



# Governor's Public Health Commission

## Commission Meeting Minutes

Thursday, April 21, 2022  
1:00 – 4:00 pm

### Members Present:

Judith A. Monroe (Co-Chair)	Virginia Caine	Kim Irwin
Luke Kenley (Co-Chair)	David J. Welsh	Dennis Dawes
Kristina M. Box (Secretary)	Mindy Waldron	Carl Ellison
Bob Courtney	Paul K. Halverson	Brian Tabor
Hannah Maxey	Cara Veale	

**Members absent:** Susan Brooks, Non-voting Citizen Representative

### Indiana Department of Health (IDOH) Staff Present:

Shane Hatchett	Micha Burkert
Lindsay Weaver	Tami Barrett
Pam Pontones	

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

Co-Chair Luke Kenley called the meeting to order at 1:03 p.m., noted the presence of a quorum following a roll call by Mr. Shane Hatchett, and called on Secretary Box and Co-Chair Monroe for opening remarks. Secretary Box expressed appreciation to the Commission members and to the Fairbanks Foundation for providing funding to support the Commission's work and emphasized to the Commission members that the recommendations presented today should be considered a starting point, subject to input and additional change. Co-Chair Monroe also thanked the Fairbanks Foundation and commented on the importance of the recommendations to be discussed today. She also commented on the amount of stress currently experienced by the public health workforce. Co-Chair Kenley then called for the approval of the minutes of the March 17, 2022, Commission meeting. Dr. David Welsh made a motion to approve the minutes as presented, the motion was seconded by Ms. Mindy Waldron, and the minutes were approved unanimously.

## II. Public Input Summary

Co-Chair Kenley recognized Mr. Shane Hatchett, IDOH Chief of Staff, who presented a summary of the 105 comments received through the GPHC website since the March meeting, including 75 similar responses that all voiced opposition to the expansion of public health authority and mandates. He also summarized the comments presented at the Jasper, New Castle, and Huntington listening tour meetings by 40 individuals and indicated that summaries for the remaining four listening tour meetings would be presented at the May Commission meeting. He noted that the Department was pleased with the turnout.

## III. Workforce Recommendations

Dr. Hannah Maxey presented the draft recommendations for the workforce workstream, which include development of a state health workforce plan and initiatives to support recruitment and retention in areas of need. Co-Chair Kenley recognized various Commissioners for comments.

Dr. Welsh expressed approval for a number of the recommendations and emphasized the importance of having a centrally located resource regarding workforce needs. He also suggested that the recommended comprehensive assessment take a three-tiered approach: defining minimum needs; a moderate approach; and a more robust approach that goes beyond minimal expectations.

Dr. Virginia Caine suggested that the recommendations address the inadequacy of public health salaries and pay ranges. She also asked whether a centralized body could coordinate paid public health internship opportunities.

Commissioner Dawes asked about public health medical residencies and emphasized the importance of having paid internships.

Dr. Maxey commented on the importance of the state applying for available federal internship funding opportunities and agreed that students are looking for paid internships. Co-Chair Kenley asked Dr. Maxey to provide the Commission with more information regarding federal grant programs that fund internships. Co-Chair Monroe commented on the preventive medicine residency program in Indiana and noted that the CDC Foundation pays \$1,500 per month for master-level interns and is able to get great people this way. Mr. Carl Ellison also commented on the critical importance of paid internships for students of color. Dr. Cara Veale noted, however, that some university programs may restrict paid internships.

Ms. Mindy Waldron expressed her agreement with all of recommendations and also discussed the importance of internships. She suggested that having a centralized program to coordinate internships would be helpful and also suggested having a centralized location to post open public health positions from across the state. She also commented that current public health salary ranges were not competitive with the market and that it would be helpful to have

information on market rate pay ranges that she could tap into to answer questions from her County Council.

Ms. Kim Irwin endorsed the suggestion of having a centralized entity to coordinate public health internships and asked about regulatory workforce issues (e.g., reciprocity authorities). Dr. Maxey responded that the proposed comprehensive assessment would include a regulatory component.

Dr. Paul Halverson commented on the significant problem related to the lack of competitive public health salaries. He also commented on the need to document public health workforce job descriptions and education and experience requirements and to emphasize the need for public health training in the workforce plan, referencing the recently revised (October 2021) Public Health Job Competencies report issued by the Joint Council on Accreditation of Public Health. He noted that there are currently a little over 100 Indiana physicians who are Board-certified in preventive medicine, but that none are currently practicing in public health. He suggested that there is an opportunity to develop a multi-hospital-system collaboration around preventive medicine. He also advised that public health workforce issues be kept separate from clinical workforce issues, as public health workforce needs are often "drowned out" when they are not kept separate.

Secretary Box suggested adding a bullet to the recommendations to address the importance of having in place healthcare workforce career paths that allow health workers to progress as they gain new skills and certifications.

Mr. Brian Tabor expressed support for the loan repayment recommendation, noting that it is likely the biggest lever to address workforce issues.

#### **IV. Governance, Services, and Infrastructure Recommendations**

Ms. Pontones presented the draft recommendations for the governance, services, and infrastructure workforce workstream, which included additional support for local health departments, adopting service standards modeled after the Foundational Public Health Services (FPHS) framework, and promoting policies that incentivize better local coordination and efficiencies.

Co-Chair Kenley commented on the possibility of creating incentives for local health departments (LHDs) serving small populations to consider consolidation and a three-tiered service approach (i.e., services provided at the IDOH, district, and LHD levels). Dr. Box also responded to Co-Chair Kenley's question regarding the local health officer "standing orders." Co-Chair Kenley then recognized various Commissioners for comments.

Commissioner Dawes commented that, based on his conversations with other local officials, there would be support for regionalization if local control was ensured and if each county

continued to have input into the governance of the regional entity. He also suggested eliminating the requirement for county hospital boards and local health boards to be bipartisan, as this requirement is hard to meet in some counties. He also agreed that best practices were a critical part of governance and that IDOH-provided expertise, such as epidemiology, would be well received locally.

Ms. Waldron suggested adding the word "training" to the first bullet under Recommendation 2 and indicated that funding would be needed to encourage LHD partnerships in key service areas. Ms. Waldron also recommended that, instead of eliminating the bipartisan requirement for local health boards or the physician requirement for local health officers, a variance process be created for extreme circumstances. She recommended adding environmental inspections and permitting to the third bullet in Recommendation 5 and expressed concern regarding the second bullet under Recommendation 7 (regarding local health officers) as problematic, as physicians who serve on local health boards are generally unpaid and not covered for liability.

Dr. Welsh expressed support for Recommendations 1-3, noting that much is already being done in many places even though not codified, but said he would defer to the Commission's elected officials regarding Recommendation 4 (regarding Local Health Boards). He also agreed with Recommendation 8 (regarding accreditation). Regarding the local health officer Recommendation (7), he suggested having regional health officers covering multiple counties.

Dr. Caine expressed concern regarding the local health officer recommendation, noting that it is easier to get compliance from physicians if the local health officer is also a physician who is currently or recently in active practice. She also expressed support for maintaining the bipartisan requirement for public hospital boards.

Dr. Halverson commented on the need to modernize the state's public health statutes and expressed support for Recommendation 2 but cautioned that the IDOH staff who provide support to LHDs must have depth and experience regarding the local health officer role, but also "clout" within IDOH so that they are able to make commitments and get things done. He also commented on the high value of various resource-sharing approaches that do not require LHDs to merge. Regarding the accreditation recommendation, Dr. Halverson recommended having strong incentives or mandates for LHDs to move toward accreditation, coupled with a long on-ramp so that accreditation can happen over time. Regarding Recommendation 1, Dr. Halverson also recommended that the foundational public health services be set as the "floor" so that LHDs can choose to do more if they want to. He also recommended emphasizing the public health training for local health officers and considering how to delink medical or clinical oversight from the day-to-day administrative oversight of the LHD.

Ms. Irwin supported the accreditation recommendation but questioned whether there are elements of accreditation that the state could require for LHDs that do not pursue full accreditation. She also supported the local health officer recommendation with appropriate

accommodations to address the concerns regarding standing orders and medical oversight. She also recommended the public health code be modernized.

Mr. Tabor commented that he felt that accreditation remained aspirational currently and also opposed any recommendations that would narrow the pool of people needed within the public health workforce. He also emphasized the importance of Recommendation 2A. He noted that the regional hands-on kind of approach, led by high-level IDOH staff, will be critical for identifying where opportunities for efficiencies are going to come from and encouraging shared services arrangements.

Co-Chair Monroe commented on the potential for a district-level physician to issue standing orders. She remarked that a local health officer with advanced public health training is the best of both worlds.

Dr. Caine commented that there are not enough physicians with a master's in public health in Indiana and discouraged any requirements that would narrow the eligible pool of local health officers.

Dr. Veale agreed with the local health officer recommendation but questioned whether a statutory scope of practice change would be needed. Dr. Maxey responded that APRNs are not currently recognized in state licensure laws (as they are in most other states). Dr. Veale also agreed with the suggestion for a variance process for the bipartisan local health board requirement.

Mayor Bob Courtney commented on the importance of consensus building across state and local officials and other stakeholders and the potential reluctance by some to change current governance statutes. He emphasized the need to demonstrate the value of a regional approach, noting that it will generate better outcomes than the current approach. He cited an example of a successful regional approach and another example that was less successful, as well as the difficulty of negotiating interlocal agreements (or MOUs).

Dr. Caine cautioned that the Commission could do great damage if it tries to change statutes without laying the proper foundation, as it could end up getting the opposite results than those desired. She expressed opposition to accreditation mandates and also expressed a need for better integration and communication between public health and clinical care systems regarding public health preparedness. Dr. Box noted that this issue would be addressed in the emergency preparedness recommendations that the Commission would discuss at its next meeting.

Co-Chair Kenley recommended that the local health officer recommendation be readdressed at the May Commission meeting and also invited Dr. Halverson to suggest revised language that the Commission might consider and vote on.

## V. Data and Information Integration Recommendations

Dr. Weaver presented the draft recommendations for the Data and Information Integration workstream, which included establishing a State Public Health Data System Advisory Committee, formalizing and strengthening the state's relationship with a Health Information Exchange (HIE) partner, and additional data analytics transformations to support local and state public health systems. Co-chair Kenley recognized various commissioners for comment.

Dr. Caine supported all of the recommendations but suggested that the word "sustain" in Recommendation 4A be replaced with "increased" or some other term that indicates an intention to respond to the growing demand to support LHD data-related needs.

Ms. Waldron was also supportive of the recommendations but suggested that the Data System Advisory Committee referenced in Recommendation 1 include local representation.

In response to a question from Dr. Veale, Dr. Weaver indicated that the data analytics referenced in Recommendation 3 includes three components: the technology and data receipt component; the analysis component of how to use the data to "build the story"; but also, the next level of how to communicate the results to the public.

Mayor Courtney commented that data is critical for everything we do but questioned how to provide the needed training. Dr. Weaver commented that a specific skill set is needed that could be provided through regional support teams where the data expertise is integrated with other public health expertise (e.g., epidemiology). Dr. Box agreed on the need for a data analyst and epidemiologist at the regional or district level that can interact with their peers in clinical care settings (e.g., hospitals). Dr. Caine observed that epidemiologists help interpret the data. Mayor Courtney commented that a lack of good data during the pandemic made decision-making difficult, which led to unnecessary conflict.

Dr. Veale agreed with the recommendation for district-level data support.

Dr. Maxey agreed with the recommendations and commented on the need to identify the skill sets needed and create a related workforce plan.

Mr. Dawes commented on Indiana's strong Health Information Exchange (HIE) and questioned whether it should be named in the document. Dr. Box responded that the recommendation was intentionally vague in case another HIE was created.

Dr. Welsh commented that information is the difference between success and failure and expressed support for the recommendations.

Ms. Irwin questioned how the state can make sure LHDs have the resources they need to implement the data recommendations beyond items mentioned in Recommendation 3B. Dr. Caine noted that an assessment might be needed to determine what other resources are needed.

Dr. Halverson asked about assuring data reciprocity – that LHDs that submit data will also be able to receive data. Dr. Box agreed that reciprocity was essential. Dr. Halverson also asked about how to ensure interoperability. Dr. Box commented on the need for a whole-state solution that goes beyond public health, as many LHDs utilize county-administered and county-wide data systems.

Co-Chair Monroe commented on the societal data advancements that have occurred over the past decade.

Dr. Caine questioned whether the recommendations need to address cybersecurity. Dr. Weaver agreed.

## **VI. Final Thoughts and Adjourn**

Co-Chair Kenley noted that the next Commission meeting is Thursday, May 19, 2022, from 1-4 p.m. and the main topic will be consideration of recommendations relating to Funding, Child and Adolescent Health, and Emergency Preparedness. He then adjourned the meeting at approximately 3:50 p.m.