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Appendix A: State Health Agency Governance Classification

The Association of State and Territorial Health Officials (ASTHO) categorizes state approaches for delivering public health services into the following four categories which generally describe the relationship between the state health agency and regional or local public health departments: [1]

- **CENTRALIZED OR LARGELY CENTRALIZED STRUCTURE:** Local health units are primarily led by state employees and the state retains authority over most fiscal decisions (14 states).
- **SHARED OR LARGELY SHARED STRUCTURE:** Local health units might be led by state employees or by local government employees. If they are led by state employees, then local government has the authority to make fiscal decisions and/or issue public health orders (4 states).
- **MIXED STRUCTURE:** Some local health units are led by state employees, and some are led by local government employees. No single structure predominates (6 states).
- **DECENTRALIZED OR LARGELY DECENTRALIZED STRUCTURE:** Local health units are primarily led by local governments employees and the local governments retain authority over most fiscal decisions (27 states, **including Indiana**).

ASTHO 2019 State Health Agency Governance Classification

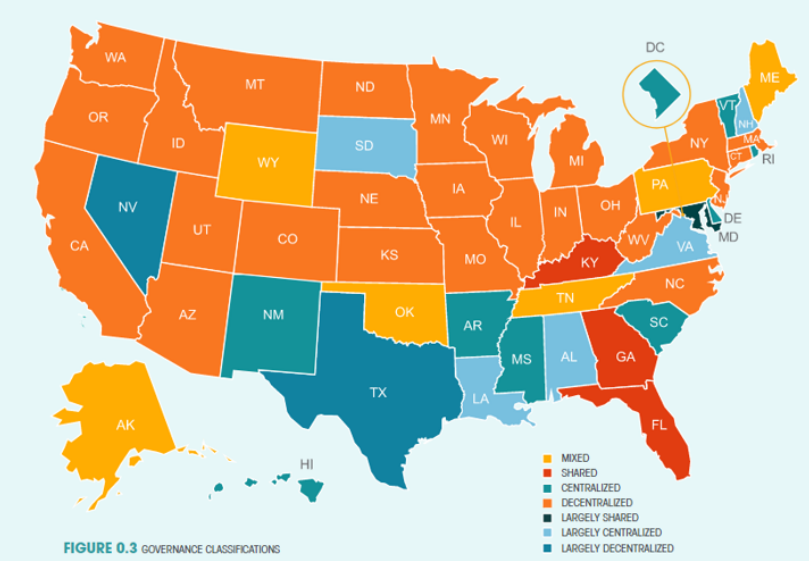
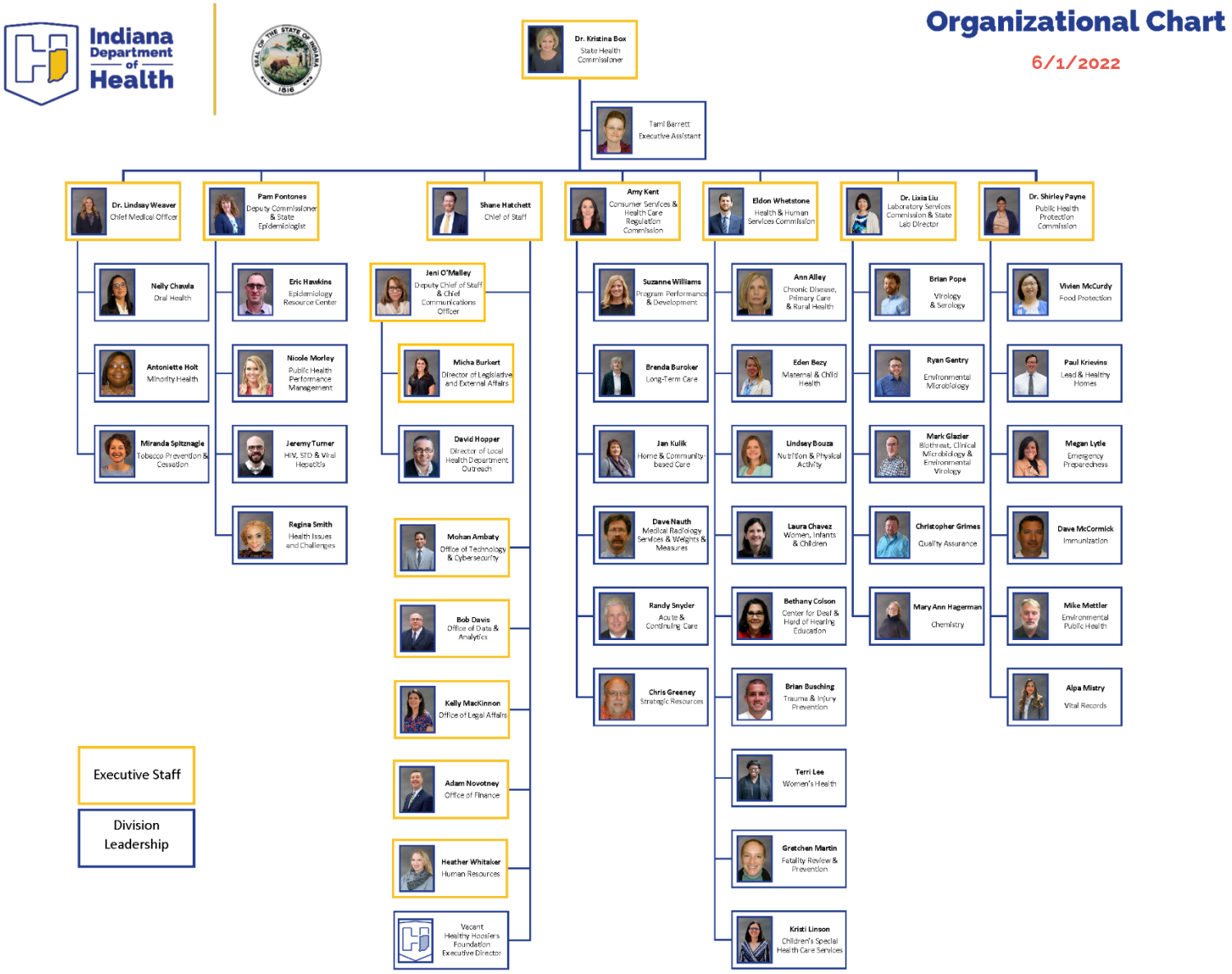


FIGURE 0.3 GOVERNANCE CLASSIFICATIONS

Appendix B: Indiana Department of Health Organizational Chart



Appendix C: Indiana Code Sections Pertaining to Local Health Board Membership and Appointment

County-based Local Health Boards

IC 16-20-2-4 Composition of board

Sec. 4. A local board of health is composed of seven (7) members, not more than four (4) of whom may be from the same political party.

IC16-20-2-5 Membership Selection Criteria

Sec. 5. The members of a local board of health shall be chosen as follows:

(1) Four (4) persons knowledgeable in public health, at least two (2) of whom are licensed physicians. The other two (2) appointees may be any of the following:

(A) A registered nurse licensed under IC 25-23.

(B) A registered pharmacist licensed under IC 25-26.

(C) A dentist licensed under IC 25-14.

(D) A hospital administrator.

(E) A social worker.

(F) An attorney with expertise in health matters.

(G) A school superintendent.

(H) A veterinarian licensed under IC 25-38.1.

(I) A professional engineer registered under IC 25-31.

(J) An environmental scientist.

(2) Two (2) representatives of the general public.

(3) One (1) representative described in either subdivision (1) or (2).

IC 16-20-2-6 Appointment of members

Sec. 6. Except as provided in section 7 of this chapter, the county executive shall appoint the members of a local board of health.

IC 16-20-2-7 Appointment of members in certain circumstances

Sec. 7. (a) In the following counties, the county executive and the executive of the most populous city located in the county shall appoint the members of the local board of health as provided in subsection (b):

(1) A county having a population of more than one hundred seventy-five thousand (175,000) but less than one hundred eighty-five thousand (185,000).

(2) A county having a population of more than seventy-one thousand (71,000) but less than seventy-five thousand (75,000).

(b) The executive of each second-class city located in a county described in subsection (a) shall appoint a number of members of the board in the proportion that the city's population is to the total county population to the nearest whole fraction. The appointments made under this subsection shall be made in order, according to the population of a city, with the city having the largest population making the first appointments. The county executive shall appoint the remaining number of members of the county board of health.

Multiple County LHDs

IC 16-2-3-2 Board members; qualifications; appointment

Sec. 2. (a) There must be at least seven (7) members of a multiple county board of health.

(b) The county executives establishing a multiple county health department shall determine the following for the multiple county board of health:

(1) The number of members.

(2) The qualifications of members.

(3) The number of appointments made by each county.

(c) The county executive of each county participating in a multiple county board of health shall appoint at least one (1) licensed physician.

(d) At least two-thirds (2/3) of the members appointed under this section must have expertise in public health. The appointees may be any of the following:

(1) A registered nurse licensed under IC 25-23.

(2) A registered pharmacist licensed under IC 25-26.

(3) A dentist licensed under IC 25-14.

(4) A hospital administrator.

(5) A social worker.

(6) An attorney with expertise in health matters.

(7) A school superintendent.

(8) A veterinarian licensed under IC 25-38.1.

(9) A professional engineer registered under IC 25-31.

(10) An environmental scientist.

Municipal LHDs

IC 16-20-4-6 Health board membership; qualifications

Sec. 6. The city health departments provided for by this chapter shall be managed by a board of health consisting of seven (7) members appointed by the city executive, not more than four (4)

of whom belong to the same political party. At least three (3) of the members must be licensed physicians. At least one (1) of the members must be a licensed veterinarian.

Health and Hospital Corporation of Marion County

IC 16-22-8-8 Governing board; membership; qualifications

Sec. 8. (a) The board consists of seven (7) members chosen at large from the county in which the corporation is established.

(b) To be eligible to be selected or serve as a member of the board, an individual must have the following qualifications:

(1) Be a resident in the county.

(2) Have been a continued resident in the county for not less than three (3) years immediately preceding the first day of the member's term.

IC 16-22-8-9 Governing board; appointment of members; term

Sec. 9. (a) The executive of the consolidated city shall appoint three (3) board members, not more than two (2) of whom may belong to the same political party. One (1) member must be a licensed physician.

(b) The board of commissioners of the county in which the corporation is established shall appoint two (2) board members who may not belong to the same political party.

(c) The city-county legislative body shall appoint two (2) board members who may not belong to the same political party. One (1) member shall be appointed for a two (2) year term, and one (1) member shall be appointed for a four (4) year term.

(d) Except as provided in subsection (c), a board member serves a term of four (4) years from the beginning of the term for which the member was appointed until a successor has qualified for the office. Board members are eligible for reappointment.

Appendix D: Excerpts From "Indiana Local Health Department Duties and Requirements by Indiana Code (IC) & Indiana Administrative Code (IAC)" *(Revised October 2021)*

Prepared by the Indiana Local Health Department Managers Association and represents their analysis and views.

This document is designed simply to guide local health departments in providing an outline of duties that are *required* ("shall do" or "must do") of local health departments in Indiana and those duties that are *allowable* ("may do") and may be conducted by choice by local health departments in Indiana. This was derived as a helpful tool – but has not been formally legally reviewed and is subject to change as needed. It is also subject to interpretation per locality and again, is merely a guide. All sections denoted in blue font below are generalizations of whether or not a statute/rule is funded or unfunded (with "funded" meaning either by way of directly-provided state/federal funds or by the authority provided in the rules to allow a local health department to charge for the services with a local ordinance). This may vary county-to-county based upon whether or not their budget is fully tax-based – in which case, these duties would technically not be considered unfunded as taxes could technically be considered to be funding them. It is merely listed as a tool for local discussion and mainly references whether or not duties are considered a state or federal unfunded mandate.

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In general, the following are statutorily-required duties that Indiana Local Health Departments must perform via Indiana Code or Indiana Administrative Code:

General Rules Governing Local Health Departments and Boards of Health (Formation, Type, Meetings, etc.)

IC 16-19 and 16-20 **Boards of Health and Local Health Department Duties & Restrictions**
These chapters go over what Executive Boards of Health must do and discusses budgets, annual reports, salaries, enforcement, etc. – basically prescribes the general duties of a local health department and their board.

IC 16-20-1-23 **Inspection of private property by local health officer**
This is the section that provides guidance for how to seek consent for inspection of private property, what to do if denied entry, how to seek an inspection warrant, and what circumstances allow for urgent entry, etc.

IC 16-20-1-25 **Unlawful conditions; abatement order; enforcement; providing false information**

IC 16-20-1-26 **Injunctive enforcement; legal representation of health authorities**

Vital Records/Birth/Death

Collection, recording, filing, and submission of Vital Statistics and all associated duties

FUNDED OR UNFUNDED: In general, local health departments have the statutory authority to and do charge fees for services for Vital Records associated duties, so this is not considered an unfunded mandate.

IC 16-20-1-17 *(Vital Statistics; birth and death records)*
IC 16-21-11-6 *(Disposition by cremation or interment; costs; permits; confidential information – regarding a miscarried fetus)*
IC 16-34-3-4 *(Disposition by cremation or interment; permits; confidential information – regarding an aborted fetus)*
IC 16-35-7 *(Child Deaths)*
IC 16-37 *(General Statutes regarding Vital Records)*
IC 16-37-1-9 *(Coroner's Continuing Education Fund)* ***Unfunded Mandate***
IC 16-38-2-7 *(Release of Confidential Information – regarding cancer patients and information released by IDOH to local health departments)*
IC 16-38-4 *(Birth Problems Registry)*
IC 16-38-6-7 *(Releasing Confidential Information – regarding IDOH releasing information to local health officers about chronic disease patients)*
IC 16-41-6-9 *(Information on confidential part of birth certificate- regarding HIV tests performed under certain conditions)*
IC 23-14-31 *(Cremation)*
IC 23-14-57 *(Disinterment, Disentombment and Disinurnment)*
IC 31-19-5 *(Indiana Putative Father Registry)*
IC 31-19-13 *(New Birth Certificate Following Adoption)*
IC 34-28-2 *(Change of Name)*
IC 36-2-14 *(County Coroner)*
IC 10-13-5-11 *(Indiana Clearinghouse for Information on Missing Children)*
410 IAC 18 *(Vital Records)*

Control of Disease

Public Health Measures for the Prevention and Treatment of Disease as well as all required follow-up of Reportable Communicable Diseases

FUNDED OR UNFUNDED: With the exception of certain IDOH -provided medications, large pandemics receiving federal funding initiatives such as H1N1, COVID-19, and some IDOH-provided STD testing, the performance of these duties is considered an unfunded mandate as no monies are provided to local health departments to perform these duties and they are often performed under emergency circumstances to protect the community. For many years, these services were provided completely free of charge in most local health departments (TB testing, TB treatment, STD testing, STD treatment, etc.). Some local health departments may now seek reimbursement from Medicaid/Medicare/Private Insurance, and some may have begun charging fees for some clinical services to begin to offset the costs of providing these services if local tax funding is falling short of covering all departmental costs. Large outbreaks of communicable diseases and the required responses, however, are still generally unfunded and take a large toll on local budgets. Further, all investigations of reportable diseases generally are considered just "regular required" duties for local health departments.

IC 16-20-1-21 *(Communicable disease control; powers)*

IC 16-20-1-24	*(Epidemic control; powers)*
IC 16-41	*(Public Health Measures for the Prevention and Control of Disease --All General Communicable Disease Prevention Rules)*
410 IAC 1-2.2-5	*(Reports to Local Health Officers regarding Communicable Disease)*
410 IAC 1-2.5	*(Communicable Disease Reporting Rule)*
410 IAC 2-1	*(Tuberculosis Control)*
410 IAC 2-2	*(Payment for TB treatment under certain circumstances & Patient Movement/Transfers)*
410 IAC 29	*(Childhood Lead Poisoning)*
IC 16-41-19	*(Vaccination Provisions for Indigent Persons; payment and forms)*
410 IAC 6-9-5(b)	*(Agricultural Labor Camps; notification of communicable disease only)*

Food Protection

Food Protection, Inspection, Sanitary Requirements, Food Handler Certification, Bed & Breakfast Establishments

FUNDED OR UNFUNDED: In general, local health departments have the statutory authority to and do charge fees for services for Food Establishment Permitting and Inspection-associated duties, so this is not considered an unfunded mandate.

IC 16-18-2-137	*(Food Establishment Sanitary Requirements Exception)*
IC 16-20-8	*(Food Service Inspections)*
IC 16-41-31	*(Regulation of Lodging Facilities and Bedding Materials: Bed & Breakfast Establishments – these are the authorities IDOH has in this regard but defines some basic things)*
IC 16-42	*(Regulation of Food, Drugs, and Cosmetics)*
IC 16-42-5	*(Sanitary Food Requirements for Food Establishments)*
410 IAC 7-15.5	*(Bed & Breakfast Rule)*
410 IAC 7-22	*(Food Handler Certification Rule)*
410 IAC 7-23	*(Civil Penalties Rule)*
410 IAC 7-24	*(Indiana Food Sanitation Rule)* *NOTE: HEA 1260 (in 2018) made changes to IDOH's hospital survey/inspection processes and resulted in the retail food inspection portion of accredited hospitals being passed down to local health departments to carry out starting 1/1/2019.*

Pollution Control

Monitoring and Regulation of Wastewater/Sewage Disposal

FUNDED OR UNFUNDED: In general, local health departments have the statutory authority to and do charge fees for services for Pollution Control/Onsite Sewage System Permitting and Inspection-associated duties, so this is not considered an unfunded mandate.

410 IAC 6-8.3	*(Residential Sewage Disposal Rule)*
410 IAC 6-10.1	*(Commercial On-Site Wastewater Disposal*
410 IAC 6-12	*(Plan Review, Construction Permits, and Fees for Service)*

IC 16-41-25 *(Health, Sanitation, and Safety: Residential Septic Systems, Required Lid Covering, Fill Soil, Notice Regarding Sewer Districts)*
IC 13-26-5-2.5-2.6 *(Septic tank soil absorption system exemption from Sewer Connection and Local Health Department Duties in this Regard)*

Vector Control

Pest Control and Vector Abatement Programs

FUNDED OR UNFUNDED: Direct funding is not provided to carry out these duties. It is sometimes considered covered under local tax monies allocated in local health department budgets. This section allows for the creation of a tax levy for these services, but the current tax caps laws likely would make this allowance moot.

IC 16-41-33 *(Pest Control – General Provisions)*
IC 16-41-34 *(Pest Control – Eradication of Rats)*

Dwellings Unfit for Human Habitation

General Health, Sanitation, Inspection and Safety Provisions

FUNDED OR UNFUNDED: Direct funding is not provided to carry out these duties, however, it is a core duty of local health departments that is considered covered under local tax monies allocated in local health department budgets.

IC 16-41-20 *(Dwellings Unfit for Human Habitation – and associated duties, powers, orders to vacate, costs)*

Childhood Lead Poisoning

Reporting, Monitoring, Case Management, and Preventive Procedures for Childhood Lead Poisoning

FUNDED OR UNFUNDED: These duties are considered unfunded mandates. These duties originated with *some* available IDOH (CDC pass-through) funding many years ago when the legislation initially passed (and some local health departments applied for the funding), but those funds have gone away, and the duties remain. For some local health departments, this is a very large unfunded mandate.

410 IAC 29 *(Lead Poisoning Rule)*
IC 16-41-39.4 *(Childhood Lead Poisoning, Sales of Consumer Products, Lead Safe Rules. Local Health Department Responsibilities)*

Railroad Camp Cars

Requiring inspection and allowing licensing of railroad mobile camp cars

FUNDED OR UNFUNDED: In general, local health departments have the statutory authority to and can charge fees for services for Railroad Camp Car Permitting and Inspection-associated duties if they perform these duties, so this is not considered an unfunded mandate. It is worth noting that it is not a duty that seems to fit within the LOCAL health department duties since these trains move throughout the state and therefore it seems more fitting to be inspected at the STATE level. These are lengthy inspections and often involve inspectional aspects that are not related to public health but must be done (electrical, heating, mechanical, etc.).

IC 8-9-10 *(Indiana Camp Car Sanitary Rules)*

IC 16-10-3-4.4 *(Mobile Camps – railroads)*
410 IAC 6-14 *(Indiana Camp Car Sanitary Rule)*

"OTHER Miscellaneous Requirements"

IC 13-23-16 ***(Unfunded Mandate)*** *(LHD Reporting of Spills & Overfills from UST's) -- Local health departments have to pay to have these spills advertised for IDEM*

318 IAC 1 ***(Unfunded Mandate)*** *(Referred to as the "Methamphetamine Rule") -- Depending on the level of response and involvement each local health department engages in with identified meth/clandestine labs, this is a very large unfunded mandate. It is often difficult to think of charging fees for local health department services as most of the time those who are responsible for these meth labs are incarcerated, etc. This is a very difficult thing to enforce as well as capture any reimbursement for provision of services.*

IC 24-5-13, sections 4.1, 16.1, 16.2, and 24 *(Methamphetamine Labs in Vehicles)* ***(Unfunded Mandate)***

410 IAC 6-7.1-16 and 7.1-33 *(Campgrounds / Temporary Campgrounds)*

IC 10-14-3 *(Emergency Mgmt. and Disaster Law – health related areas)*

IC 5-14-1.5 *(Public Meetings – OPEN DOOR LAW)*

IC 5-14-3 *(Access to Public Records)*

410 IAC 24-1 *(Local Health Maintenance Funds and Fees for Service)*

IC 16-20 *(Throughout this statute, there are many duties LHDs "may" do – please read this section in full as it defines what must be done, what cannot be done, and what can be done.)*

IC 16-20-1-25 *(Investigation and Ordered Abatement of all conditions that may transmit, generate, or promote disease; complaints)*

IC 16-41-8 *(Communicable Disease Confidentiality Requirements)*

IC 16-41-19-2 ***(Unfunded Mandate)*** *(Antitoxins and Vaccines – this section requires "all counties, cities and towns" --- doesn't specifically obligate the local health department, but it is usually construed that way --- to "provide diphtheria, scarlet fever, and tetanus antitoxin and rabies vaccine to persons financially unable to purchase the antitoxin or vaccine, upon the application of a licensed physician." This is an old rule and work continues to get it removed.*

IC 16-41-22-12 *(Health, Sanitation, and Safety: Mass Gatherings) – see Section 12.*

IC 16-41-22 *(Health, Sanitation & Safety of Mass Gatherings – see IC 16-41-22-12 as it relates to local health dept. responsibilities)*

IC 16-41-30 *Regulation of Lodging Facilities and Bedding Materials: Fresh Bedding for Hotel Guests*

IC 16-41-34 ***(Unfunded Mandate)*** *(Pest Control: Eradication of Rats, inspections) – note that there are both some required and allowed duties under this statute. (NOTE: There is an older provision in the statutes that allows for local health departments to request an increase to their tax levy to cover the costs of this sort of program. However, when the tax cap laws took effect, this eliminated even the possibility of requesting this as taxes are now capped in most*

	counties and no new levies can be implemented without offsetting other taxes.)
IC 16-49-2 & 3	*(Establishing Local Child Fatality Review Teams)*
15 U.S.C. 8001-8008 ("Virginia Graeme Baker Pool and Spa Safety Act") – section 32(e) (Unfunded Mandate)	*All public and semi-public pools and spas must comply with this rule relative to drain covers and local health departments who regulate pools OR receive complaints on this issue are, in general, responsible for ensuring compliance with this federal rule (this is because although the federal rule may designate states as the enforcers of this rule, in Indiana, the State does not regulate swimming pools and usually defers to local health departments for this type of enforcement, therefore compliance with this act falls on any local health department who regulates swimming pools).*

In general, the following are duties Indiana Local Health Departments MAY/CAN perform but they are not required duties under the statutes/rules (and since these are not required, none are considered unfunded mandates per se, as conceivably fees could be charged to administer most of them, or you can choose not to do these duties). SEVERAL COUNTIES HAVE LOCAL ORDINANCES OR PROGRAMS THAT GOVERN THESE ACTIVITIES FOR THEIR AREA:

ADDITIONAL OPTIONAL PROGRAMS WHICH ARE MENTIONED IN STATE STATUTES OR ADMINISTRATIVE RULES (therefore, if counties opt to pass local ordinances to do them, they generally adopt the state rules in that regard to enforce, but likely add to them for local needs):

Syringe Services Programs (SSPs)

IC 16-41-7.5 *(Communicable Disease: Syringe Service Programs)*

STD's, HIV Prevention (the clinical side of things – testing, treatment, partner services, etc.)

IC 16-41-15 *(Communicable Disease: Prevention and Control of Sexually Transmitted Diseases)*

Mobile Homes

IC 16-41-27 *(Health, Sanitation, & Safety of Mobile Homes – see IC 16-41-27-32)*

Pest/Vector/Mosquito/Rodent Control

IC 16-41-33 *(Pest Control; Local and State Programs for Vector Abatement)*

Swimming & Wading Pools
410 IAC 6-2.1 (Swimming and Wading Pool Operations Rule)

Tattoo & Body Piercing
410 IAC 1-5 (Sanitary Operation of Tattoo Parlors & Body Piercing Establishments)

Campgrounds and Bathing Beaches
410 IAC 6-7.1 (Campgrounds and Bathing Beaches; inspections/investigations, testing)

Youth Camps
410 IAC 6-7.2 (Youth Camps; inspections/investigations, testing)

OTHER:
IC 16-46 (State Health Grants and Programs to Local Boards of Health)
IC 7.1-5-12 (Smoking Ban)
IC 8-2.1-27 (Transportation of Food)

OTHER PUBLIC HEALTH PROGRAM ACTIVITIES THAT ARE DONE IN MANY HEALTH DEPARTMENTS BY THEIR OWN (or their elected official's own) CHOICE – BUT ARE NOT COVERED IN INDIANA STATUTE OR ADMINISTRATIVE RULES:

- Housing/Unfit for Human Habitation Complaints and Inspections
- Public Nuisance Ordinances
- Open Burning Enforcement
- Lead Risk Assessments, Mold Programs, etc.
- Massage Parlor Establishments
- Health-related programs for either education or attempting to lower the impacts of infant mortality, obesity, smoking, maternal child issues, etc.
- Refugee Care
- Travel Clinics – Immunizations, Medications, Counsel on International Travel & Disease
- Random Ordinances already in existence in cities/counties (not mentioned in current statutes or administrative rules)
    - Beekeeping Ordinances
    - CPR Ordinances
    - Patient Safety or other Safety-related Ordinances
    - Well Ordinances
    - Onsite Wastewater Management District Ordinance (Allen County only per IDEM requirements)
- Fee Ordinances – that cover a large portion of LHD operations (for permits, vital records, etc.)
- WIC Clinics for those who have this included in with their Health Department.
- Civil Surgeon Exam programs

*~**Childhood and/or Adult Immunizations** (although most LHDs offer some sort of immunization services, they are not generally required duties -- other than those required in accordance with IC 16-41-19 or if they are associated with some form of outbreak where IDOH/CDC prescribes a required response). In general, though, this is one of the unrequired, but core programs health departments offer across the state.*

*~**Emergency Preparedness Planning and Response** (other than any implied duties found under IC 10-14-3)*

*~**HOTELS/MOTELS/LODGING FACILITIES** – although there are no specific statutes/rules pertaining the regulation of hotels/motels/lodging facilities, local health departments are responsible for the sanitation standards of those types of facilities and generally do follow-up inspections upon receiving complaints from the public. Some counties have developed local ordinances to set forth standards, penalties and for outlining inspectional requirements, but most counties in Indiana do complaint-based inspections.*

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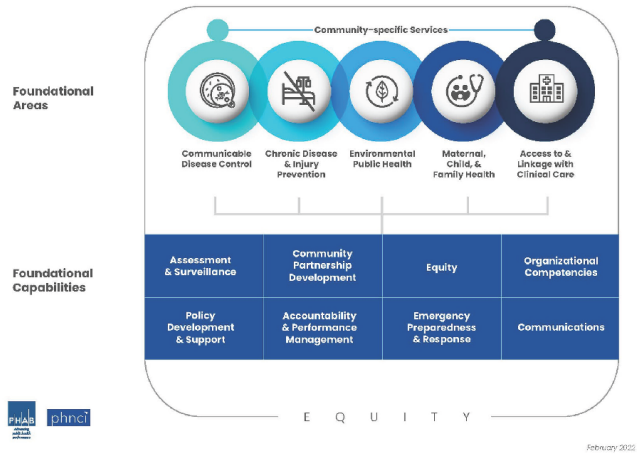
Appendix E: Foundational Public Health Services Fact Sheet

Foundational Public Health Services

Health departments have a fundamental responsibility to provide public health protections and services in a number of areas, including: preventing the spread of communicable disease; ensuring food, air, and water quality are safe; supporting maternal and child health; improving access to clinical care services; and preventing chronic disease and injury. In addition, public health departments provide local protections and services specific to their community's needs.

The infrastructure needed to fulfill these responsibilities works to provide fair and just opportunities for all to be healthy and includes eight capabilities: 1) Assessment & Surveillance, 2) Community Partnership Development, 3) Equity, 4) Organizational Competencies, 5) Policy Development & Support, 6) Accountability & Performance Management, 7) Emergency Preparedness & Response, and 8) Communications. Health departments serve their communities 24/7 and require access to a wide range of critical data sources, robust laboratory capacity, preparedness and policy planning capacity, partnerships with community, and expert staff to leverage them in support of public health protections.

The Foundational Public Health Services framework outlines the unique responsibilities of governmental public health and defines a minimum set of foundational capabilities and foundational areas that must be available in every community.



Community-specific Services are local protections and services that are unique to the needs of a community. These services are essential to that community's health and vary by jurisdiction.

Foundational Areas

Public health programs, or Foundational Areas, are basic public health, topic-specific programs and services aimed at improving the health of the community.. The Foundational Areas reflect the minimum level of service that should be available in all communities.

Foundational Capabilities

Public health infrastructure consists of Foundational Capabilities that are the cross-cutting skills and capacities needed to support basic public health protections, programs, and activities key to ensuring community health, well-being and achieving equitable outcomes.

Foundational Capabilities

There are eight Foundational Capabilities that are needed in Public Health Infrastructure.

Assessment & Surveillance

- Ability to collect timely and sufficient foundational data to guide public health planning and decision making at the state and local level, including the personnel and technology that enable collection.
- Ability to collect, access, analyze, interpret, and use data from a variety of sources including granular data and data disaggregated by geography (e.g., census tract, zip code), sub-populations, race, ethnicity, and other variables that fully describe the health and well-being of a community and the factors that influence health.
- Ability to assess and analyze disparities and inequities in the distribution of disease and social determinants of health, that contribute to higher health risks and poorer health outcomes
- Ability to prioritize and respond to data requests and translate data into information and reports that are valid, complete, statistically accurate, and accessible to the intended audiences.
- Ability to conduct a collaborative community or statewide health assessment and identify health priorities arising from that assessment, including analysis of root causes of health disparities and inequities.
- Ability to access 24/7 laboratory resources capable of providing rapid detection.
- Ability to participate in or support surveillance systems to rapidly detect emerging health issues and threats.
- Ability to work with community partners to collect, report and use public health data that is relevant to communities experiencing health inequities or ability to support community-led data processes

Community Partnership Development

- Ability to create, convene, support, and sustain strategic, non-program specific relationships with key community groups or organizations representing populations experiencing health disparities or inequities; private businesses and health care organizations; relevant federal, Tribal, state, and local government agencies; elected and non-elected officials.
- Ability to leverage and engage partnerships and community in equity solutions.
- Ability to establish and maintain trust with and authentically engage community members and populations most impacted by inequities in key public health decision-making and use community-driven approaches
- Ability to convene across governmental agencies, such as departments of transportation, aging, substance abuse/mental health, education, planning and development, or others, to promote health, prevent disease, and protect community members of the health department's jurisdiction.
- Ability to engage members of the community and multi-sector partners in a community health improvement process that draws from community health assessment data and establishes a plan for addressing priorities. The community health improvement plan can serve as the basis for coordination of effort and resources across partners.

Equity

- Ability to strategically address social and structural determinants of health through policy, programs, and services as a necessary pathway to achieve equity.
- Ability to systematically integrate equity into each aspect of the FPHS, strategic priorities, and include equity-related accountability metrics into all programs and services.
- Ability to work collaboratively across the department and the community to build support for and foster a shared understanding of the critical importance of equity to achieve community health and well-being.
- Ability to develop and support staff to address equity
- Ability to create a shared understanding of what creates health including structural and systemic factors that produce and reproduce inequities

Organizational Competencies

- **Leadership & Governance:** Ability to lead internal and external stakeholders to consensus, with movement to action, and to serve as the face of governmental public health in the department's jurisdiction. Ability to directly engage in health policy development, discussion, and adoption with local, state, and national policymakers, and to define a strategic direction for public health initiatives, including the advancement of equity. Ability to prioritize and implement diversity, equity, inclusion within the organization. Ability to engage with appropriate governing entities about the department's public health legal authorities and what new laws and policies might be needed. Ability to ensure diverse representation on public health boards and councils.
- **Information Technology Services, including Privacy & Security:** Ability to maintain and procure the hardware and software needed to access electronic health information to support the department's operations and analysis of health data. Ability to support, use, and maintain communication technologies and systems needed to interact with community members. Ability to have the proper systems and controls in place to keep health and human resources data confidential and maintain security of IT systems.
- **Workforce Development & Human Resources:** Ability to develop and maintain a diverse and inclusive workforce with the cross-cutting skills and competencies needed to implement the FPHS effectively and equitably. Ability to manage human resource functions including recruitment, retention, and succession planning; training; and performance review and accountability.
- **Financial Management, Contract, & Procurement Services, including Facilities and Operations:** Ability to establish a budgeting, auditing, billing, and financial system and chart of expense and revenue accounts in compliance with federal, state, and local standards and policies. Ability to secure grants or other funding (governmental and not) and demonstrate compliance with an audit required for the sources of funding utilized. Ability to procure, maintain, and manage safe facilities and efficient operations. Ability to leverage funding and ensure resources are allocated to address equity and social determinants of health.
- **Legal Services & Analysis:** Ability to access and appropriately use legal services in planning, implementing, and enforcing, public health initiatives, including relevant administrative rules and due process.

Policy Development & Support

- Ability to serve as a primary and expert resource for establishing, maintaining, and developing basic public health policy recommendations that are evidence-based and grounded in law. This includes researching, analyzing, costing out, and articulating the impact of such policies and rules where appropriate, as well as the ability to organize support for these policies and rules and place them before an entity with the legal authority to adopt them.
- Ability to effectively inform and influence policies being considered by other governmental and non-governmental agencies that can improve the physical, environmental, social, and economic conditions affecting health but are beyond the immediate scope or authority of the governmental public health department.
- Ability to effectively advocate for policies that address social determinants of health, health disparities and equity.
- Ability to issue, promote compliance with or, as mandated, enforce compliance with public health regulations.

Accountability & Performance Management

- Ability to perform according to accepted business standards in accordance with applicable federal, state, and local laws and policies and assure compliance with national and Public Health Accreditation Board Standards.
- Ability to maintain a performance management system to monitor achievement of organizational objectives.
- Ability to identify and use evidence-based or promising practices when implementing new or revised processes, programs and/or interventions.
- Ability to maintain an organization-wide culture of quality and to use quality improvement tools and methods.
- Ability to create accountability structures and internal and external equity-related metrics to measure the equity impact of a department's efforts and performance.

Emergency Preparedness & Response

- Ability to develop, exercise, and maintain preparedness and response strategies and plans, in accordance with established guidelines, and to address a range of events including natural or other disasters, communicable disease outbreaks, environmental emergencies, or other events, which may be acute or occur over time.
- Ability to integrate social determinants of health, and actions to address inequities, including ensuring the protection of high-risk populations, into all plans, programs, and services.
- Ability to lead the Emergency Support Function 8 – Public Health & Medical for the county, region, jurisdiction, and state.

- Ability to activate the emergency response personnel and communications systems in the event of a public health crisis; coordinate with federal, state, and local emergency managers and other first responders, and private sector and non-profit partners; and operate within, and as necessary lead, the incident management system.
- Ability to maintain and execute a continuity of operations plan that includes a plan to access financial resources to execute an emergency and recovery response.
- Ability to establish and promote basic, ongoing community readiness, resilience, and preparedness by enabling the public to take necessary action before, during, or after a disaster, emergency, or public health event.
- Ability to issue and enforce emergency health orders.
- Ability to be notified of and respond to events on a 24/7 basis.
- Ability to access and utilize a Laboratory Response Network (LRN) Reference laboratory for biological agents and an LRN chemical laboratory at a level designated by CDC.

Communications

- Ability to maintain ongoing relations with local and statewide media including the ability to write a press release, conduct a press conference, and use electronic communication tools to interact with the media.
- Ability to effectively use social media to communicate directly with community members.
- Ability to appropriately tailor communications and communications mechanisms for various audiences
- Ability to write and implement a routine communications plan and develop routine public health communications including to reach communities not traditionally reached through public health channels
- Ability to develop and implement a risk communication strategy for communicating with the public during a public health crisis or emergency. This includes the ability to provide accurate and timely information and to address misconceptions and misinformation, and to assure information is accessible to and appropriate for all audiences.
- Ability to transmit and receive routine communications to and from the public in an appropriate, timely, and accurate manner, on a 24/7 basis.
- Ability to develop and implement a proactive health education/health communication strategy (distinct from risk communication) that disseminates timely and accurate information to the public designed to encourage actions to promote health in culturally and linguistically appropriate formats for the various communities served, including using electronic communication tools.

Foundational Areas

There are five Foundational Areas, also known as Public Health Programs. **Social determinants of health and actions to address health inequities should be integrated throughout all activities.**

Communicable Disease Control

- Provide timely, statewide, and locally relevant and accurate information to the health care system and community on communicable diseases and their control.
- Identify statewide and local communicable disease control community partners and their capacities, develop, and implement a prioritized communicable disease control plan, and ability to seek and secure funding for high priority initiatives.
- Receive laboratory reports and other relevant data; conduct disease investigations, including contact tracing and notification; and recognize, identify, and respond to communicable disease outbreaks for notifiable conditions in accordance with local, national, and state mandates and guidelines.
- Assure the availability of partner notification services for newly diagnosed cases of communicable diseases according to Centers for Disease Control and Prevention (CDC) guidelines.
- Assure the appropriate treatment of individuals who have reportable communicable diseases, such as TB, STIs, and HIV in accordance with local and state laws and CDC guidelines.
- Support the recognition of outbreaks and other events of public health significance by assuring capacity for the identification and characterization of the causative agents of disease and their origin, including those that are rare and unusual.
- Coordinate and integrate categorically-funded communicable disease programs and services.

Chronic Disease & Injury Prevention

- Provide timely, statewide, and locally relevant, complete, and accurate information to the health care system and community on chronic disease and injury prevention and control.
- Identify statewide and local chronic disease and injury prevention community partners and their capacities, develop, and implement a prioritized prevention plan, and ability to seek and secure funding for high priority initiatives.
- Reduce statewide and community rates of tobacco use through a program that conforms to standards set by state or local laws and CDC's Office on Smoking and Health, including activities to reduce youth initiation, increase cessation, and reduce secondhand exposure to harmful substances.
- Work actively with statewide and community partners to increase statewide and community rates of healthy eating and active living through a prioritized approach focusing on best and promising practices aligned with national, state, and local guidelines for healthy eating and active living.
- Coordinate and integrate categorically-funded chronic disease and injury prevention programs and services.

Environmental Public Health

- Provide timely, statewide, and locally relevant, complete, and accurate information to the state, health care system, and community on environmental public health threats and health impacts from common environmental or toxic exposures.
- Identify statewide and local community environmental public health partners and their capacities, develop, and implement a prioritized plan, and ability to seek and secure action funding for high priority initiatives.
- Conduct mandated environmental public health laboratory testing, inspections, and oversight to protect food, recreation sites, and drinking water; manage liquid and solid waste streams safely; and identify other public health hazards related to environmental factors in accordance with federal, state, and local laws and regulations.
- Protect workers and the public from chemical and radiation hazards in accordance with federal, state, and local laws and regulations.
- Participate in broad land use planning and sustainable development to encourage decisions that promote positive public health outcomes and resilient communities (e.g., housing and urban development, recreational facilities, transportation systems and climate change).
- Coordinate and integrate categorically-funded environmental public health programs and services.

Maternal, Child, & Family Health

- Provide timely, statewide, and locally relevant, complete, and accurate information to the health care system and community on emerging and on-going maternal child health trends.
- Identify local maternal and child health community partners and their capacities; using life course expertise and an understanding of health disparities, develop a prioritized prevention plan; and ability to seek and secure funding for high priority initiatives.
- Identify, disseminate, and promote emerging and evidence-based early interventions in the prenatal and early childhood period that promote lifelong health and positive social-emotional development.
- Assure newborn screening as mandated by a state or local governing body including wraparound services, reporting back, following up, and service engagement activities.
- Coordinate and integrate categorically funded maternal, child, and family health programs and services.

Access to & Linkage with Care

- Provide timely, statewide, and locally relevant, complete, and accurate information to the health care system and community on access and linkage to clinical care (including behavioral health), healthcare system access, quality, and cost.
- Inspect and license healthcare facilities, and license, monitor, and discipline healthcare providers, where applicable.
- In concert with national and statewide groups and local providers of healthcare, identify healthcare partners and competencies, develop prioritized plans for increasing access to health homes and quality health care, and seek funding for high priority policy initiatives.

Appendix F: Characteristics and Examples of Service Delivery Models from Washington State

Model Type	Characteristics	Examples
Local solely responsible	• Maximizes local knowledge • Quality/standards vary across state • Smaller LHJs disadvantaged by staff/ expertise hiring/retention difficulty • Expertise; costly per capita coverage; professional isolation	On-site sewage system inspections and solid waste enforcement activities – vary depending on prevalence and local codes.
Mutual aid/interlocal agreements/ contracting	• Responsive to demand • Dependent on personal relationships • Mode of delivery not typically co-planned • Vulnerable to changes in personnel/ elected officials and failure to negotiate mutually agreeable terms • Negotiations expensive/time-consuming	Clallam contracts Kitsap PH epidemiologists for comm. disease reports and data dashboards. Skamania and Yakima have the same Health Officer who is also the deputy health officer in Clark County.
Hub and spoke	• Efficiencies of scale in administration and other hub functions • Provides natural venues for standardization and information sharing • Creates relationships between institutions	State-funded Disease Investigation Specialists are embedded in five LHJ locations in Washington and they serve outlying LHJs in STD response.
Centers of Excellence	• Similar advantages as hub and spoke, but less formal • Develops capacity that can be responsive to surge demand • Areas may be left out due to informality and as-needed structure	In the TB Control Demonstration Project, Public Health – Seattle & King County's expertise in tuberculosis is available statewide through an online consultative program, to help LHJs assess and treat cases.
Combination (jurisdictions combine programs)	• Pools resources while retaining regional-level local control • Rural areas will face the same hiring and resource issues as full local control • Vulnerable to changes in personnel and elected officials	Lewis and Thurston counties have combined their Nurse-Family Partnership programs into a joint team to make home visits to low-income, first-time mothers in the combined region.
Centralized	• Fewer redundancies • Able to attract and retain specialized personnel • Less aware of and responsive to local need	DOH centrally manages statewide data systems and surveillance related to public health, e.g., the Behavioral Risk Factor Surveillance System and the WA Disease Reporting System (former Public Health Information Management System)

Appendix G: CDC and HRSA Grant Funding to Indiana

FY 2017 per capita grant funding for selected public health-related programs administered by the Health Resources and Services Administration (HRSA) ranged from a high of $114.78 and $59.12 in Alaska and Montana, respectively, to a low of $16.26 and $17.55 in Nevada and Minnesota, respectively, with Indiana ranking 40th at $23.48 per person.[2]

FY 2017 HRSA Grants to States by Key Program Area (Selected Programs)

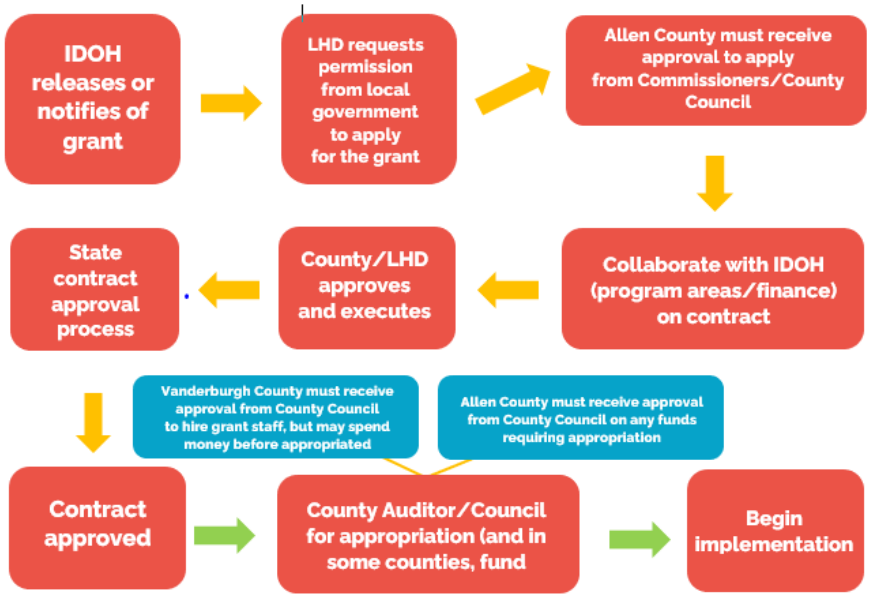
Grant	Amount
Primary Health Care Funding	$ 72,261,175
Health Professions Funding	$ 6,002,885
Maternal & Child Health Funding	$ 28,287,493
HIV/AIDS Funding	$46,094,931
Total State Funding	**$ 156,520,318**
Total State Funding, Per Capita	**$23.48**
Total State Funding, Per Capita State Ranking	**40th**

Much of the Centers for Disease Control and Prevention's (CDC's) annual funding is granted to states, localities, tribes, and territories. For FY 2020, per-person CDC funding ranged from $18.11 per person in New Jersey to $209 per person in the District of Columbia. Indiana ranked 50th, just above New Jersey, at $18.61 per person. [3]

CDC Program Funding to Indiana, FY 2020

Grant	Amount
Birth Defects, Developmental Disabilities, Disability and Health	$264,581
CDC-Wide Activities and Program Support	$2,981,039
Chronic Disease Prevention and Health Promotion	$8,685,751
Emerging and Zoonotic Infectious Diseases	$3,097,647
Environmental Health	$1,427,630
HIV/AIDS, Viral Hepatitis, STI and TB Prevention	$10,066,808
Immunization and Respiratory Diseases	$5,334,991
Injury Prevention and Control	$9,883,317
Occupational Safety and Health	732,282
Public Health Preparedness and Response	$11,238,343
Public Health Scientific Services (PHSS)	$182,756
Vaccines for Children	$71,818,947
Total State Funding	**$125,714,092**
Total State Funding, Per Capita	**$18.61**
Total State Funding, Per Capita State Ranking	**50th**

Appendix H: County Budget and Grant Approval Process, Allen/Vanderburgh Counties Case Study



[1] Association of State and Local Health Department Governance Classification System, accessed at https://www.astho.org/globalassets/pdf/state-local-governance-classification-tree.pdf.

[2] *A Funding Crisis for Public Health and Safety, Trust for America's Health, Issue Report, March 2018; accessed at https://www.tfah.org/report-details/a-funding-crisis-for-public-health-and-safety-state-by-state-and-federal-public-health-funding-facts-and-recommendations/.*

[3] The Impact of Chronic Underfunding on America's Public Health System: Trends, Risks, and Recommendations, 2021, Trust for America's Health; accessed at https://www.tfah.org/wp-content/uploads/2021/05/2021_PHFunding_Fnl.pdf.