He also cited the critical workforce challenges in healthcare generally right now. In response to a question posed by Co-Chair Kenley, Mr. Tabor observed that if some services could be delivered on a regional basis, it might change the county's incentive to apply for a grant.

Ms. Medlock then summarized the data available regarding Indiana's healthcare workforce, noting shortages of primary care physicians, psychiatrists, long-term care workers, and nurses in some regions. She also noted the number of physicians that reported an LHD as a practice location (28 of 17,384), the number of registered nurses (out of a total of 81,539) that reported a public health primary role or setting (307), a primary school health role or setting (1,380), or a nursing faculty primary role (100).

Ms. Medlock then turned to possible approaches to address foundational issues. To address the limited state-level data regarding the public health workforce, IDOH could promulgate rules to establish minimum LHD reporting requirements and conduct an assessment of talent retention across public health graduates, employees in the public health sector and government public health employees.

To address workforce and skill shortages, Ms. Medlock noted the state could establish a Health Workforce Incentive Program (addressing both public health and healthcare) that could recommend incentives such as student loan repayment and/or tuition reimbursement programs, scholarships, or tax incentives. Additionally, the state should consider removing burdensome barriers to the licensure of foreign nurses. Academic and employer-based partnerships could also provide training opportunities for public health students and fellowships for recent graduates.

Ms. Medlock shared ways the Commission could better coordinate workforce policy. This included supporting the addition of public health representation on the Indiana Graduate Medical Education (GME) board. The Commission could also establish or identify an entity to support ongoing coordination across Indiana health workforce initiatives.

IV. Discussion

Several Commission members offered comments and observations.

Dr. Halverson noted a potential opportunity to train Physician Assistants in public health. He also indicated that he would applaud a regional approach to service delivery, including local health officer education. He noted that local health officers within a region could share their expertise across the region. He further commented that having part-time LHD employees means that a county can avoid the cost of benefits for those employees. He also suggested reaching out to the American College of Surgeons on issues related to disaster preparedness.

Commissioner Dawes commented that Hendricks County has a population of 180,000 yet 11 LHD staff, which would be considered small for a county of that size (according to Dr. Yeager's presentation). He indicated that he was supportive of doing things regionally and sharing expertise, for example, having one LHD for four or five counties, but retaining county funding. He commented that the Hendricks County Auditor's Office manages all grants and handles the reporting and management and that the county has an emergency preparedness office that is separate from the LHD.

Mayor Courtney questioned whether some public health services are being provided by the private sector in counties with small LHDs. Dr. Yeager responded that while not-for-profit hospitals are required to have community benefit programs, these programs are often limited. There are no other responsible partners that provide the public health services that a small LHD is unable to provide. In those cases, the services are not being provided. Mayor Courtney cited other policies outside of public health that create barriers. For example, state-imposed property tax caps work against investments that local officials might like to make. Dr. Yeager cited the potential revenues that could be raised through a tobacco tax and also noted that LHD staff capacity limits meant that these staff just do not have time to partner with other community stakeholders. Mayor Courtney also commented on the need for city representation on the county local health board.

Secretary Box commented on the heavy reliance on local funding for Indiana LHDs. Mayor Courtney observed that emergencies overwhelm local staff, and she agreed that there was no ability to staff up at the local level to respond to the pandemic.

Before defining workforce needs, Dr. Halverson commented that the Commission first needs to address the heart of the issue by defining the functionality that we expect from our public health system. It is not possible to modernize our laws until we know what the public health system should do. Currently, service levels depend on where you live and are not necessarily related to

need. He also recommended that the Commission examine public health in the rest of the country so it can decide what "good" looks like. Other sources of national standards include the Public Health Accreditation Board that accredits public health departments and the National Board of Public Health Examiners, which credentials public health professionals. He noted that Indiana has incredible people working in public health every day, but we ask them to do a lot for not much. This is a systems problem that we should approach from a systems level.

Co-Chair Monroe applauded the systems thinking that she heard at the meeting and that we want to design improvements that will produce the desired outcomes. Ms. Waldron commented that it is good to know where we are starting from and that the Commission should consider how current data sources might be developed to generate more Indiana-specific data. She observed that it is currently hard to verify the information collected, as different surveys use differing terms and different LHDs use terms differently too.

V. Adjournment

Co-Chair Judy Monroe noted the next Commission meeting is Thursday, November 18, 2021, and the main topic would be public health financing and funding. She then adjourned the meeting at 3:00 p.m.