The Indiana Governor's Public Health Commission

An Analysis and Lessons for Vermont

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Executive Summary

In August of 2021, the sitting governor of Indiana, Eric J. Holcomb, passed Executive Order 21-21 to establish the Governor's Public Health Commission (GPHC). This decision originated from concerns for Indiana's low national ranking in public health, outdated governing statutes, and weaknesses exposed by the 2019 Coronavirus Pandemic.[1] The commission was tasked with reviewing the state's public health system and identifying ways to improve care delivery, promote equity, and address funding and sustainability challenges, among other goals. This culminated in a 2022 report identifying six important areas of focus with recommendations for improving each.[2]

As reflected by Indiana's GPHC, commissions are well-suited to perform in-depth analysis of an issue and formulate policy recommendations in response. Other states with systemic concerns, such as Vermont, may find inspiration in this model. Vermont legislators have expressed heightened interest in restructuring aspects of the state's healthcare system. In 2022, the Vermont legislature passed Act 167 which called for payment and delivery reforms, including drafting a proposal for a multi-payer alternative model and expanding and integrating health care databases.[3] Act 167 entrusted the Green Mountain Care Board (GMCB) with appropriations to aid in the completion of some of these tasks. In September of 2024, the GMCB published a report in partnership with Oliver Wyman, LLC which detailed the results of a hospital engagement process to improve equity, affordability, and access. The report identified challenges facing Vermont, including poor affordability, worsening financial sustainability, inequity and lack of access in healthcare, and an aging population. It further proposed solutions to these challenges.[4]

Mention of Vermont's public health infrastructure was absent from Act 167 and the Oliver Wyman report. Enhanced public health and preventative services may help to further address the issues facing Vermont. Given these challenges and an identified need for system-level review and reform, it is possible that Vermont could benefit from the creation of a dedicated public health commission.

This report will provide an overview of Indiana's GPHC, including its formation, structure, and impacts. Interviews with GPHC members contributed greatly to the details regarding each of these elements. This report aims to inform Vermonters about the capabilities of a public health commission and highlight important considerations in organizing one, should it be desired.

Introduction

Commissions, like Indiana's GPHC, may be used to review a state's public health care infrastructure. They can expertly assess how it is functioning and identify shortcomings. A commission's independence gives members the ability to consider an issue in depth and act creatively. Other groups, like state health departments, government officials, or health delivery systems may lack the time, resources, flexibility, or expertise needed to do the same. Indiana's GPHC provides an example of how collaboration and communication between state and local players can foster creative solutions to problems in the public health system.

What is a commission?
A multiheaded body created to perform a particular function, whether it be administrative, legislative, or judicial in nature.[5]

FAQs

- Where do they exist?
  - Commissions can span the levels of government, from federal to local. Large federal commissions often function as regulatory bodies; these include the Federal Trade Commission (FTC), Federal Communication Commission (FCC), and others.[5] Local government commissions may be zoning boards, planning commissions, or other related bodies.[6]
- What do they do?
  - Commissions can perform a variety of functions. They may take on regulatory, advisory, or investigative roles. They can also recommend or help implement policies.
  - **This report focuses on commissions that analyze issues and recommend policy changes.**
- How are they formed?
  - Commissions are typically formed through legislation. This could be Congressional legislation or local ordinance. Commissions may also be formed by executive order.
  - The directive that establishes a commission also sets the terms of its operation.[7] This includes mandated task(s), functional structure, membership, compensation, funding, and duration.

FAQs *continued*

- Who are they composed of?
  - Members can be those with specialized knowledge in a certain field, current or former government officials, or members of the public. It is common for relevant organizations to have a representative serve on a commission.
  - The directive that establishes the commission outlines the requirements for appointed members. These members are often selected by whichever authority established the commission.
- Why have a commission?
  - Commissions can perform more in-depth work on a topic than legislators may have the time for themselves.[7] In addition, commissions can bring an elevated level of expertise to an issue. They also can enhance visibility for certain topics and invite more discussion. Lastly, many commissions are intentionally bipartisan, which may make recommendations more acceptable
- When may a commission not be helpful?
  - *No political will*: if state leadership has no intention of considering or implementing recommendations
  - *More urgent action needed*: if an immediate response is required for an urgent public health threat
  - S*tructures already exist*: if there are already effective mechanisms in place to determine and address structural challenges
  - *No implementation funding*: if there is no feasible way to finance policy implementation costs
  - *Highly politicized issue*: if findings may be disregarded due to their political polarization

Indiana's Public Health System: Overview

Indiana's public health system is made up of the Indiana Department of Health (IDOH) and Local Health Departments (LHDs). Indiana is a "home rule" state, meaning that local governments have autonomy over local affairs, unless otherwise prohibited by the State. Many public health services fall into local affairs, and are thus funded and delivered through local departments (**Figure 1**).

Public health is "the science and art of preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organizations, public and private communities, and individuals."[8]

The IDOH is an agency within the state executive branch. It operates through four major Commissions, which are the Consumer Services & Health Care Regulation Commission, the Health and Human Services Commission, the Laboratory Services Commission, and the Public Health Protection Commission. Statewide, IDOH collects, analyzes, and reports on health statistics, maintains laboratories, establishes state public health standards, distributes federal funding, and has a role in education, licensure, policymaking, and state emergencies.[9]

Figure 1: State and Local Responsibilities

State Responsibilities	LHD Responsibilities
• Provide grants and funding to local boards of health • Use data-driven policy for evidence-based activities • Evaluate public health activities • Bring essential partners together • Engage partners in policy making and programming • Integrate public health and health care activities • Promote health care quality • License healthcare facilities, agencies, clinics, centers, and providers • Ensure accurate state vital records and statistics	• Vital records and health permits • Core environmental services • Infectious disease surveillance and contact tracing • Immunizations • Liason with local hospitals and health professionals

adapted from Halverson, PK & Yeager, VA (2020)

Local Health Departments (LHDs) directly facilitate most of the public health services in Indiana. Prior to the Commission, there were 94 local health departments (LHDs). Home rule creates wide variation in how LHDs are run, although Indiana Code provides some rules for appointments of officials. LHDs and their staff conduct inspections and provide childhood vaccinations, communicable disease control, and health screenings.[9] They also maintain vital community records like birth and death certificates. Some LHDs provide clinical services. Mandated activities are listed in **Appendix A**. LHDs serve a range of population sizes, from under 10,000 to almost 1 million.[9] About one-third of LHDs serve communities of under 25,000, while over two-thirds of LHDs serve communities of under 50,000.[9] There is similar variation in the number of staff at each LHD. In 2020, the majority had fewer than 10 employees in both full- and part-time positions.[9]

Issues Facing the State

The life expectancy in Indiana in 2019 was 77 years compared to a U.S. average of 78.8, placing the state 40th in the nation for this metric.[2] This was the result of a years-long decline since a peak life expectancy of 77.5 in 2010.[2] Within the state, there was a difference of 9 years between the counties with the highest and lowest life expectancies.[2]

In 2019, Indiana was ranked 41st out of 50 states for overall health outcomes by America's Health Rankings.[2,10] The 2021 US News and World Report ranked Indiana ranked 40th for overall public health.[2] Despite other positive rankings in quality of life metrics, Indiana struggled with infant mortality, early adult mortality, mental health, obesity, and smoking. Indiana also had low rankings for childhood immunizations, at 44th of 50 states.[11]

A 2020 report done through the Indiana University Richard M. Fairbanks School of Public Health analyzed Indiana's public health system.[9] The report identified underfunding as a driver of these systemic issues. In 2018, America's Health Rankings placed Indiana at 48th for public health funding.[9,12] At the time, the national median per-capita spending for LHDs was $41. All but two of Indiana's LHDs had spending below this, with at least 37 of 92 counties spending less than $10 per capita. Spending ranged from $1.25 to $82.71 per person, and did not correlate with location. LHDs predominantly rely on local funds in contrast to many other US states where state funds support local services.[18] Property tax caps put even greater strain on funds.[18]

In smaller, under-resourced communities, LHDs and their community partners were unable to provide core services. **Figure 2**, taken from the Fairbanks report, shows the average proportion of 20 select activities completed by LHDs in 10 districts weighted by population. These activities were defined by previous national studies quantifying the strength of a public health system.[13,14] Lighter colors represent provision of a higher percentage of these public health activities. On average, 50% of these activities were being provided by Indiana LHDs.[9]

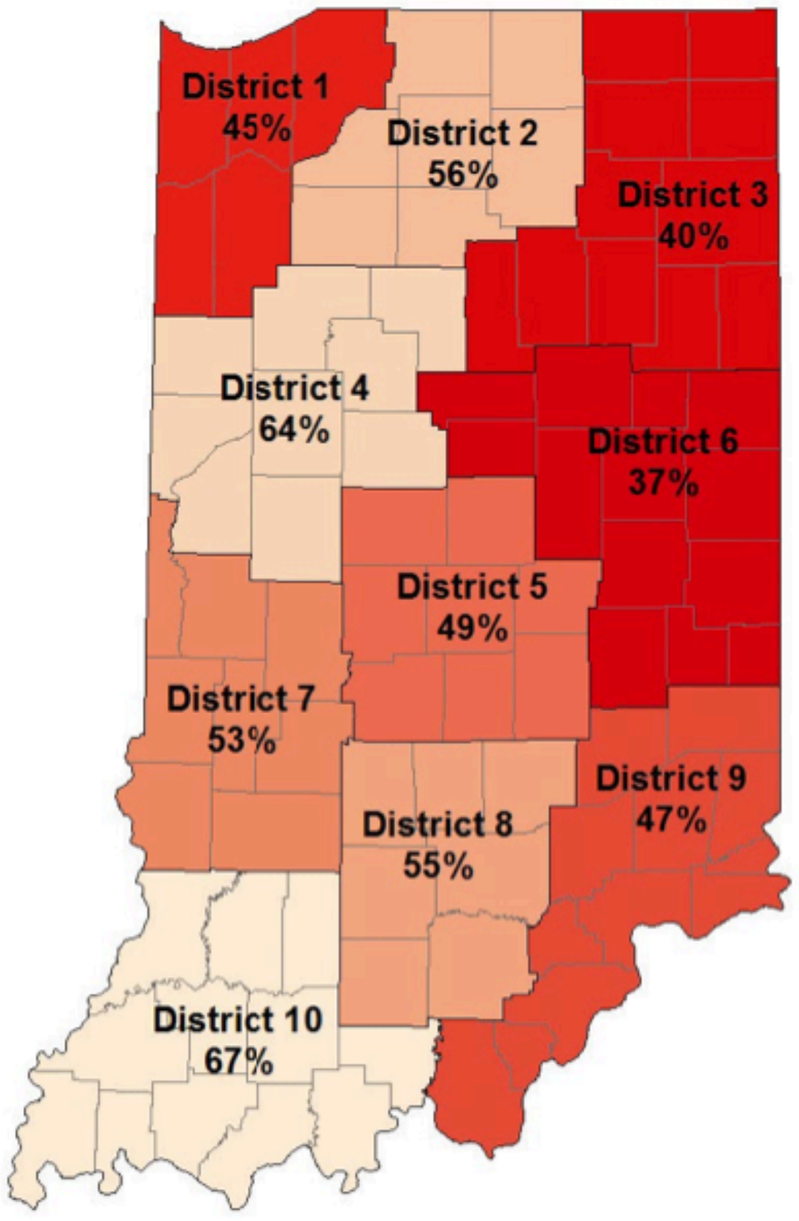


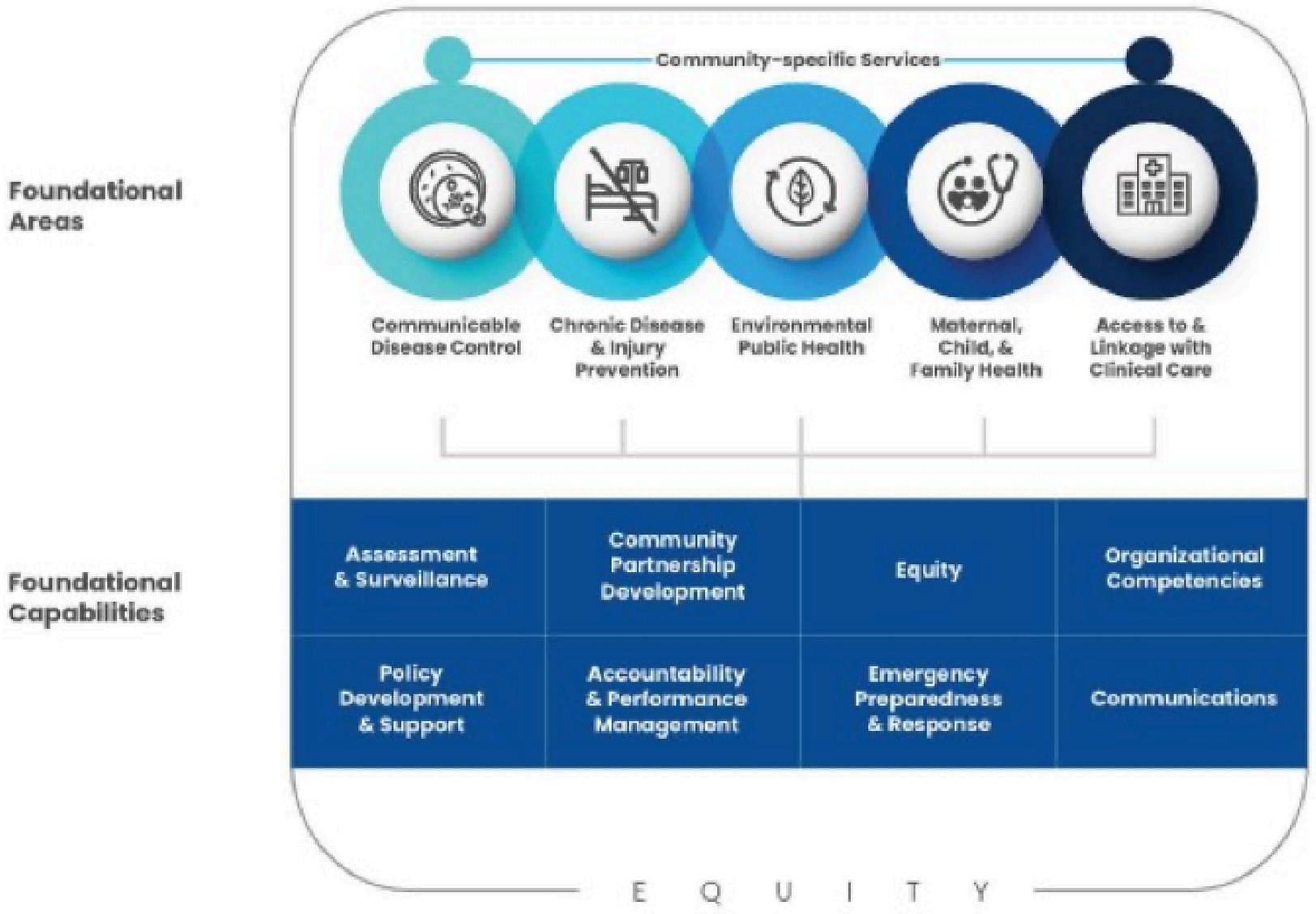
Figure 2: Average proportion of activities completed by LHDs, by district (weighted by population)

adapted from Halverson, PK & Yeager, VA (2020)

The Fairbanks report proposed that Indiana create a uniform approach to deliver the Foundational Public Health Services (FPHS). This framework, developed in 2013 by the Public Health Leadership Forum,[15] defines a minimum set of services that should be available everywhere and gives local communities flexibility in implementation[2] (**Figure 3**). Indiana's existing statutes governing provision of services were written prior to the development FPHS Framework.[9]

Critically, the Fairbanks report also recommended the creation of a statewide committee for the purposes of implementing the report's recommendations.[9]

Figure 3: The Foundational Public Health Services Framework



taken from The Public Health Accreditation Board (2022)

The Indiana Governor’s Public Health Commission

On August 18, 2021, Governor Eric Holcomb signed Executive Order 21-21 which established the Governor’s Public Health Commission (GPHC). The document cited outdated governing statutes, the COVID-19 pandemic, and Indiana’s public health ranking as motivators for the establishment of the Commission (see **Appendix B**). It characterized the 15 members who would be appointed to the Commission and tasked them with analyzing the public health system and issuing policy proposals in a report (specifics in **Appendix B**). Executive Order 21-21 also allocated powers to the IDOH for support of the Commission and tasked them with documentation.

All 15 appointed members are shown in **Figure 4**, with the addition of a single non-voting citizen advisor. To support the Commission’s work, there were four additional Commission Staff. Another six individuals were brought in as Designated Policy Advisors; one of these staff was a Commissioner and another was Commission Staff. Designated Policy Advisors led research, engaged with stakeholders, and drafted policy recommendations across six identified workstreams (**Figure 5**). Various members of the IDOH were present at meetings.

Figure 4: Indiana Governor’s Public Health Commission Members and their Roles at the Time

Judith A. Monroe, MD, FAAFP
Former State Health Commissioner
Co-Chair

Hon. Luke Kenley, JD
Former State Senator
Co-Chair

Hon. Susan Brooks, JD
Non-Voting Citizen Advisor

Kristina M. Box, MD, FACOG
Current State Health Commissioner
Secretary

Virginia Caine, MD
Director and Chief Medical Officer, Marion County Public Health Department

David J. Welsh, MD, MBA
Ripley County Local Health Officer

Mindy Waldron, REHS
Allen County Public Health Administrator

Paul K. Halverson, DrPH, FACHE
Founding Dean, Indiana University Fairbanks School of Public Health

Hannah L. Maxey, PhD, MPH, RDH
Associate Professor and Director of IU Bowen Center for Health Workforce Research & Policy

Brian C. Tabor
President of Indiana Hospital Association

Carl Ellison
President and CEO of Indiana Minority Health Coalition

Cara Veale, DHS, OTR, FACHE
CEO at Indiana Rural Health Association

Kim Irwin, MPH
Administrator of Indiana Public Health Association

Hon. Mark Bardsley
Grant County Commissioner

Hon. Bob Courtney, CPA
City of Madison Mayor

Hon. Dennis Dawes, MHA
Hendricks County Commissioner

adapted from Indiana Governor’s Public Health Commission (2022)

Figure 5: Governor's Public Health Commission Workstreams

WORKSTREAM	PURPOSE
Emergency Preparedness	Analyze the State and local health departments' response to the COVID-19 pandemic; make recommendations for future improvements
Public Health Funding	Review public health funding sources, current levels, and suggestions for standardization
Governance, Infrastructure, and Services	Review public health governance and infrastructure, public health services delivered through LHDs, and shared service models
Workforce	Consider policies to support public health workforce planning and to identify and address workforce shortages
Data and Information Integration	Consider policies to improve the use and integration of public health data to better support public health programming and delivery
Child and Adolescent Health	Review opportunities to improve school-based health education, prevention, and wellness activities and improve access to child and adolescent health care

adapted from Indiana Governor's Public Health Commission (2022)

Schedule and Proceedings

Commission meetings occurred monthly at the Indiana Government Center and State Library; only one in January of 2022 was held online. Meetings were live-streamed and the recordings are archived online. Meeting minutes, presentations, and other informational documents referenced during the meetings are also archived online. The Commission's work was supported by Health Management Associates, Inc. (HMA).[2] HMA consultants assisted with project management and research. The project was supported by a $250,000 grant from the Richard M. Fairbanks Foundation.[2]

The Commission met for the first of 10 times on September 16, 2021. This meeting centered around the Indiana's Public Health System Review conducted by IU Fairbanks School of Public Health in 2020. This presentation highlighted the issues facing the state and contextualized the Commission's purpose moving forward. Meetings thereafter were dedicated to one of the six workstreams. Workstream presentations drove the discussion and Commissioners had access to additional supporting materials.

Commissioners reviewed draft recommendations on April 21 and May 19 of 2022. The final meeting occurred on June 30, 2022 during which the Commissioners reviewed the draft report in full. The Commission agreed to turn over responsibility for final revisions and submission of the report to the IDOH. With the submission of the final report on August 1, 2022, the Commission sunsetted.

Public Engagement

Multiple strategies were used to engage with those external to the Commission. All GPHC meetings were open to the public in addition to being live-streamed. Virtual listeners had the option to submit comments through an online REDCap form. These comments were summarized and read at the next meeting.

To further incorporate the public, the Commission hosted seven listening sessions across the state. Locations were intentionally selected to engage with a blend of urban and rural populations (see **Appendix C**).[16] Public testimony was limited to three minutes, with the option for submission of additional written testimony.[16] Initial discussions were dominated by opinions on COVID-19 responses. This led the Commissioners to develop a short informational presentation which was used in subsequent tours to guide opening remarks. This presentation listed major public health achievements, clarified the purpose of the Commission, and listed the hearing guidelines.[17] Listening tour synopses were reviewed at Commission meetings and are archived online.

Over 30 additional stakeholder meetings were conducted by the State Health Commissioner, Dr. Kristina Box, and one of the Co-Chairs.[2] These occurred between September 2021 and May 2022. Stakeholders included trade associations and local public health officials.[18] Staff at the IDOH were regularly updated on the Commission's proceedings. Their input was sought formally during an "internal listening tour" on April 8, 2022.[2]

GPHC Report and Impacts

The Governor's Public Health Commission report was submitted to the Governor on August 1, 2022, marking the conclusion of the Commission. The report summarizes findings across the six workstreams and proposes 32 policy recommendations (see **Appendix D**).

The Indiana Department of Health was crucial to publicizing the report. During the 2023 legislative session, which spanned October 2022 through April 2023, the IDOH hosted a Public Health Day at the state capitol.[18] This provided attendees with the opportunity to hear speeches from the governor and Commission co-chairs as well as learn more about the benefits of pubic health initiatives. After the release of the GPHC report, the IDOH also convened the Core Services Leadership Committee to develop a list of core public health services and their key performance indicators.[18] These proceedings were communicated to local health departments for feedback and helped shape the implementation process.

Resulting Legislation

Many of the Commission's non-financial recommendations were incorporated into Senate Enrolled Act 4.[19] This piece of legislation was signed into law on May 4, 2023 with strong bipartisan support.[18] Senate Bill 4 amends the Indiana Code and defines 23 core public health services to be provided at the local level. It also incorporates public health knowledge into state health leadership by adding or expanding position requirements. Importantly, the bill helped establish new public health funding structures and reporting requirements. These changes created the Health First Indiana (HFI) initiative, which the IDOH took charge of implementing.

House Enrolled Act 1001, the state budget bill for 2024-2025, allocated funds to support the changes.[20] The bill established a new funding formula for local health departments[18] and appropriated money to fund public health: $75 million in FY2023-2024, then $150 million in FY2024-2025. This funding was not generated through new state taxes.

Health First Indiana (HFI)

Health First Indiana is a direct result of the findings and recommendations published by the Governor's Public Health Commission. This initiative allows counties to opt-in to receive additional public health funding from the state while maintaining control over local implementation of core public health services. To receive funding, counties must submit annual budgets, report how they used the funds, and publish data related to statewide and local key performance indicators.[18] HFI also stipulates how much can be spent on certain core services (**Figure 6**). Counties are allowed to withdraw in future years if they vote to do so. During the first year of the program, 86 out of 92 counties and 89 of 95 local health departments opted in to receive funding.[21,22] By the September 1 opt-in deadline for 2025, all 95 LHDs had opted in.[22]

Figure 6: Health First Indiana (HFI) Funding Allocation Requirements

At least 60% HFI funding must go towards:	No more than 40% of HFI funding may go towards:
• Infectious disease prevention and control • Vital records • Tobacco and vaping prevention and cessation • Student health • Fatality review (child, suicide, overdose) • Maternal and child health • Testing/counseling for HIV, HCV, STI • TB prevention and case management • Emergency preparedness • Referrals to clinical care • Chronic disease prevention and reduction • Childhood lead screenings and case management • Trauma and injury prevention and education • Child and adult immunizations	• Food protection • Pest/vector control and abatement • Public/semipublic pool inspection and testing • Residential onsite sewage system permitting and inspections • Orders for decontamination of property used to illegally manufacture controlled substances • Sanitary inspection and surveys of public buildings • Sanitary operation of tattoo parlors and body piercing facilities • Sanitary operation of facilities where eyelash extensions are performed

adapted from the Health First Indiana (HFI) Quick Facts Sheet (2023)

The IDOH developed a county health scorecard which currently tracks 9 health measures.[23] These are: Adult Obesity, Children < 3 Years Old Completing Recommended Vaccine Series, Infant Mortality Rate, Life Expectancy, Opioid Overdose Rate, Smoking Rate, Suicide Rate, Tobacco and Vaping Use During Pregnancy, and Years of Potential Life Lost Due to Injury. County data and rankings are displayed comparatively on this online tracker. Through HFI, the IDOH also tracks 25 core service progress measures, categorizing counties into Not Started, Planning, In Progress, and Completed.[24] Currently, data is available for three timepoints.

During the first year of funding, evaluation was based on capacity building.[18] This included actions which expanded the ability of a county to provide services, whether by hiring new staff, promoting existing staff, or creating partnerships. Counties were also required to develop and define local key performance indicators to track the local provision of core services.

HFI Initial Impacts

A preliminary evaluation of the Health First Indiana initiative was done through the Center for Health Policy at the Indiana University Richard M. Fairbanks School of Public Health. This December 2024 report estimated cost savings from three key service areas: prenatal care, blood pressure screenings, and fall prevention.[22] The full report is scheduled to come out in early 2026.

Prior to the creation of HFI, counties received about $7 million combined from the state each year. The funding provided through HFI, which totals $225 million over two years, is a 1500% increase in the state's average annual investment for public health. This report examines 89 LHDs and the data they reported between January and August of 2024. There were 581,073 total individual services delivered across all HFI core service areas. An estimated $94,394,667 in cost savings was attributed to the three services examined in the report (prenatal care, blood pressure screenings, fall prevention). These calculations included both direct and indirect cost savings. Furthermore, the report predicted that Indiana's public health spending ranking would rise to 35th in 2024-25. Assuming no changes in other states, this would be a 12-place jump from pre-HFI years.

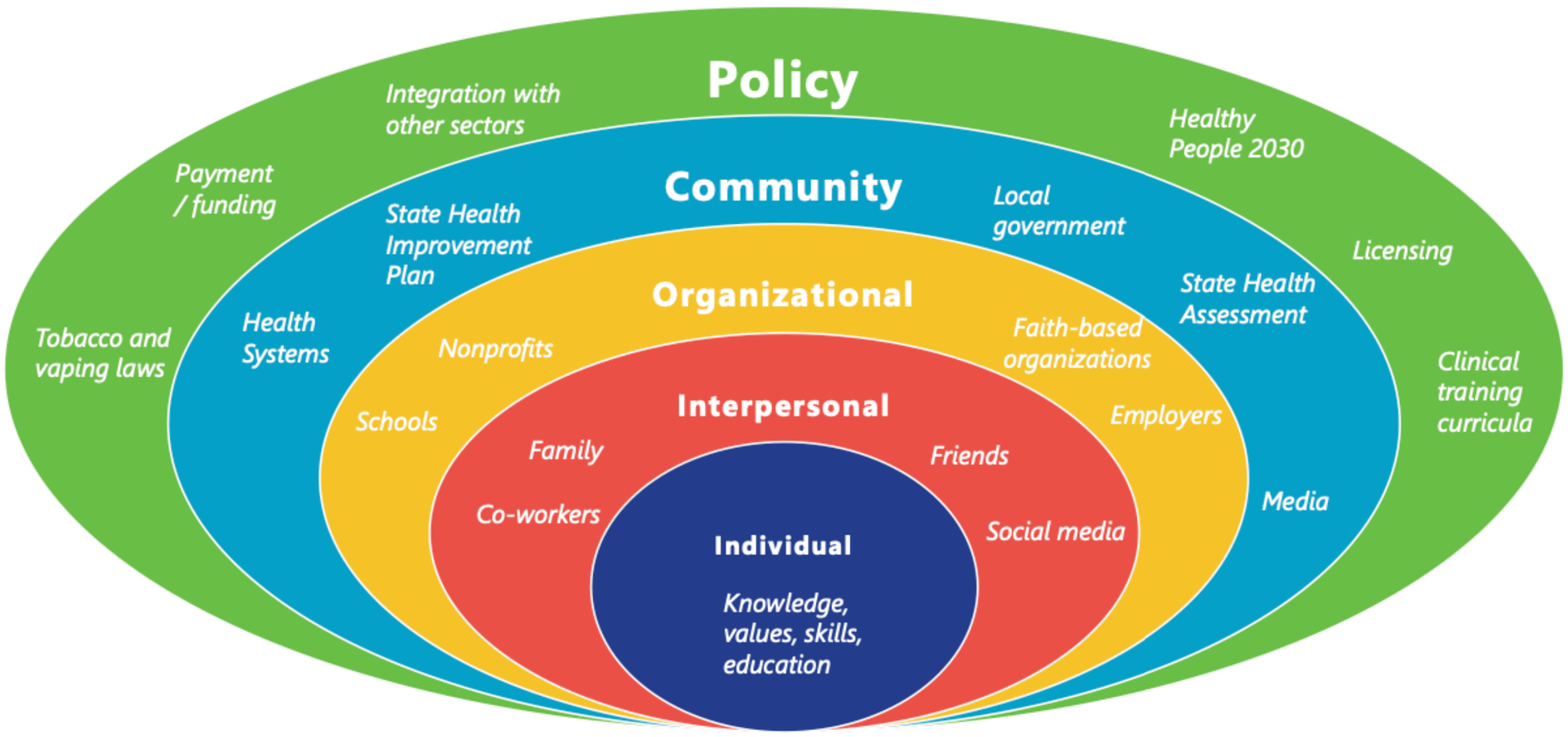
The authors suggest that this is a conservative underestimate of the cost savings and impact of the program up until the point of analysis.

Analysis and Indiana Stakeholder Insights

In public health, the social determinants of health (SDOH) are the "conditions in the environments where people are born, live, learn, work, play, worship, and age" that altogether impact their health, quality of life, and longevity.[25] A variety of conceptual models exist to explain SDOH domains and their interrelatedness. Some of these models explicitly indicate policy as a high-level influence.[26,27,28,29] The GPHC utilized the socio-ecological model of health to frame its work (**Figure 7**).[11]

The Indiana Governor's Public Health Commission is a case study in how strategic, cooperative partnerships and open-forum discussion can be utilized to influence policy and thereby achieve downstream public health goals. Studying the GPHC may inspire other states to act similarly. For example, Maryland established a Commission on Public Health in 2023, and a state delegation attended Indiana's second Public Health Day to learn about Indiana's experience.[30,18] The Indiana GPHC can be separated into three pieces for analysis: the planning phase, the people, and the process. Interested stakeholders may find it helpful to consider the key elements which contributed to the Commission's success.

Figure 7: The Socio-ecological Model of Health



taken from Box, K. (2021)

Planning

What is being referred to as the “planning” portion of the GPHC encapsulates all of the elements that preceded Executive Order 21-21. This includes the environment, political motivations, and other drivers.

Indiana’s poor national rankings in life expectancy, overall health outcomes, overall public health, and public health funding signaled room for improvement. Furthermore, the statutes governing public health had remained unchanged for over 30 years. The impacts of these deficiencies were made tangible by the COVID-19 pandemic, which revealed critical shortcomings in emergency preparedness and response capacity at a local level. The pandemic also placed public health at the forefront of people’s minds, forming a window of opportunity. All three of these aspects were cited in Executive Order 21-21.

Indiana’s governor at the time, Eric J. Holcomb, was essential to the formation and promotion of the Commission. Close coordination between the State Health Department and the Governor during the years of the pandemic created shared experience. Governor Holcomb established the Commission through his executive power, lending legitimacy to the Commission and its mission.

Lastly, the 2020 Report by Indiana University Richard M. Fairbanks School of Public Health created a shared body of knowledge about the gaps in Indiana’s public health system. It established and analyzed a baseline, which gave direction to the Commission.

Key Takeaways

- **Public health deficiencies were made prominent (including to those outside public health)**
- **Government support in initiating and promoting Commission activities**
- **Prior body of knowledge established a baseline and gave direction**
- **More baseline data could have enhanced pre- and post-HFI comparisons**

People

Commissioners were appointed to ensure a balance of different perspectives, not only so the final deliverable would be comprehensive but also to increase its impact. Associations and academicians could speak freely in ways the IDOH, as an extension of the executive branch, might not. They were also not merely self serving; additional funding would not directly benefit them. Two highly credible co-chairs guided the work of the Commission. One, a former state senator, brought budgeting experience and was well known for his financial conservatism.[18] The second was Indiana's previous state health commissioner and current CEO of the CDC Foundation who had a wealth of public health knowledge.[31] A former U.S. Representative, acting as a citizen advisor, brought federal experience with emergency preparedness and public health workforce.[31] Involvement of local elected officials strengthened legislators' understanding of the issues and aims, an important factor in getting the recommendations pushed through for consideration.[16] All of the GPHC members signed final report, uniformly endorsing the recommendations.

Other key players supported and gave direction to the Commission. Designated Policy Advisors brought expertise to their assigned workstreams. The IDOH was involved throughout the process, offering organizational support to keep the Commission functioning. Their involvement was also necessary for the transition of responsibility after the Commission concluded. Alongside continued public support, the governor encouraged skeptics to consider the possible benefits of a stronger public health system.[18] The governor's office was a crucial communication coordinator, working with stakeholders to provide updates and transmit feedback.

The Commissioners, in tandem with the IDOH and governor's office, worked tirelessly to ensure bidirectional communication with the public. Statewide listening tours engaged citizens and informed them about the Commission's mission. These tours occurred between Covid waves, and citizen feedback about the pandemic response proved that it was necessary to broaden people's understanding of public health and clarify the Commission's tasks. The Commissioners adapted to this feedback, thereafter opening each tour with a short informational presentation. Important local stakeholders were directly invited to these tours, demonstrating earnest effort to connect.[18]

There were some missed opportunities for involvement. As a state with a home-rule public health system, the power for implementation rests with local officials. State legislation created new funding mechanisms as recommended by the GPHC, yet those individuals with local financial decision-making power (County Councils) were not involved in policy development. Legislators could have also been more involved, and earlier in the process. This may have helped manage expectations regarding the HFI initiative. During the recent 2025 legislative session, massive budget cuts dropped HFI funding down to $40 million for each FY2025-26 and FY 2026-27.[32] These budget cuts illustrate the volatility of public health funding in the absence of strong, clear buy-in from decision makers.

Key Takeaways

- **Diverse perspectives represented**
- **Included vocal, free-speaking organizations & individuals**
- **Continued, public government support**
- **Financially prudent legislator with budget experience in a leadership position**
- **Field experts with lived experience and knowledge**
- **Staff for technical support and project management**
- **Bidirectional communication with various stakeholders**
- **Stakeholders, including citizens, invited to participate & feedback was visibly incorporated**
- **Recommendations uniformly endorsed**
- **Odd number of Commissioners for no voting ties**
- **Missed opportunity to involve more legislators**
- **Lacking involvement from local decision makers**

Process

The “Process” refers to Commission proceedings and marketing. From the beginning, the Commission’s tasks were clearly outlined. Executive Order 21-21 identified focus areas, defined the final deliverable, and established a firm end date. Commissioners did not develop the process iteratively nor did they do much investigative work outside of the meetings. Hired consultants, IDOH staff, and Designated Policy Advisors did a majority of the legwork. This included research, drafting policy recommendations, compiling information, taking meeting minutes, and more. The IDOH Chief of Staff acted as a central liaison for the various workgroups. He assisted in level-setting by organizing and distributing documents to the Commissioners prior to meetings. Attendance was high and meetings worked “like clockwork;” expert presentations set the scene and accessible reference materials gave Commissioners the information they needed to make decisions.

The Commissioners and associated staff worked diligently to manage public awareness and perception. Transparency was key. A press release was issued after each meeting to highlight key points for the public. IDOH staff helped create similar meeting summaries tailored for legislators.[18] Commissioners and IDOH staff met with members of Senate and House public health committees to provide them with more comprehensive updates.[18] The GPHC was also strategically marketed. Funding from the Richard M. Fairbanks Foundation, a respected local nonprofit organization, made its purpose more compelling. Commissioners prioritized the economic benefits of public health investment in their messaging. This broad, forward-looking approach prevented any political polarization. However, avoiding sensitive topics like the social determinants of health may have limited the GPHC’s overall impact on underlying public health problems.

Key Takeaways

- **Defined timeline and tasks**
- **Level-setting through presentations and accessible reference documents**
- **High attendance**
- **Transparency**
- **Philanthropic support legitimized the work**
- **Strategic marketing to reduce polarization**
- **“Behind-the-scenes” support allowed Commissioners to focus**
- **Inadequate attention to social determinants of health**

Conclusion: What About Vermont?

There is no one single way to develop and structure a public health commission. Rather, a commission can be tailored to the surrounding context. The composition, proceedings, and specific aims may vary widely depending on a state's capacity and goals. Indiana's government and health leaders identified a broad gap in public health infrastructure, pushing them to tackle this issue with a dedicated team of experts. The GPHC allowed for an intensive review of the state's shortcomings. Ultimately, the findings resulted in bipartisan legislation creating new appropriations and the Health First Indiana Initiative.

It remains to be determined whether Vermont would benefit from a public health commission. A Vermont commission would likely deviate from Indiana's in major ways. Vermont's centralized public health system of 12 local health offices contrasts with Indiana's home-rule system of 95 Local Health Departments. Responsibilities, powers, and partnerships are organized and distributed differently in these systems. Thus, the composition of a potential commission, the topics it discusses, and its recommendations and the way they are leveraged would need to be uniquely adapted for Vermont.

There are many potential topics to explore. The 2019-2023 State Health Improvement Plan identifies six health priorities,[33] whereas the Oliver Wyman report highlights affordability, sustainability, and access concerns. Other prominent topics are natural disaster response and preparedness, workforce, data modernization, and Vermont's rural nature. A public health commission may target all, some, or none of these issues. A commission could also be used to more broadly map assets, identify gaps, and establish a "state of the state." It would be necessary to assess whether or not there is an appetite for this work. Public health commissions remain a flexible mechanism for scoping systemic review. If done well and with adequate buy-in, they can initiate statewide policy change.

Acknowlegdments

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APPENDIX A: Mandated Activities to be Provided at Local Health Departments

Halverson, PK & Yeager, VA. Indiana Public Health System Review. IU Richard M. Fairbanks School of Public Health. December 2020.

Provide vital records services and access to public records, birth and death services e.g., Birth/Death records, name changes, etc. *Associated Legislation: IC 5-14-3; IC 16-20-1-17; IC 16-21-11-6; IC 16-34-3-4; IC 16-35-7; IC 16-37; IC 16-37-1-9; IC 16-38-2-7; IC 16-38-4; IC 16-38-6-7; IC 16-41-6-9; IC 23-14-31; IC 23-14-57; IC 31-19-5; IC 31-19-13; IC 34-28-2; IC 36-2-14; IC 10-13-5-11; 410 IAC 18*
Ensure safe and sanitary food and lodgings e.g., food inspections, regulations of food/drugs/cosmetics, certifications for food handlers, and establishment of sanitary requirements for establishments which provide food and/or lodging *Associated Legislation: IC 16-18-2-137; IC 16-20-8; IC 16-41-31; IC 16-42; IC 16-42-5; 410 IAC 7-15.5; 410 IAC 7-22; 410 IAC 7-23; 410 IAC 7-24; IC 16-41-30*
Ensure a healthy, clean environment by monitoring and regulating waste and sewage disposal e.g., set standards for residential sewage disposal and commercial wastewater disposal) *Associated Legislation: 410 IAC 6-8.3; 410 IAC 6-10.1; 410 IAC 6-12; IC 16-41-25; IC 13-26-5-2.5*
Perform disease control measures and infectious disease surveillance e.g., reporting communicable diseases, ensuring confidentiality of individuals is not compromised in reporting, implementing public health measures to control communicable diseases and epidemics, providing vaccination for indigent individuals *Associated Legislation: IC 16-20-1-21; IC 16-20-1-24; IC 16-41; 410 IAC 1-2.2-5; 410 IAC 1-2.3; 410 IAC 1-2.5-48; 410 IAC 29; IC 16-41-19; 410 IAC 6-9-5(b); IC 16-20-1-25; IC 16-41-8*
Control pests and vectors e.g., provisions for eradication of rats *Associated Legislation: IC 16-41-33; IC 16-41-34*
Minimize childhood lead poisoning through reporting, monitoring, management of cases, and implementing preventive measures *Associated Legislation: 410 IAC 29; IC 16-41-39.4*
Provide immunization services e.g., all child immunizations and basic adult immunizations (including influenza), provide vaccinations/antitoxins to persons unable to purchase (for diphtheria, scarlet fever, tetanus, and rabies) *Associated Legislation: IC 16-41-19-2*
Inspect and license railroad camp cars *Associated Legislation: IC 8-9-10; 410 IAC 6-14*
Ensure that dwellings are safe for human habitation *Associated Legislation: IC 16-41-20*
Authorize mass gatherings through licensing *Associated Legislation: IC 16-41-22-12; IC 16-41-22*
Establish child fatality review teams *Associated Legislation: IC 16-49-2 & 3*
Assume jurisdiction over temporary campgrounds (campgrounds operated not more than 10 consecutive days per event, and not more than 30 days per calendar year) *Associated Legislation: 410 IAC 6-7.1-16 and 7.1-33*
Reporting of spills and overflows from underground sewage tanks *Associated Legislation: IC 13-23-16*
Inspection and cleanup of property/vehicles contaminated by methamphetamine production *Associated Legislation: 318 IAC 1; IC 24-5-13, sections 4.1, 16.1, 16.2, and 24*
Notify the public (at least 48 hours beforehand) of board and agency meetings *Associated Legislation: IC 5-14-1.5*
Assume responsibility for health-related areas during emergencies/disasters *Associated Legislation: IC 10-14-3*
Ensure public and semi-public pool/spa compliance with established standards *Associated Legislation: 15 U.S.C. 8001-8008*

APPENDIX B: Executive Order 21-21

Ind. Exec. Order No. 21-21. 18 August 2021.

STATE OF INDIANA

EXECUTIVE DEPARTMENT
INDIANAPOLIS

EXECUTIVE ORDER 21-21

FOR: ESTABLISHING THE GOVERNOR'S PUBLIC HEALTH COMMISSION

TO ALL WHOM THESE PRESENTS MAY COME, GREETINGS:

WHEREAS, the Indiana Department of Health (Department) was established to protect the health and safety of Hoosiers;

WHEREAS, Indiana's public health system currently consists of the Department, 94 local health departments, hospitals, and other healthcare facilities;

WHEREAS, Indiana's public health system has evolved significantly since the Department was created, yet the statutes governing the structure of the public health system have not been substantially updated in over 30 years;

WHEREAS, addressing and managing the Coronavirus Disease 2019 pandemic has highlighted challenges within Indiana's public health system and the need for modernization;

WHEREAS, Indiana ranks 41st overall in the nation based on all public health measures evaluated by America's Health Rankings (2019) as measured by our lower life expectancies and higher health care costs; and

WHEREAS, Indiana would benefit from a comprehensive review and evaluation of its existing public health system resulting in recommendations for improved efficiency and efficacy to better promote the health and safety of Hoosiers.

NOW, THEREFORE, I, Eric J. Holcomb, by virtue of the authority vested in me as Governor by the Indiana Constitution and the laws of the State of Indiana, do hereby order:

1. <u>The Governor's Public Health Commission</u>

   A. The Governor's Public Health Commission (Commission) is hereby established and convened to advise the Office of the Governor and the Department on the functioning of Indiana's public health system.

   B. The Commission is charged with the following:

      i) analyzing Indiana's current public health system to identify both strengths and weaknesses;

      ii) analyzing the performance of state and local health departments during the Coronavirus Disease 2019 pandemic;

      iii) identifying the following:

         a) ways to improve the delivery of public health services throughout the State;

         b) the funding challenges for the State's public health system and ways to address those challenges;

         c) ways to promote health equity;

         d) ways to ensure the sustainability of our local health departments; and

         e) ways to improve responses to future public health emergencies;

      iv) identifying potential legislative proposals to address the Commission's findings and recommendations; and

      v) issuing a written report of the Commission's findings and recommendations.

   C. The Commission will be made up of the following 15 members, appointed by and serving at the pleasure of the Governor:

      i) two representatives of the public, who will serve as co-chairs;

      ii) the State Health Commissioner;

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iii) two local health officers;
iv) a public health administrator representing the Local Health Department Managers Association;
v) an academician from the public health field;
vi) a representative for healthcare workforce initiatives;
vii) a representative from the Indiana Hospital Association;
viii) a representative from the Indiana Minority Health Coalition;
ix) a representative from the Indiana Rural Health Association;
x) a representative from the Indiana Public Health Association; and
xi) three elected officials.

D. The Commission should meet at least monthly and at the call of the Co-Chairs. A majority of members constitutes a quorum, which is necessary for all business to occur. Decisions will be by majority vote.

E. All members of the Commission shall serve without salary or per diem, except that members of the Commission shall be reimbursed in accordance with state law and the policies of the Indiana Department of Administration and the State Budget Agency for actual expenses incurred in carrying out their responsibilities as Commission members.

F. The Commission shall sunset upon the delivery of the written report to the Governor and the Department which shall be no later than December 31, 2022.

2. **The Indiana Department of Health**

A. The State Health Commissioner is hereby directed to provide all necessary support to staff the work of the Commission.

B. The Department may use any legal appropriation, grant, or other financial resource in furtherance of this Executive Order. The Department may apply for and receive grants, gifts, or donations to support the work of the Commission.

C. The Department may enter into contracts, agreements, and memoranda of understanding in support of the Commission's work subject to the statutory approval normally given by the State Budget Agency, Indiana Department of Administration, and Office of the Attorney General.

D. The Department will document the work of the Commission, ensure adherence to the Open Door Law (Ind. Code § 5-14-1.5), and maintain public records (Ind. Code § 5-14-3).

3. **Cooperation**

All state agencies, departments, institutions and other instrumentalities of the executive, shall cooperate and provide assistance to the Commission and the Department to the fullest extent permitted by law in connection with this Executive Order.

IT IS SO ORDERED.

IN TESTIMONY WHEREOF, I, Eric J. Holcomb, have hereunto set my hand and caused to be affixed the Great Seal of the State of Indiana, on this 18th day of August, 2021.

Eric J. Holcomb
Governor of Indiana

ATTEST: Holli Sullivan
Secretary of State

APPENDIX C: Geographic Distribution of GPHC Listening Tours

Indiana Department of Health. Governor's Public Health Commission Engagement Plan Listening Tours. 11 February 2022. https://www.in.gov/health/files/GPHC-Listening-Tours_2022-02-11.pdf

Feb. 18: **Jasper** – Vincennes University, Center for Technology Innovation & Manufacturing (CTIM) Building, 850 College Ave., Jasper 47546

Feb. 25: **New Castle** - New Castle-Henry County Public Library, 376 South 15th St., New Castle 47362

Mar. 4: **Seymour** – Ivy Tech Jackson County Learning Center, 323 Dupont Dr., Seymour 47274 - Community Room

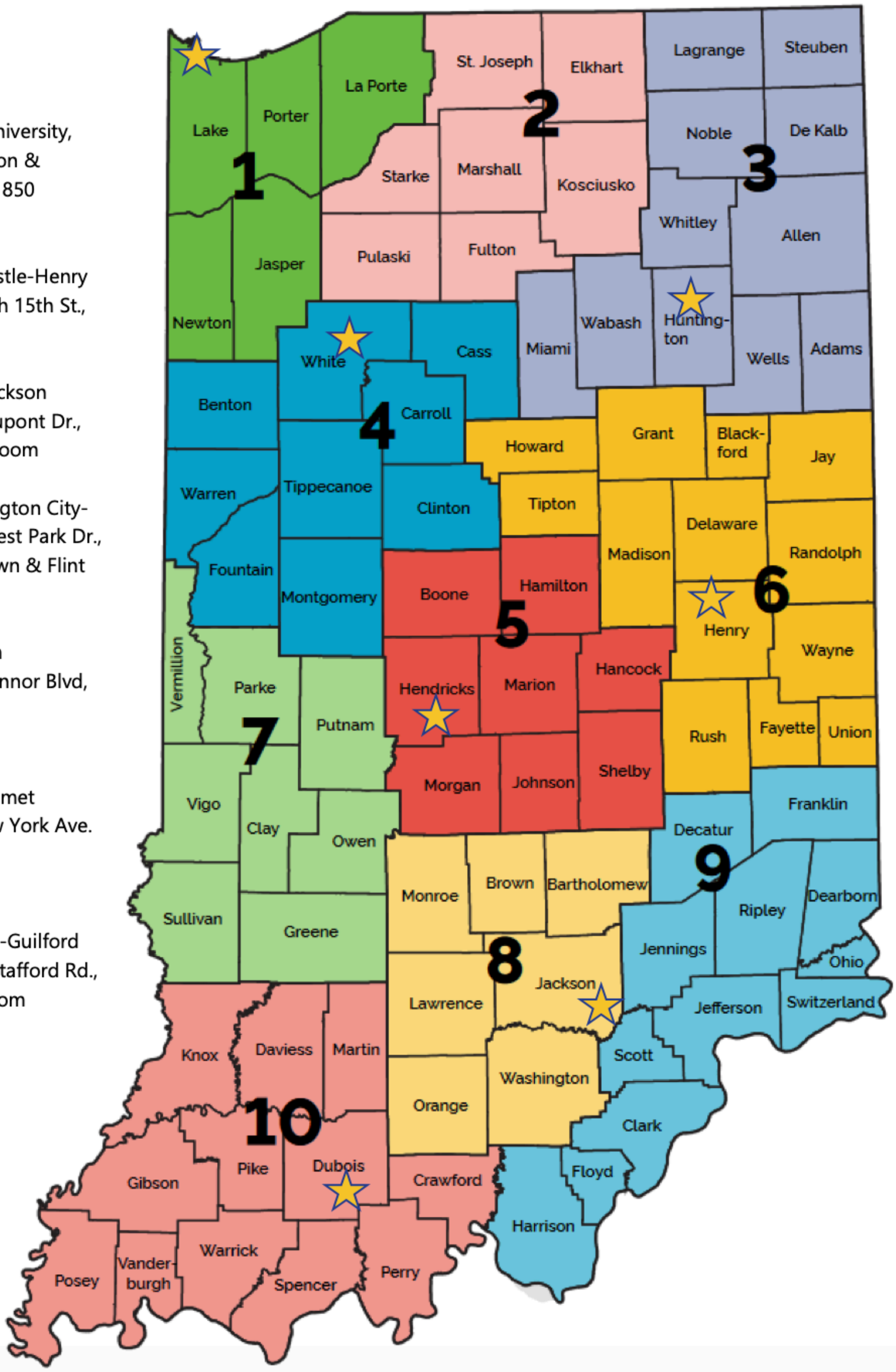
Mar. 11: **Huntington** – Huntington City-Township Public Library, 255 West Park Dr., Huntington 46750 - Drover Town & Flint Springs Meeting Rooms

Mar. 18: **Monticello** – Ivy Tech Community College, 1017 O'Connor Blvd, Monticello 47960 - Room 104
(rescheduled from Jan. 7)

Mar. 25: **Whiting (CST)** – Calumet College of St. Joseph, 2400 New York Ave. Whiting 46394
(rescheduled from Jan. 14)

Mar. 31: **Plainfield** – Plainfield-Guilford Township Public Library, 1120 Stafford Rd., Plainfield 46168 - McMillan Room
(rescheduled from Jan. 28)

Current as of 11 February 2022



APPENDIX D: GPHC Report Recommendations

Indiana Governor's Public Health Commission. Report to the Governor in fulfillment of Executive Order 21-21. *In.gov*. 1 August 2022.

Governance, Infrastructure, and Services

Goals

- Ensure consistent delivery of public health services across Indiana
- Promote collaboration and increased technical assistance
- Modernize structure of public health
- Enhance engagement with local community partners and elected officials
- Encourage sharing of expertise and skilled professionals
- Promote culture of continuous quality improvement

Recommendation 1: Establish baseline service standards for all local health departments.

Action items:

A. Define minimum required services with stakeholder engagement.
B. Provide technical assistance to Local Health Departments (LHDs) to support implementation and shared resources.

Recommendation 2: Expand IDOH resources to support LHDs and interlocal collaboration.

Action items:

A. Provide staff and resources to support LHDs in a district with epidemiology, data analytics, legal consultation, communications, grant writing, training, and other functions, as necessary.
B. Encourage partnerships among LHDs for key service areas (e.g., TB, STIs, Lead), including, for example, through the provision of funding.

Recommendation 3: Assist LHDs to engage local businesses, health providers, schools, and other governmental and non-governmental organizations to promote public health in the community.

Action items:

A. Provide LHDs with guidance and best practices on how to create, convene, and sustain strategic relationships.
B. Sustain partnerships and collaborations developed during the pandemic.
C. Partner to promote the importance and value of local public health.

Recommendation 4: Update Local Health Board (LHB) appointments to reflect current public health workforce and key community representation.

Action items:

Amend Indiana law to:

A. Retain LHB bipartisan structure, but add an option for no more than two independent members (i.e., with no partisan affiliation).
B. Add to the list of persons knowledgeable in public health eligible to be appointed to an LHB (currently listed in IC 16-20-2-5(1)) a professional from the public health field, such as an epidemiologist or similar professional.
C. For large counties with populations of 200,000 or greater (excluding Marion County), increase the number of LHB members from seven to nine to allow for increased engagement and representation and to provide for:
    a. Five members, appointed by the county commissioners, who are knowledgeable in clinical and public health
    b. One member, appointed by the county commissioners, who represents the general public
    c. One member, appointed by the county council, who represents the general public or is knowledgeable in public health
    d. One member appointed by each of the executives of the two most populous cities in the county
D. For counties with populations under 200,000, provide for:
    a. Five members, appointed by the county commissioners, who are knowledgeable in public health
    b. One member appointed by executive of the most populous city in the county
    c. One member, appointed by the county council, who represents the general public
E. Repeal IC 16-20-2-7, Appointments of Members in Certain Circumstances.

Recommendation 5: Ensure policy supports sharing of resources or consolidation of LHDs if desired by local partners.

Action items:

A. Ensure that the creation of a multi-county LHD does not result in lower overall funding for the combined entity.

B. IDOH will provide technical assistance for requesting counties considering LHD resource sharing or consolidation, including legal consultation, model ordinance language, and a toolkit with other recommendations and guidance.
C. For counties choosing to form a multiple-county LHD, amend the statute to require that the resulting multiple-county LHD maintain at least one physical office in each component county that, at a minimum, offers consumer-accessed services, such as vital records, immunizations, and certain environmental inspections and permitting.

Recommendation 6: Promote delivery of public health services at the county level or higher, including allocation of funding.

Action items:

A. Amend IC 16-20-4 to grandfather current municipal LHDs and ensure that local public health services are delivered at a county level or higher going forward.
B. Allocate new funding for public health to the county, which may choose to subgrant to municipalities and/or establish satellite offices or annexes.

Recommendation 7: Expand personnel eligible to serve as a Local Health Officer and require new appointees to complete public health training.

Action items:

A. Amend Indiana law to allow an Advanced Practice Registered Nurse (APRN) or Physician's Assistant (PA) with formal public health training (e.g., master's in public health or equivalent) to serve as a local health officer at the Local Health Board's discretion.
    a. For the purposes of this Recommendation, an APRN is an individual who meets the definition of the Indiana State Board of Nursing and IC 25-23-1-1(b) and holds prescriptive authority.
B. Require an APRN or PA serving as local health officer to be clinically supervised by a district health officer who is a physician and is from a neighboring county or employed by the IDOH.
C. An LHB, with approval of local elected officials, may submit to the IDOH Executive Board a request to appoint an LHO who is not a physician, APRN, or PA, provided that individual has at least a master's in public health or equivalent degree and 5 years of experience in the public health field. The request must detail how the jurisdiction plans to ensure appropriate clinical oversight for medical services. The IDOH Executive Board will review the request and render a decision based on the needs of the jurisdiction and qualifications of the individual.

D. Require newly appointed local health officers to complete a public health foundations training to be developed by IDOH and earn a Certified Public Health (CPH) credential within one (1) year of being eligible to sit for the exam.

Recommendation 8: Provide financial and technical assistance to LHDs pursuing accreditation or reaccreditation.

Action items:

A. Provide technical assistance to LHDs pursuing accreditation.
B. Assist with funding to defray the costs of LHDs pursuing accreditation or reaccreditation.
C. Consider other incentives to encourage LHDs to pursue accreditation.

Public Health Funding

Goals

- Increase public health funding to achieve consistent per capita spending at 2019 national average of $91 per person as compared to Indiana's $55 per person[10]
- Adjust for inflation and sustain public health investments to ensure long-term improvement in health outcomes through consistent programming
- Maximize all available public health funding sources
- Provide transparency and accountability for public health expenditures

Recommendation 9: Provide local health departments with stable, recurring, and flexible funding to build and sustain their foundational public health capacities.

Action items:

A. Request an increase in annual appropriations for the 2024-25 biennium and future biennial budgets.
B. Increase state-funded Local Health Maintenance Fund (LHMF) allocations to support the provision of an essential set of public health services in each county, taking into account county population and district support services.
C. Condition receipt of additional LHMF allocations at the county level on:
   (1) a vote by local elected officials' every five years to opt in to expanded services, with education to local elected officials to delineate ramifications of an opt-out vote; a county could rescind its opt-out vote within a year.
   (2) maintenance of effort for local health budgets of up to 20% local cost-sharing with approval of county fiscal body.

Recommendation 10: Provide LHDs with administrative supports and other flexibilities to leverage all available funding sources.

Action items:

A. Create an IDOH surge staffing program to increase the capacity of LHDs to maximize grant opportunities.
B. IDOH will facilitate insurance and Medicaid billing for direct clinical services provided by LHDs that request this support.
C. Allow consolidated LHDs to operate as Municipal Corporations, subject to the appointment of the Municipal Corporation's governing board by the county executives of each constituent county.

Recommendation 11: Establish consistency in the tracking of the public health resources and calculate the return on investment of additional funding allocations.

Action items:

A. Track public health revenues and expenditures across IDOH and all LHDs on a consistent basis, in conjunction with the State Board of Accounts and the Department of Local Government Finance. Consider adopting the Public Health Uniform Chart of Accounts.
B. Offer IDOH-sponsored annual training regarding public health and public health finance for county auditors, commissioners, and councilors.

Workforce

Goals

- Ensure Indiana has sufficient information on the health (public health and health care) workforce to identify shortages and support workforce planning
- Enhance training, recruitment, and retention to ensure workforce capacity and skills are sufficient to support Hoosier health

Recommendation 12: Coordinate current initiatives and provide a framework for the development of a state health workforce plan.

Action items:

A. Establish a health workforce council co-chaired by the State Health Commissioner and Secretary of FSSA to coordinate and plan health workforce programs and initiatives.

B. Leverage existing processes and programming to identify clinical healthcare shortages and areas requiring further evaluation.
C. Complete a comprehensive local and state public health workforce assessment to collect and analyze job descriptions, salary ranges, full-time equivalent (FTE) counts, training, and services delivered.
D. Use these workforce assessments to develop a comprehensive healthcare workforce plan for the state.
E. Provide standardized job descriptions in public health and suggested salary ranges for these position to local elected officials for guidance.

Recommendation 13: Ensure representation of public health on Indiana workforce initiatives.

Action items:

A. Include IDOH representative on the Indiana Graduate Medical Education Board.
B. Coordinate with the Indiana Governor's Workforce Cabinet.

Recommendation 14: Through the Health Workforce Council, enhance workforce reporting to understand public health and clinical workforce needs and the status of the talent pipeline.

Action items:

A. Develop a set of standardized workforce reporting measures for state and local health departments.
B. Work with state and local public health to understand their workforce needs and gaps
C. Create a central repository for LHD position postings from across the state.
D. Partner with the Commission for Higher Education and institutions of higher education to quantify and describe Indiana's health workforce pipeline and retention.

Recommendation 15: Expand health workforce recruitment, training, placement, and retention into areas of need.

Action items:

A. IDOH and FSSA will collaborate with other state agencies on incentive program strategies (e.g., loan repayment) that target Indiana's health workforce needs and complement existing federal programs.
B. Promote experiential learning opportunities in public health through paid internships and fellowships.

C. Create cross-training opportunities in public health for students in clinical health programs.
D. The Office of the Governor, the Indiana Professional Licensing Agency, and IDOH should evaluate whether centralizing licensure functions within IDOH for all healthcare professionals would enhance the state's ability to more efficiently recruit and license healthcare professionals.

Data and Information Integration

Goals

- Ensure coordination of data across health and human services entities at the state level
- Maintain privacy protections and appropriate consents for use of data
- Promote integration of public health data for clinical use by providers to optimize health outcomes
- Provide tools to assist local public health officials to make data-informed decisions.
- Modernize public health systems and processes to increase efficiency and enhance service delivery to Hoosiers

Recommendation 16: Establish a State Public Health Data System Advisory Committee that includes local representation.

Action items:

A. Develop data governance across entities with appropriate privacy protections and security provisions, including cybersecurity protections.
B. Develop a strategic plan for public health data initiatives.

Recommendation 17: Formalize and strengthen the state's relationship with a Health Information Exchange (HIE) partner to promote improved clinical outcomes and outbreak management.

Action items:

A. Codify the state-HIE relationship and leverage funding opportunities (federal and non-profit) to enhance services and promote sustainability.
B. IDOH will recommend policies and initiatives to Increase number of providers connected to HIE partner.
C. Work with HIE partners to establish dedicated public health focus.

Recommendation 18: Enhance data analytics tools and resources for local public health.

Action items:

A. Establish district-level data services, integrated with epidemiology assistance, to support LHDs and cross-county analysis.
B. Ensure bi-directional data flow that allows LHDs to access and analyze all submitted data.
C. Establish baseline technology, security, and resource requirements for LHDs, with financial and logistical support for LHDs to achieve compliance.
D. Promote digitization of inspection and permit records to improve access to key public health data.

Recommendation 19: Maintain state-led digital transformation efforts to modernize public health systems and paper-based processes.

Action items:

A. Dedicate funding to support the IDOH Office of Data and Analytics and its ability to fully implement all GPHC recommendations.
B. Establish funding to continue digital transformation efforts to support implementation and ongoing operations of GPHC recommendations.

Emergency Preparedness

Goals

- Ensure connectivity and facilitate information exchange in preparation for and during public health emergencies
- Enhance LHD, IDOH, and EMS readiness
- Improve the scalability of emergency response efforts beyond the local level
- Ensure state and local agencies have tools to prioritize and maintain responder resilience

Recommendation 20: Increase utilization of IDOH's EMResource tool across all Indiana hospitals, local public health departments, first responders and applicable government agencies.

Action Items:

A. Secure funding and infrastructure for EMResource, the state's resource tracking and decision support tool for public health emergency preparedness.
B. Include EMResource participation as a condition of hospital licensure.

C. Ensure awareness and training on use of EMResource and WebEOC of all relevant partners.
D. Require local health departments to utilize EMResource.

Recommendation 21: Require LHDs to participate in the CDC Public Health Emergency Preparedness (PHEP) grant program.

Action items:

A. Require each LHD to have a PHEP coordinator (0.5 FTE minimum).
B. Provide technical assistance as needed for grant activities and reporting.

Recommendation 22: Enhance IDOH's emergency services and supplies capacity.

Action items:

A. Maintain IDOH vendor contracts that can be activated during a public health emergency.
B. Evaluate the need for a state strategic stockpile to ensure the availability of personal protective equipment and (PPE) and medical counter measures (MCM).
C. Engage Health Care Coalitions, LHDs, and statewide partners to develop strategies for extending PPE and MCM supplies so that both are available when needed most.
D. Direct Indiana Department of Homeland Security and IDOH on coordination of public health emergencies through training exercises.

Recommendation 23: Ensure local level EMS readiness through expansion and sustainability of EMS workforce.

Action items:

A. A. IDOH in conjunction with the EMS Commission, will conduct a needs assessment of specific EMS gaps in local jurisdictions.
B. Ensure funding for prioritized recruitment to address EMS workforce shortages and provide mechanisms for cost-sharing related to equipment purchases, particularly in underserved and geographically remote areas of the State.
C. Establish long-term promotional and retention plans for EMS personnel.
D. Enhance ongoing higher levels EMS training and expansion of community paramedicine programs.
E. Improve health outcomes related to preventable injuries and other trauma through enhanced analysis and educational initiatives, increased access to EMS, and other efforts to strengthen the trauma system.

Recommendation 24: Improve regional coordination efforts to ensure a seamless emergency response.

Action items:

A. Initiate a stakeholder engagement process to redefine the IDOH Emergency Preparedness Districts.

B. Initiate a stakeholder engagement process to redefine roles, responsibilities and authorities of regional partners to improve public health emergency preparedness coordination.

Child and Adolescent Health

Goals

- Improve student learning by mitigating health barriers
- Enhance early childhood education and school-based health education, prevention, and wellness activities
- Improve access to child and adolescent health care
- Reduce childhood injuries

Recommendation 25: Support policies to increase the availability of school nurses.

Action items:

A. Implement policies to improve the school nurse to student ratio.

B. Implement policies to support school nurse recruitment and retention, such as addressing low pay and incentivizing school nurse credentialing.

Recommendation 26: Increase access to services to support whole child wellness.

Action items:

A. Implement policies to improve the school counselor, social worker, and psychologist to student ratio.

B. Provide technical assistance to schools interested in providing School Based Health Clinics (SBHCs) in partnership with local health systems .

Recommendation 27: Support evidence-based health education, nutrition, and physical activity in schools and early childhood education settings.

Action items:

A. Make evidence-based curricula on health and oral health matters available for schools and early childhood education settings to access.

B. Provide technical assistance in implementing curricula.

C. Support schools and early childhood education settings in identifying opportunities to increase physical activity and healthy nutrition during the school day.

Recommendation 28: Support access to health screenings and services that can be appropriately delivered in school and early childhood education settings while maintaining parental/guardian consent mechanisms.

Action items:

A. Make best-practices information about screenings and services accessible to schools and early childhood education settings.
B. Convene a representative workgroup comprised of schools, community-based organizations, clinicians, and public health leadership to identify best-practices.
C. Support policies to increase the availability of nutritious meals, and reduce the availability of non-nutritious food, in schools and early childhood education settings.
D. Identify opportunities to provide resources and referrals to children identified during a school screening as requiring a service or supply (e.g., eyeglasses or hearing aids).
E. Ensure all strategies are equitable for children regardless of demographics and needs.
F. Explore opportunities to incorporate oral health screenings in school settings, in addition to the vision and hearing tests currently required.

Recommendation 29: Reinforce meaningful implementation of school wellness policies.

Action items:

A. Fund and leverage IDOH, IDOE, and community partners to collaborate with school districts regarding the benefits of evidence-based wellness policies.
B. Fund direct technical assistance to implement evidence-based school wellness policies.
C. Incentivize school districts to prioritize wellness policy via school grant processes.

Recommendation 30: Support the development of SBHCs.

Action items:

A. Provide technical assistance to school systems interested in developing a SBHC.
B. Leverage best practices from established SBHCs and in compliance with parental consent requirements.
C. Identify opportunities for connecting local health systems with schools interested in implementing SBHCs.
D. Increase oral health education and awareness and, if desired, oral health screenings in SBHCs.

Recommendation 31: Increase provider awareness of public health initiatives, opportunities, and requirements.

Action items:

A. Engage relevant community stakeholders in developing technical assistance framework for Indiana healthcare providers on public health best practices and available resources.
B. Address practice variance across the state on public health matters.

Recommendation 32: Address childhood injury and violence prevention.

Action items:

A. Establish an interprofessional coalition of experts focused on keeping youth safe from unintentional firearm deaths and suicide.
B. Fund and leverage IDOH to develop policies to address safety issues and increase equitable access to safety equipment shown to significantly decrease child injuries (such as car seats, bike helmets, cabinet locks, and stair gates).