



# Governor's Public Health Commission

## Commission Meeting Minutes

Meeting held via Zoom (for members)

Thursday, January 20, 2022

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

Dennis Dawes

Carl Ellison

Brian Tabor

*Non-voting Citizen Advisor*

Susan Brooks

**Members absent:** Bob Courtney

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

Shane Hatchett

Dr. Lindsay Weaver

Pam Pontones

Jeni O'Malley

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. She commented on the procedures for participating in the virtual meeting and provided an overview of the meeting agenda. She noted that the second meeting of the CDC Foundation's "Lights, Camera, Action: Future of Public Health" National Summit would occur on January 25, 2022. The topic is creating an interoperable and modern data and technology infrastructure, and both Secretary Box and Dr. Lindsay Weaver will be participating. She also noted that on January 26, 2022, Dr. Caine and Dr. Welsh would be leading a meeting of local health officers and on January 27, she, Dr. Weaver, and Commissioner Box would be participating in the Indiana Rural Health Association's public policy meeting. She then recognized Co-Chair Luke Kenley, Commissioner Box, and Susan Brooks for opening remarks.

Co-Chair Kenley provided an update on the ongoing meetings he and Secretary Box are conducting with various stakeholder groups. He also commented on Governor Holcomb's recent

State of the State address, which included recognition and support for the Commission's work. He then updated the Commission on his meeting with other officials, who remain very supportive of the Commission's work.

Secretary Box informed the Commission that the three Listening Tour public meetings previously scheduled to occur in January are being postponed in light of the recent surge in COVID-19 cases. She then commented on IDOH's heavy reliance on data for making day-to-day policy decisions and provided examples of how data is used. She noted that during the pandemic the IDOH added a Chief Data Officer and created a new data division.

Congresswoman Susan Brooks informed the Commission that at 1p.m. on February 8, 2022, Secretary Box and Co-Chair Judy Monroe would be participating in a podcast for the Center for Strategic International Studies and its America's Health Security Commission. She also observed that the state's data rolls up to the federal government and thanked the IDOH for its COVID-19 dashboard, which she regularly follows.

Co-Chair Monroe then called for approval of the minutes of the December 16, 2021, Commission meeting. Dr. David Welsh made a motion to approve the minutes as presented, the motion was seconded by Dr. Paul Halverson, and the minutes were unanimously approved.

## **II. Public Comments Summary and Remarks from Selected Commissioners**

Co-Chair Monroe recognized Mr. Shane Hatchett, IDOH Chief of Staff, who presented a summary of the approximately 160 comments received through the Governor's Public Health Commission (GPHC) website since the December meeting. Most were related to the COVID-19 pandemic response, as well as vaccine and mask mandates. He also reported on a comment received from the Indiana Environmental Health Association concerning food safety and prevention of foodborne illness. Co-Chair Monroe then called on Ms. Mindy Waldron, Mr. Carl Ellison, and Mr. Brian Tabor for comments.

Ms. Waldron commented on her 31 years of experience working with local health departments (LHDs) of varying sizes, noting that she has witnessed first-hand service disparities driven by differences in population size, local tax collections, and the level of support from state and local officials. She commented on the need to practice teamwork in the public health system with two-way communication between the state and local level and allowing local public health officials to be part of the state-level decision-making process. She noted that the strains on the public health system pre-date COVID, but that the pandemic has made things worse. She expressed hope, however, that COVID would be a catalyst for positive change. She further noted

the negative impact of the pandemic, including the sometimes-strained relationships between county elected officials and LHD staff and the need to convince local officials of the value of public health changes that can enhance local economic development efforts and quality of life.

Mr. Ellison noted his experience serving on the St. Joseph County Local Health Board and expressed his support for both a local public health presence but also the need for regionalization or resource sharing. He also recommended that the Commission's recommendations be aspirational, recognizing long-term aspirational goals to drive improvements over the next 10 years. In addition to the legislature, he recommended that the Commission take its recommendations to the community, along with the outcomes that it expects to achieve.

Mr. Tabor expressed appreciation for the Governor's public health remarks in his State of the State address and supported the idea of the Commission setting aspirational goals. He also emphasized the need to engage with constituents and stakeholders outside of health care and public health, including talking to the business community about why public health matters in terms of worker productivity, quality of life, and making Indiana a more attractive place to live and do business. He commented on the need to consider regionalization, as public health does not stop at the county line, and supported the goal of ensuring a basic level of public health support regardless of where a person lives. He also commented on the Indiana Hospital Association's "Nursing Indiana Back to Health" proposed legislation to address the nursing shortage.

### **III. Data/Integration Presentation by Dr. Lindsay Weaver, IDOH Chief Medical Officer**

Co-Chair Monroe introduced Dr. Lindsay Weaver, IDOH Chief Medical Officer. Dr. Weaver described generally how the work of the IDOH is founded on data and how data collection and reporting was enhanced to respond to the pandemic. She noted that, today, Indiana has one of the most robust and interactive COVID dashboards in the country. She also noted that the pandemic-related changes have created momentum for further growth and transformation.

Dr. Weaver then described the progress over the last two decades to move healthcare providers to paperless electronic medical records (EMRs) but noted continuing information gaps, including long-term care facility and pharmacy information. EMR data loaded into a Health Information Exchange (HIE) can be used for public health purposes – for example, for local disease surveillance to identify outbreaks. She also observed that, historically, public health data has

been siloed by disease conditions, federal funding sources, and the related reporting requirements, and that there is a lot of duplication of effort at every level, including at LHDs, hospitals, laboratories, and nationally. She then noted the national movement toward data modernization and improving connectivity and related state efforts.

Dr. Weaver described HIEs generally and the Indiana Health Information Exchange (IHIE) specifically, noting that IHIE is the oldest HIE in the U.S. and one of the nation's largest clinical data repositories, with participation of more than 120 hospitals, 18,000 practices and 50,000 providers. She described the ways that HIEs are funded and how several other states leverage HIEs to promote data connectivity and health initiatives. She then discussed LHD responsibilities for data collection and reporting in Indiana but noted significant capacity disparities across LHDs. She also described the results of an LHD survey conducted in December 2021 regarding data collection and reporting: over half of responding LHDs expressed the need for additional data access and reported experiencing barriers to data access, while over three-quarters reported needing assistance with data analysis. She noted that all LHDs are connected to the state's immunization registry (CHIRP) and electronic disease reporting system (NBS), but that only two LHDs are currently connected to IHIE (Marion County and St. Joseph County) and only Marion County has electronic lab reporting.

Dr. Weaver described the IDOH's digital transformation initiatives and ongoing efforts, with other stakeholders, to define the roadmap for the future, including expanding IHIE access to additional practitioners and defining IDOH's role in using metadata to develop actionable reports and predictive analytic models. She commented on the ongoing national focus on improving public health data and concluded with the following recommendations for the Commission to consider: continue IDOH digital transformation and development of a statewide data roadmap for public health; formalize IHIE partnership and investment; formalize partnerships with state public health schools and research organizations; and invest in LHDs' data access and utilization. Dr. Weaver also thanked the External Data Advisory Group, LHDs, the Family and Social Services Administration, and external HIEs for their participation in the Commission's data activities.

#### **IV. Data/Integration: Open Discussion**

Several Commission members offered comments, observations, and questions following Dr. Weaver's presentation.

In response to questions from Dr. Welsh, Dr. Weaver noted that addressing data governance and the need for corrections when appropriate was important and also agreed with the goal of

working with adjacent states, which is also a national goal. Dr. Welsh noted that Indiana has used wastewater analysis to detect COVID and that there were possibilities to extend this to other disease states in the future. He cited the INSPECT, the state's prescription drug monitoring program, as an example of good cooperation with other states.

Dr. Halverson commented on the value and cost effectiveness of an image repository, especially when treating trauma cases, but also recommended not losing track of the day-to-day public health data system needs, including the need to digitize environmental health and food inspection data to enable trend identification. He also noted the current lack of adequately trained staff to do something with the data once it is collected. In addition to clinical data, Dr. Halverson noted the value of the large databases needed to identify patterns for things like poverty, areas that lack access to running water or septic tanks, etc. He also noted the emergence of artificial intelligence and smart systems that look at hundreds of thousands of data points to make sense of them and identify trends. These systems, however, depend on having good foundational data systems being in place.

Commissioner Dawes indicated that he was very familiar with IHIE but wanted to know if being a "state-designated" HIE was helpful, for example, in generating more funding or making expansion easier. He also noted his experience, early in his career, with the Indiana Health Careers program, in which he traveled the state to talk to high school students about health careers. He noted that perhaps there was an opportunity to implement a similar program today.

In response to questions from Congresswoman Brooks, Dr. Weaver commented generally on best practices from other states and funding for HIEs, including Medicaid funding and funding from the 2009 Health Information Technology for Economic and Clinical Health (HITECH) Act (which has now expired). Dr. Weaver noted that Medicaid funding for IHIE is currently being studied as one possible way to promote sustainable IHIE funding and also commented that she thought having regional data support resources would be enormously helpful for LHDs.

Dr. Hannah Maxey commented that IHIE was developed initially as a private sector initiative. She then asked about the partnership opportunities moving forward and whether there were examples of other state HIEs that started out as private initiatives. She further noted that it is not currently possible for LHDs to pay for IHIE access. Dr. Weaver responded that there are private HIEs that are state-designated and that IDOH has partnered with IHIE in the past but there are opportunities to expand that partnership.

Dr. Caine commented on the history of IHIE, noting that she was a founding member and currently serves on its board along with Secretary Box and Mr. Tabor. She noted that IHIE is

ranked as one of the top five HIEs in the country. She observed that IHIE recognizes the importance of public health in Indiana and believes that more can be done in this area but would probably not want to be taken over by the state.

Mr. Tabor commented that IHIE is a private, mission-driven organization and that its current structure is not a barrier to developing a public/private partnership. For example, the state could choose to help pay the connection fees for long-term care providers (that are largely Medicaid funded).

Ms. Waldron reenforced an earlier comment regarding the importance of LHD environmental data. Currently, there is a wealth of data, but LHDs cannot see each other's data. Some of the data is digitized and some is not.

Dr. Halverson asked about the current IDOH capacity to perform data analysis. Dr. Weaver responded that capacity is limited. While IDOH has a data analytics team for COVID, further investments are needed to enable IDOH to better utilize data, to ask the right questions, scrub the data to make sure that it is accurate, and communicate the information to the public in a way that it can be easily understood and is actionable. Secretary Box concurred that we do not currently have adequate personnel to do the analysis at the state level. She noted that when IDOH does provide data to LHDs, we often hear back that the LHD does not know what to do with it. She commented on the need to present data in a manner that is understandable and usable by stakeholders.

In response to a question from Dr. Maxey as to whether legislation is needed for IHIE public/private partnerships, Dr. Caine commented that such partnerships are likely easier to accomplish and can be more flexible without legislation. Secretary Box expressed interest in determining how to leverage Medicaid funding for IHIE. Co-Chair Kenley agreed that Indiana is likely to be more successful with IHIE public/private partnerships without additional legislation and also observed that obtaining Medicaid funding for IHIE might be "low-hanging fruit" in the current policy environment.

In response to a question from Dr. Cara Veale, Dr. Caine commented that perhaps the state could fund the IHIE fees for small LHDs or that there might be other federal or philanthropic funds that could be used of this purpose.

Dr. Welsh commented that since not everyone is well-versed with data analytics, this could be an area for regional resources. It could also be a good area for collaboration with local hospitals.

Mr. Tabor noted that IHIE is missing input from other data entry points (e.g., nursing homes) and that public funding is needed to support this.

Dr. Caine commented on the need for someone on the LHD side to deal with the data and not just rely on a regional person.

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

Co-Chair Monroe noted that the next Commission meeting is Thursday, February 17, 2022, and the main topic will be child and adolescent health. She then adjourned the meeting at 3:01pm.