



Governor's Public Health Commission

Commission Meeting Minutes

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

Thursday, December 16, 2021
1:00 – 3:00 pm

Members Present:

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

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

Dennis Dawes
Carl Ellison
Brian Tabor

Non-voting Citizen Advisor
Susan Brooks

Members absent: None

Indiana Department of Health (IDOH) Staff Present:

Shane Hatchett
Pam Pontones

Micha Burkert
Tami Barrett

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

Co-Chair Luke Kenley called the meeting to order and noted the presence of a quorum after a roll call of Commission members by Shane Hatchett. He provided an overview of the meeting agenda and then called for approval of the minutes of the November 18, 2021, Commission meeting. Dr. David Welsh made a motion to approve the minutes as presented, the motion was seconded by Mindy Waldron, and the minutes were unanimously approved.

Co-Chair Kenley then referred to a meeting handout summarizing the “road show” meetings that he and Secretary Box have held with various organizations for the purpose of educating them on the work of the Commission, what it hopes to achieve, and the timeline for submitting recommendations to the Governor and pursuing enabling legislation during the 2023 legislative session. Eight meetings have been held so far. He invited Commission members to recommend

other groups or organizations that he and Dr. Box should reach out to. He then recognized Co-Chair Judy Monroe for opening remarks.

Co-Chair Dr. Judy Monroe thanked Secretary Box and Co-Chair Kenley for the impressive number of road show presentations completed to date and commented on the critical importance of today's topic for the Commission meeting. She also recognized Pam Pontones, today's presenter, as an "Indiana treasure" for her work with the IDOH for many years. She then recognized and thanked Mindy Waldron for participating in the first "Lights, Camera, Action" National Summit on the Future of Public Health, representing both Indiana and the Commission as well. The next summit meeting will be January 25, 2022 and will likely feature Indiana again as the topic will be information technology and data modernization where Indiana has been a leader.

Secretary Box offered opening commenting on the challenges of the current pandemic surge to hospitals and the state generally. She urged all Hoosiers to get vaccinated and receive their booster doses when eligible noting that we owe that to our hospitals, our families, and ourselves. She then highlighted examples of resource sharing that have occurred across local health departments (LHDs) in the state, noting that this is one of the topics that would be addressed during today's Commission meeting.

II. Public Comments Summary and Remarks from Selected Commissioners

Co-Chair Kenley recognized Shane Hatchett, IDOH Chief of Staff, who presented a summary of the seven comments received through the GPHC website between November 4 and December 13, 2021. He noted that the summary would be posted on the GPHC website. Mr. Hatchett then presented a handout summarizing the proposed location and dates for seven "Listening Tour" public meetings in 2022. He noted that meeting locations were chosen, including rural locations, to ensure a broad representation of voices across the state, and that planning was underway to develop meeting parameters, for example, a 3-minute time limit on testimony. He also invited Commission members to provide any feedback they might receive so it can be incorporated in the record of the Commission's proceedings. In response to a question from Dennis Dawes, Mr. Hatchett noted that the meeting times were still forthcoming and would be sent to the Commission members so that they can attend if desired. In response to questions from Co-Chair Kenley and Bob Courtney, Mr. Hatchett confirmed that IDOH would extend individual meeting invitations to various community leaders and that Commission members were encouraged to attend as they are able.

Co-Chair Kenley then called on Commissioner Mark Bardsley for comments. Mr. Bardsley thanked the Co-Chairs, Secretary Box, and the Commission members and provided a snapshot of Grant County, the 25th largest county in the state, in the upper third but still mostly rural. While all counties are different, Mr. Bardsley commented that all should have the greatest health advantages from the largest counties to the smallest. He then described staffing levels at the Grant County HD and noted that within the last two months they had actually inspected railroad cars. Mr. Bardsley commented that the question is "where should we be going." He noted that his local health officer stated "we don't know what we don't know" when it comes to what is available and how we can be more proactive at the local level. He noted that the LHD is just trying to survive and get basic work done. He described the high percentage of out-of-wedlock births in the county and growing intergenerational poverty which both have health impacts. He noted that a better understanding of rural health is needed and also described the need for an additional public health nurse who could focus on childhood immunizations, STD testing, TB case management and lead investigation. He suggested that having a regional nurse that could move from county to county and work side-by-side with LHD nurses would give us a better understanding of how we could be more effective in the field. He closed by noting that unfunded mandates and poor communication would be detrimental to progress and also expressed concern regarding proposals to lower state taxes given the need to improve public health funding.

Co-Chair Kenley then called on Mayor Bob Courtney for comments. Mayor Courtney described the impact of the COVID-19 pandemic in Jefferson County – overwhelming the county's infrastructure (leadership, staff, schools, public safety officers) and exposing its weaknesses, especially the lack of investment in the past. In addition to COVID, the county is still dealing with tremendous unmet needs and the need for emergency response related to the continuing mental health/substance use disorder crisis and growing drug crime and overdose deaths. He observed that LHDs are overwhelmed and tremendously under-resourced. He noted that his LHD is funded with 1.5 cents per \$100 of assessed value – there is hardly anything in the community that is a lower funding priority. The LHD therefore must go out and find other grant resources to operate. He expressed concern regarding proposals to reduce state taxes when additional investments are needed. Regarding public health governance, Mayor Courtney described the need for greater engagement noting that the City of Madison, as a third-class city, has no representation on the Jefferson County Local Health Board even though it is the most populous/dense community in the county with significant in-migration of workers and visitors. He closed by advocating for expanded engagement to other stakeholders and the need to make a greater investment in public health than we ever have before.

Co-Chair Kenley then called on Kim Irwin for comments. Ms. Irwin described the Indiana Public Health Association (IPHA), a member organization with a volunteer board, and shared information on the IPHA's membership, mission, and goals, and the work that the IPHA is doing that is largely aligned with the Commission's work to address "upstream" issues and root causes rather than just downstream problems and clinical issues. She noted that the further you go upstream, you realize that in addition to resources and infrastructure, there is a need to address the role of cultural and societal norms, like racism and other forms of power and oppression. She noted that "how" we do things is as important as "what" we do and also noted the need for complex systems change with a focus on convening, connecting, communicating, collaborating, coordinating, and creating programs, policies, and opportunities. She highlighted the need for people who wake up each day thinking about systems change and expressed her hope that through the Commission's work we will begin to build systems where we have people who are focused on the "how" allowing us to address the problems that we want to solve.

III. Governance/Infrastructure, Presentation by Pam Pontones, Deputy Health Commissioner & State Epidemiologist

Co-Chair Kenley introduced Pam Pontones, Deputy State Health Commissioner and State Epidemiologist. Pam thanked the key informants, IDOH staff, and consultants who provided information and assistance with today's presentation.

Ms. Pontones then described the challenge of ensuring that our public health governance systems meet current public health needs and demands, and the varying public health roles and responsibilities carried out at the federal, state, and local levels. She noted that Indiana, like 26 other states, follows a largely decentralized governance model and that most of the state's 94 LHDs serve fewer than 50,000 people. She highlighted advantages and disadvantages to the decentralized governance model that were expressed in several focus group calls. The chief advantages cited were local credibility and the value of having a local physical presence. The main disadvantage cited was that county councils often lacked an understanding of public health.

Ms. Pontones then generally described LHD services that are currently required under state law and other services that are non-mandatory and/or sometimes required under local ordinances. According to participants in the focus group calls, current areas of strength for LHDs are vital records services, food inspections, and immunizations. Areas of inconsistency cited were tattoo and body piercing safety and sanitation, STD and HIV prevention, and syringe service programs. Ms. Pontones then described the Foundational Public Health Services (FPHS) model that was

created to define the minimum package of public health services that no community should be without, no matter how they might be provided (by state, regional or local government). She noted the growing interest in the FPHS model and highlighted the 21st Century Learning Community – a group of states in various stages of adopting the FPHS framework that include Ohio and Kentucky.

In response to a question from Mr. Tabor, Ms. Pontones confirmed that the current state public health statute has never been comprehensively reviewed other than an overhaul of the communicable disease provisions in 1993.

Ms. Pontones turned to LHD accreditation and reported the advantages to accreditation cited by the three currently accredited LHDs as well as the main disadvantage – the initial cost/resource investment needed. She noted that all three LHDs are likely to pursue reaccreditation, although one noted that it may depend on funding availability. She then commented on the experience of Missouri, Ohio, and Kentucky in adopting the FPHS framework. She also described the spectrum of resource sharing arrangements (from looser integration to greater integration) and also presented characteristics and examples of shared service delivery models from the State of Washington.

Ms. Pontones then summarized the results of a shared services LHD survey that the IDOH conducted in late November and early December. Forty-nine LHDs participated in the survey. She noted that equipment and supplies were the most commonly shared resource over the past year and that communications and public health messaging, epidemiology expertise, and communicable disease investigation were the top three resources LHDs would like to share. Also, almost all the responding LHDs reported an interest in taking advantage of a broad range of services (e.g., legal and enforcement guidance and communications) if they were made available by the IDOH.

Ms. Pontones closed her presentation by listing possible considerations for future Commission recommendations.

IV. Governance/Infrastructure: Open Discussion

Several Commission members offered comments and observations following Ms. Pontones' presentation.

Co-Chair Kenley thanked Ms. Pontones for her presentation and noted the Commission would likely need to address all of the considerations noted on the final slide: ensuring public access to

a LHD in every county, defining a core set of public health services and capabilities, determining the feasibility of resource sharing arrangements to fill LHD service and capability gaps, addressing state policy regarding LHD accreditation, and considering whether to modernize Indiana's public health code.

In response to a question from Ms. Irwin, Ms. Pontones noted that there was a degree of LHD resource sharing pre-COVID, but COVID resulted in more LHDs looking at resource sharing and this is unlikely to go away after COVID and could be a roadmap going forward.

Mr. Tabor commented that the slide showing the desire of LHDs to share resources helps reinforce the suggestion he made earlier related to regionalization and is also consistent with Dr. Virginia Caine's earlier comments regarding the low-hanging fruit of collaboration. He also noted that an overhaul of Indiana's public health statute is unprecedented and underscored the importance of such a review and compared it to Indiana's past efforts to reform property taxes and criminal justice. Congresswoman Brooks and Ms. Waldron commented that the last time there was a front-to-back review of the public health statute was in 1949.

In response to a question from Dr. Hannah Maxey regarding LHD interest in IDOH enforcement supports, Dr. David Welsh explained that LHDs often reach out to IDOH for guidance on enforcement steps to deal with a problem or infraction, but are not necessarily asking the state to step in. Ms. Waldron added that local ordinances often define enforcement measures that are not consistent across the state. She noted that enforcement measures are often hard for LHDs to carry out for a variety of reasons and all LHDs do it differently or are pressured not to do it at all. LHDs frequently ask IDOH for enforcement guidance. That is why legal guidance and enforcement were listed as the two biggest needs in the survey results. She commented that LHDs are looking for consistency across counties which is not happening today. Ms. Irwin agreed noting that when the state stepped in with Senate Enrolled Act 5 last year (regarding parameters for local public health emergency orders), it created even more variation and confusion.

Dr. Caine asked about accreditation standards for smaller LHDs and whether there are minimum requirements for staff (and type of staff) and services given population size. If there are no recommendations for this, different county governments will make different decisions based on their historical experience and expectations. She also commented about the need to do something about salaries noting it is the "elephant in the room." As workforce development and capacity funding comes into the state, she questioned how the state will be able to leverage that funding in a way that will help the Commission with its recommendations.

Dr. Paul Halverson responded that there is no minimum staffing number requirement and noted past research studies that have tried to address this. He noted that it would depend on the authorizing environment but noted that some states have answered this question. For example, Nebraska has decided that to be an LHD, you must serve a minimum of 35,000 people and the state has also suggested minimum staffing levels. He commented on the need to first define the minimum service level desired and further endorsed the FPHS framework as the model that everyone is increasingly moving towards nationally. He also suggested that the state consider applying for grant funding that the Robert Wood Johnson Foundation is releasing to expand the collaborative work that states are doing, similar to the work that the Commission is doing. Co-Chair Dr. Monroe agreed with this recommendation.

Co-Chair Kenley noted the need to double check the number on slide 8 regarding the number of LHDs serving populations of less than 50,000. He also asked for clarification about the WIC program in Kentucky. Ms. Pontones explained that WIC was a federal program that Kentucky has chosen to administer through LHDs.

Dr. Welsh commented about the challenge of finding the resources needed to pursue accreditation but recommended that the Commission encourage accreditation as it makes you look at what you are doing and how you are doing it, leading to improvement. Ms. Pontones agreed and further described the value of the accreditation process and the experience of the three currently accredited LHDs.

Dr. Halverson noted a revision to the current accreditation standards is planned for the coming year and will mirror the FPHS and create greater alignment. He also mentioned that the Public Health Accreditation Board is planning to implement the [Pathways Recognition Program](#) in 2022 which will include a learning community of small LHDs considering accreditation and is expected to receive federal and philanthropic support. At such a time, there will be a relook at the domains for accreditation that will make it more attainable for LHDs.

Co-Chair Kenley noted the need to be realistic about the timeframe to shoot for regarding accreditation. Dr. Halverson cited the 3–5-year window that Ohio used. Secretary Box noted the progress Ohio has made though not all LHDs are accredited yet, and also commented that now that the IDOH has been through accreditation, the department has knowledge and abilities that it did not have before.

Commissioner Dawes commented that it was good to hear about the degree of LHD sharing currently occurring, but that the leadership in those counties may not even know about all the collaboration occurring. He also commented that health care and public health really go hand-

in-hand and should not be separated. He noted that while the government's role is not to overburden people with regulation, public health is one of the roles of good government and is very important.

Mayor Courtney asked whether LHD consolidation was possible or whether we should rely on more resource sharing given the geography of the state. Ms. Pontones responded that what we heard in our research is the importance of having a footprint in every county. Currently, there is one example of two counties sharing a LHD and there have also been circumstances where a local health officer (LHO) in one county has filled in, on an interim basis, as the LHO for another county. She noted that the ultimate goal was to ensure equitable access to those foundational public health services, regardless of your zip code, and that there are multiple types of sharing arrangements that could be used to accomplish this.

Mayor Courtney then noted the unmet need for mental health (MH) and substance abuse disorder treatment (SUD) services in his community and asked whether Ms. Pontones thought those services could be integrated with public health. Ms. Pontones noted that MH and SUD services are increasingly falling within the public health realm, although the public health history with these issues is limited. The big issue that we were seeing pre-COVID was opioid use disorder and SUD and being able to provide addiction recovery services in communities, often through community partners rather than the LHD. In areas of overlap, like naloxone distribution and when there is an overlapping communicable disease outbreak, that is where you see LHDs work in concert with community providers. Secretary Box commented on the need to address upstream issues that can lead to SUD, like trauma. Public Health has a huge role in that area and also a role in ensuring access to those services and advocating at the state level as needed to improve access.

Dr. Maxey commented on a very old report that recommended one public health nurse per 5,000 population that was recently reaffirmed by the Public Health Nurses Association. In Indiana, the statewide average was approximately 1 per 5,500 population in 2019, although the distribution across the state is uneven. She also emphasized that we do not have the needed workforce right now. While we have trained workers, they are not necessarily located where we need them. Dr. Halverson noted however, that the number of public health nurses needed depends on what you are asking them to do. Dr. Maxey also noted that sharing arrangements may be necessitated due to workforce constraints.

Secretary Box commented that some counties struggle to meet the statutory requirement for a LHO that is a physician. She noted that other states allow advanced practice nurses or others with advanced training to be LHOs – a model that works well and could also include regional

oversight. Secretary Box also commented that Indiana law currently allows cities to operate LHDs which occurred during the pandemic. She noted that this results in poor communication and collaboration within the county, and she strongly recommend that LHDs should be no smaller than a county.

Mr. Tabor commented on the current healthcare workforce crisis in most settings, including unprecedented shortages, demographic challenges, and the mounting psychic and physical toll of the pandemic. He also noted that the Indiana Hospital Association would be promoting legislation during the 2022 session to change statutory limitations on the nursing pipeline.

VI. Final Thoughts and Adjourn

Secretary Box reported that on January 26, 2022, Dr. Welsh and Dr. Caine will be leading a virtual 2–3-hour meeting with LHOs so that the Commission can make sure it is hearing from the front lines. Co-Chair Dr. Monroe and Congresswoman Brooks thanked the Commissioners and wished them a happy holiday and Co-Chair Kenley then adjourned the meeting at 3:00pm.

The next Commission meeting is Thursday, January 20, 2022, and the main topic will be data/infrastructure.