



Indiana
Department
of
Health

Public Health Governance and Infrastructure

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Note of thanks

Our work included interviews with the following individuals. We thank them for their time and expertise.

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Joe Gries

The Challenge: Ensure that our governance systems meet current public health needs and demands

“Public health policy and practice is constructed and realized at many levels simultaneously – local, regional, national, and international. All are important, require different skills and should be linked to maximize effectiveness. As the context for public health changes, institutions will need to be reinvented and new networks formed to bridge the gap between these levels, and to stimulate new communities of learning and action.”



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Governance

State and local health departments retain the primary responsibility for public health under the U.S. Constitution

State and DC
Health
Departments

Tribal Health
Departments

Local Health
Departments
(2,459 in 2019*)

Territorial
Health
Departments (8)

Federal Government Roles

- Leadership (in collaboration with state and local governments and other stakeholders) in setting public health goals, policies, and standards
- Provide operational and financial resources; assistance to states lacking expertise to respond to a PH emergency
- Financing for research/higher ed
- Support for the development of PH scientific and technological tools
- Act when health threats may span more than one state

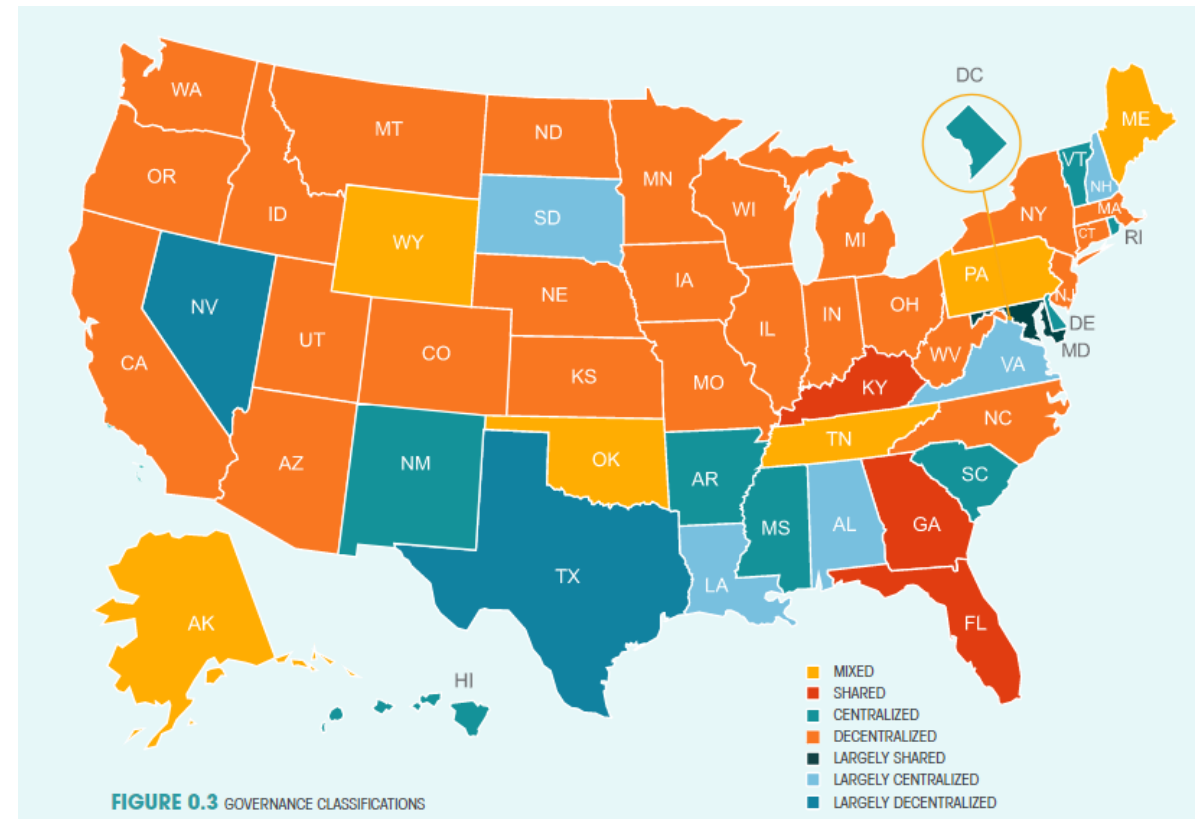
Indiana is a “home rule” state with local autonomy over public health

Indiana is one of 27 decentralized/largely decentralized states.

- Local government employees primarily lead local health units; local governments retain authority over most key decisions.

LHD funding control in Indiana rests with County Councils

2019 State Health Agency Governance Classification



Most of Indiana's 94 LHDs serve populations of 50,000 or less

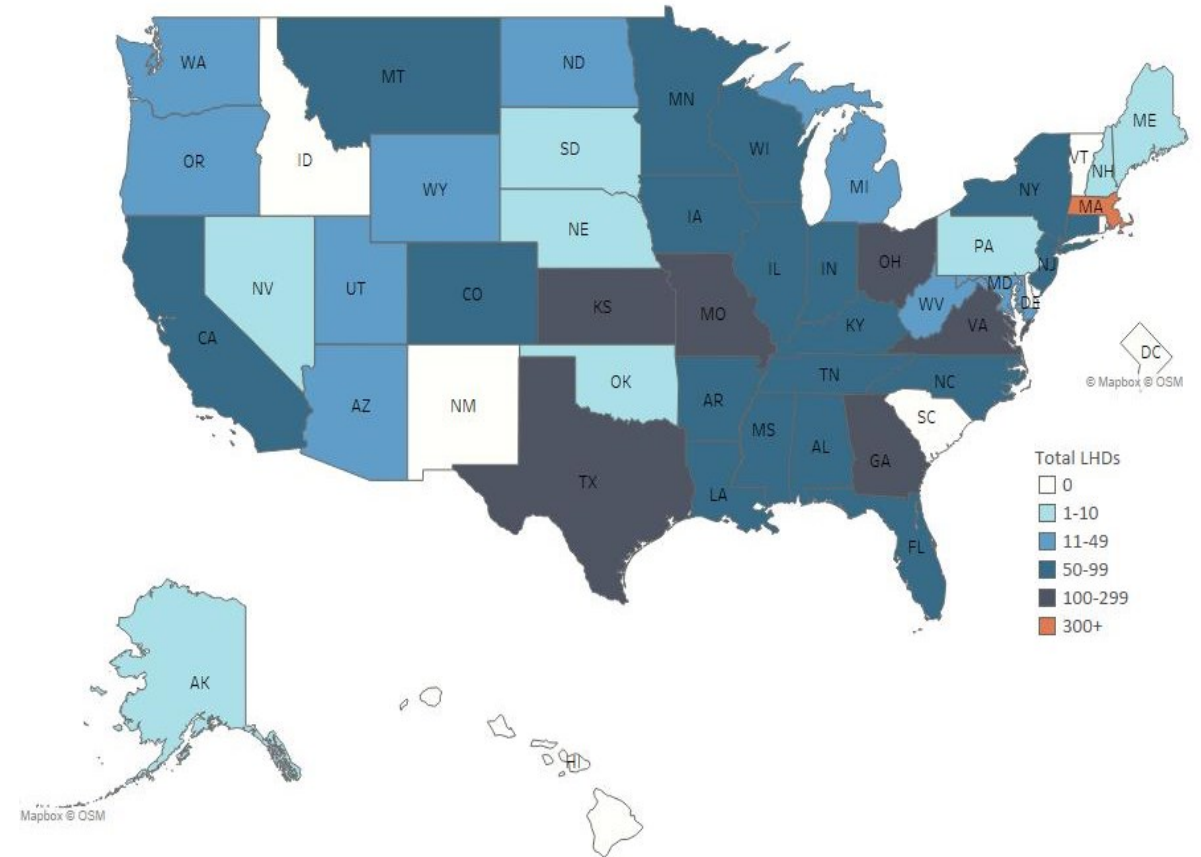
94 LHDs in Indiana

- 91 county-based (including one shared by Fountain and Warren counties)
- 3 city health departments (East Chicago, Gary and Fishers)

#of LHDs per Population Size Served

<25K	25K-50K	50K-100K	100K-250K	>250K
39	35	12	12	5

Total Number of LHDs, 2019



Current decentralized model strengths and weaknesses

Advantages	Disadvantages
<ul style="list-style-type: none">• Local credibility, trusted resource• Local physical presence• Established relationships with community stakeholders• Able to be more responsive to local public health needs• Potentially quicker response time	<ul style="list-style-type: none">• County councils often lack understanding of public health• Inconsistent availability of resources/expertise/training• Inconsistent enforcement and messaging• Inability to respond to emerging/growing needs of refugees/homeless



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Infrastructure and Services

Current statutory/regulatory structure

Mandatory

- Vital Records services
- Food protection/inspections
- Safe/sanitary lodging facility bedding
- Disease control/infectious disease surveillance
- Antitoxins/vaccines (diphtheria, scarlet fever, tetanus, and rabies)
- Childhood lead (reporting, monitoring, case management, prevention)

- Child fatality review teams
- Waste/sewage disposal – monitoring and regulation
- Reporting spills/overflows from underground storage tanks
- Ensure dwellings safe for human habilitation
- Pest Control/Vector Abatement
- Public and semi-public pool/spa drain cover compliance (*a federal requirement*)

- Health-related areas during emergencies/disasters
- Temporary campgrounds
- Inspection/clean-up of meth-related contamination of property/vehicles
- Inspect/license railroad camp cars
- Refugee care

Other Locally Driven

- WIC clinics
- Childhood immunizations
- Public nuisance ordinances
- Open burning enforcement
- Lead risk assessments/mold programs
- Massage parlor
- Health/PH education
- Travel clinics
- Beekeeping
- CPR ordinances
- Patient safety
- Well ordinances

Non-mandatory

- Tattoo and body piercing safety and sanitation
- STDs, HIV prevention (testing, treatment, partner services, etc.)

- Mobile homes safety/sanitation
- Syringe service programs
- Youth camps

- Campgrounds and bathing beaches
- Public and semi-public pool/spa compliance

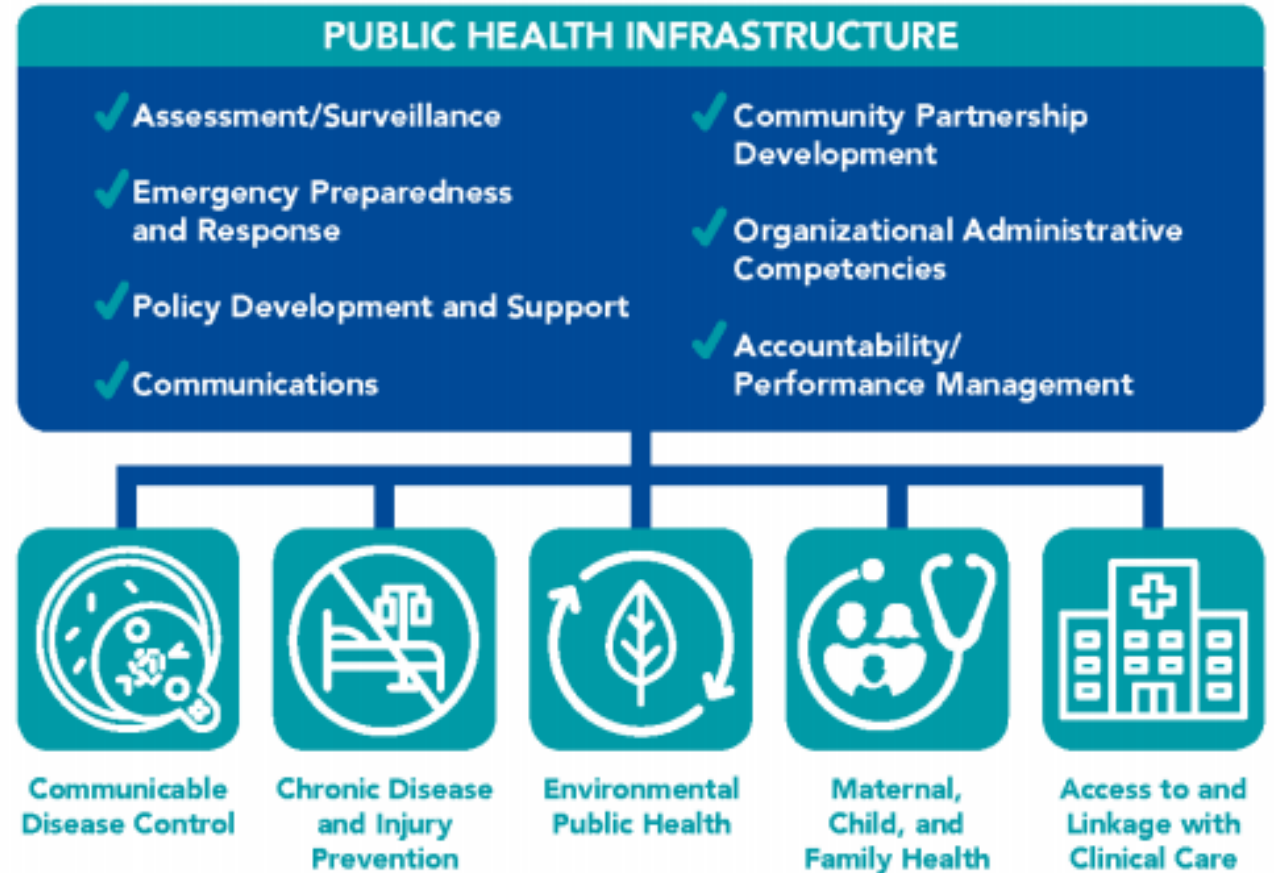
Areas of inconsistency per interviews

Areas of strength per interviews

Approach for defining “what good is:” Foundational Public Health Services

Foundational capabilities (Public Health Infrastructure): Cross-cutting skills and capacities needed to support basic public health protections

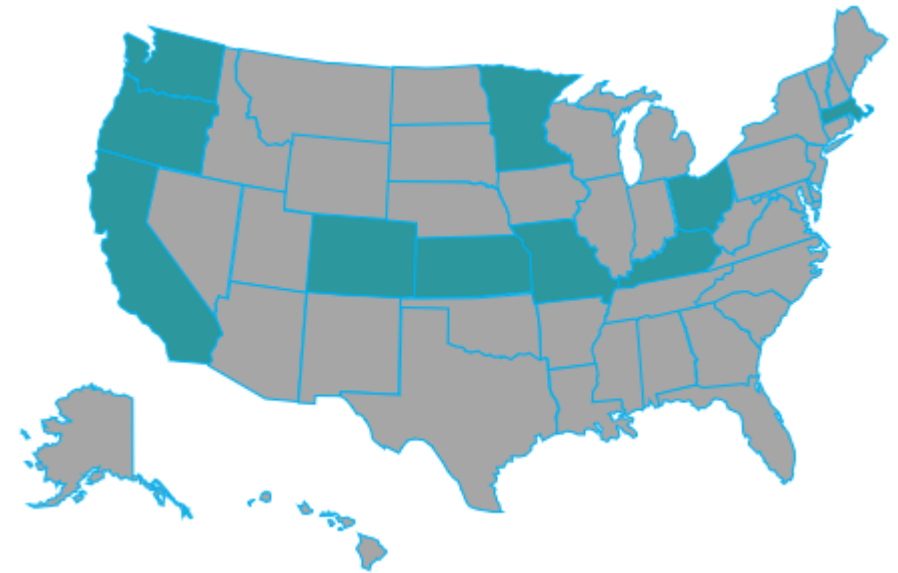
Foundational areas (Public Health Programs): Those basic public health, topic-specific programs that are aimed at improving the health of the community affected by certain diseases or public health threats



Growing interest in FPHS model because:

- **Communicates the minimum package of services needed everywhere** while leaving room for individual communities to decide how to deliver them.
- **Provides a common language**
- **Can be assessed** to determine and quantify service and funding gaps
- **Can be used as an organizing tool for strategic planning**
- **Connects clearly to national initiatives**, such as public health accreditation.

21st Century (21C) Learning Community



Group of states in various stages of adopting the FPHS framework

Supported by the Public Health National Center for Innovations, a division of the Public Health Accreditation Board

If initial cost and staff resources can be secured, many advantages to LHD accreditation

Advantages	Disadvantages
<ul style="list-style-type: none">• Increased credibility• Enhanced accountability• Made data-driven decisions part of the culture• Facilitated goal setting• Strengthened community partnerships• Built staff confidence.	<ul style="list-style-type: none">• Cost• Initial investment of staff time/resources

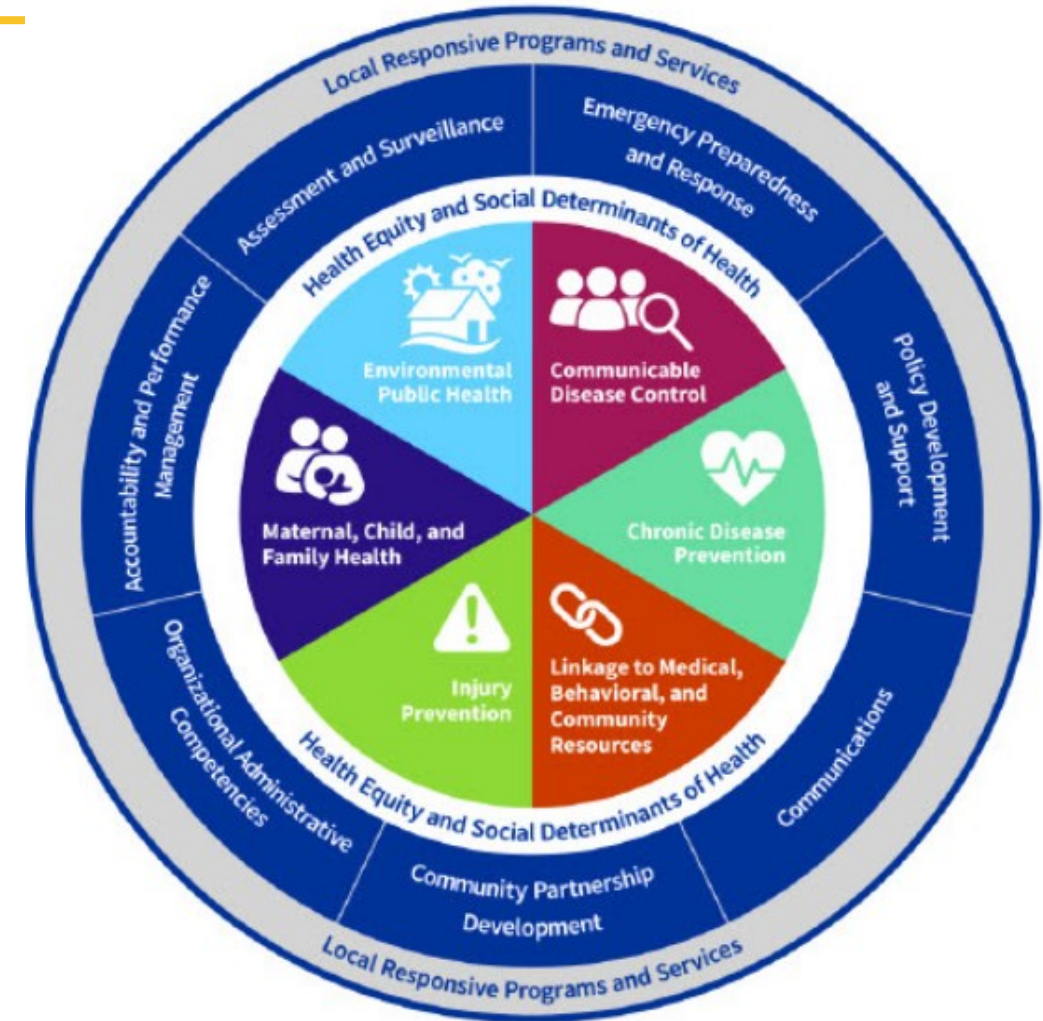
- Currently, 3 accredited LHDs: Montgomery, Rush and Vanderburgh counties
- All 3 likely to pursue reaccreditation, although one noted may depend on funding
- All three would recommend accreditation to other LHDs but would not recommend an accreditation mandate
- All agreed training resources would be welcomed

“We were convinced that we could do the impossible . . . If we made it through accreditation, we could make it through COVID.”



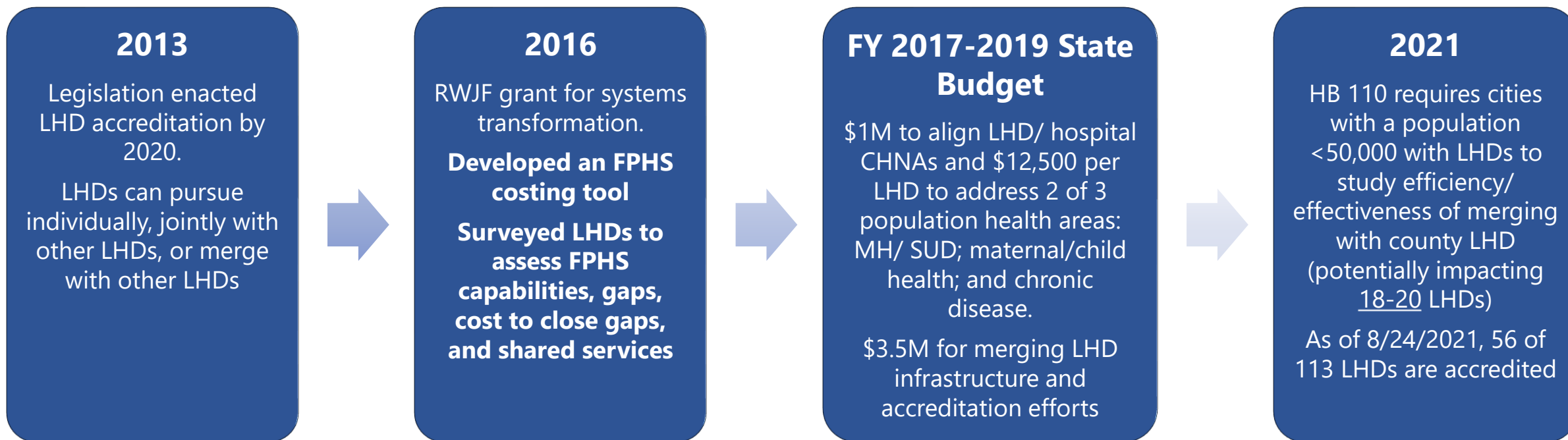
#HealthierMO: a grassroots initiative to transform Missouri's PH system – built on FPHS framework

- Directed by local public health agencies and stakeholders
- FPHS workgroup meetings 5/2019 – 1/2020
- Focus groups held in September 2019
- Model adopted December 2019
- Capacity assessment report released June 2021. Key findings included:
 - Communicable disease – area with highest statewide capacity
 - Local funding varies dramatically and level of per capita funding drives capacity
 - Administrator experience/training influence capacity



Ohio's efforts to pursue FPHS implementation have taken place alongside the state mandate for LHD accreditation

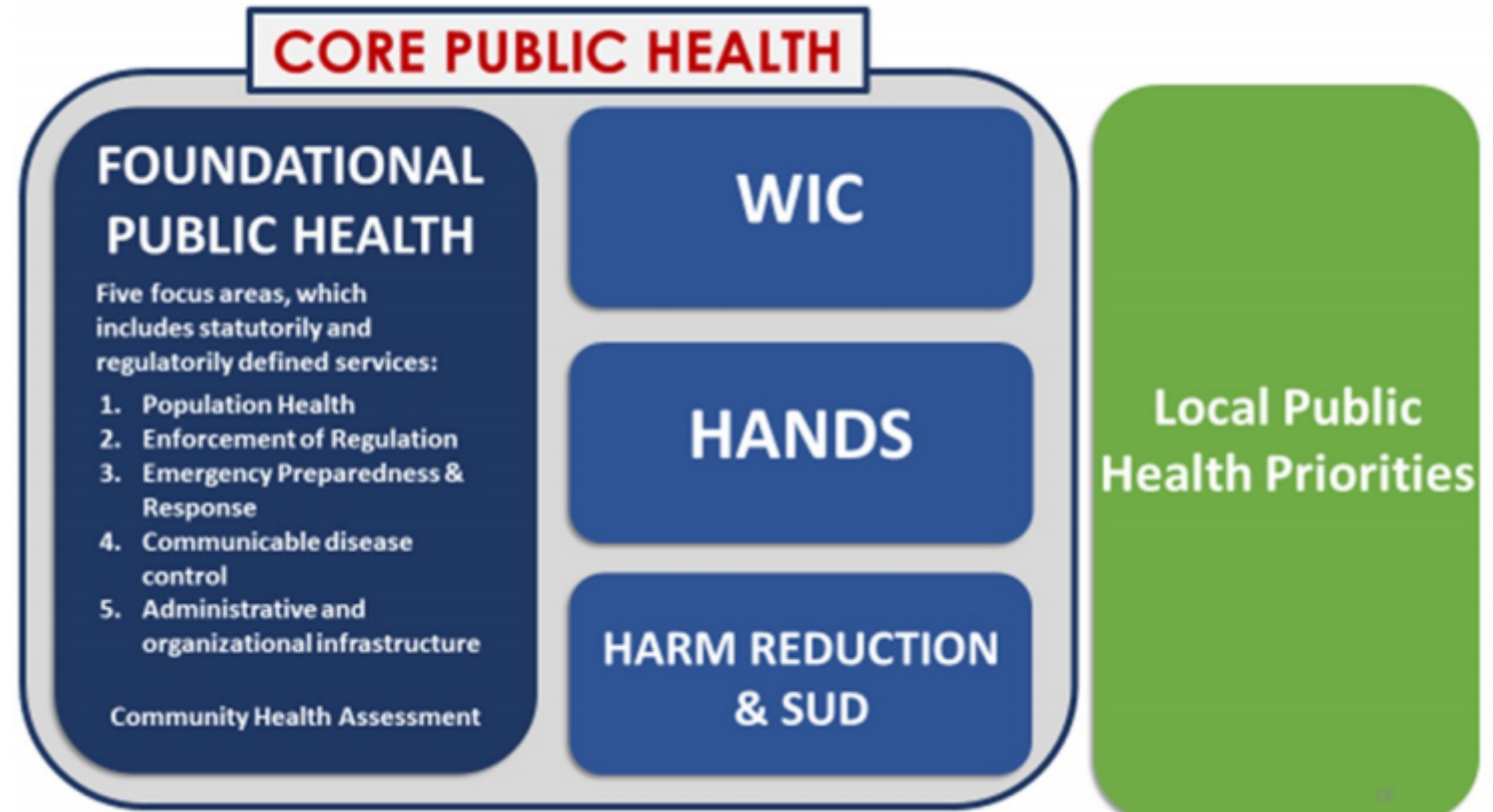
PHNCI 2018 Case Study Finding: "Adoption of FPHS can help to ensure that all Ohioans receive fundamental public health services, and while it is not a direct pathway to accreditation, may help departments in pursuing that goal."



SOURCES: IU RMF School of Public Health, *Indiana Public Health System Review*, December 2020. [PHNCI](#), *Transforming Public Health Systems: Stories for 21st Century States, PART II*, January 2018. Ohio HB 110, June 2021. Meg Shaw, [Ohio House Bill 110 calls for study of small health departments, leading to possible elimination](#), May 2021. PHAB, [Accreditation](#) Activity as of August 24, 2021, August 2021. PHCNI FPHS 21st Century Learning community Case Study: Ohio, [Final Report, June 15, 2018](#).

Kentucky defined FPHS and codified a state FPHS funding formula

- **Foundation Public Health Programs.** Includes (but is not limited to) activities and service programs that prevent and mitigate disease, protect people from injury, promote healthy lifestyles across all environments, promote population health services, enforce Kentucky administrative regulations, ensure emergency preparedness and response, monitor and mitigate communicable disease, and provide the administrative and organizational infrastructure to deliver services.
- **Core Public Health Programs.** FPHS plus WIC, Health Access Nurturing Development Services (HANDS) and SUD harm reduction services
- **Local Public Health Priorities.** Non-core PH programs that are identified through a needs assessment as an agency priority



Kentucky: Examples of non-core local public health priorities

Local Public Health Priorities

Local Public Health Priorities

Accreditation	Adult services
Arthritis	Asthma
Cancer screening	Dental/dental hygiene
Diabetes	Family planning
Home health	Maternity services
Pediatric/Adolescent health	Physical activities
Nutrition	Radiation & product safety
Radon	School health
Stay Well biometric screenings	Tobacco

Local PH priorities must:

- Demonstrate data-driven needs
- Use evidence-based or promising practices
- Identify adequate funding
- Demonstrate performance and quality management plans
- Have a defined strategy to determine when the service or program is no longer needed

Spectrum of sharing arrangements

*Looser
integration*

*Tighter
integration*

As-Needed Assistance

- Information sharing (e.g., infectious disease testing protocols, health ed. messaging)
- Equipment sharing
- Surge capacity (e.g., in a crisis, assisting with food delivery or temporary contact tracing)
- Public benefit program enrollment assistance

Service-Related Arrangements

- Service provision agreements (e.g., to provide immunization services or community grants to implement population health strategies)
- Purchase of staff time (e.g., environmental health specialist)

Shared Programs or Functions

- Joint programs/services (e.g., shared HIV program, shared data platform)
- Joint shared capacity (e.g., epidemiology, communications)
- Group purchasing/ procurement processes
- Joint grant management

Regionalization/ Consolidation

- Merging/ consolidating existing LHDs
- Consolidating health and human services into one agency
- Consolidating public health and behavioral health services into one agency

Washington State: Characteristics and examples of service delivery models

Model Type	Characteristics	Examples
Local solely responsible	<ul style="list-style-type: none"> • Maximizes local knowledge • Quality/standards vary across state • Smaller Local Health Jurisdictions (LHJ) disadvantaged by: staff/ expertise hiring/retention difficulty • Expertise; costly per capita coverage; professional isolation 	On-site sewage system inspections and solid waste enforcement activities – vary depending on prevalence and local codes.
Mutual aid/interlocal agreements/contracting	<ul style="list-style-type: none"> • Responsive to demand • Dependent on personal relationships • Mode of delivery not typically co-planned • Vulnerable to changes in personnel/ elected officials and failure to negotiate mutually agreeable terms • Negotiations expensive/time-consuming 	<p>Clallam contracts Kitsap PH epidemiologists for communicable disease reports and data dashboards.</p> <p>Skamania and Yakima have the same health officer, who is also the deputy health officer in Clark County.</p>

Washington State: Characteristics and examples of service delivery models *(cont.)*

Model Type	Characteristics	Examples
Hub and spoke	<ul style="list-style-type: none"> • Efficiencies of scale in administration and other hub functions • Provides natural venues for standardization and information sharing • Creates relationships between institutions 	State-funded Disease Investigation Specialists are embedded in five LHJ locations in Washington and they serve outlying LHJs in STD response.
Centers of excellence	<ul style="list-style-type: none"> • Similar advantages as hub and spoke, but less formal • Develops capacity that can be responsive to surge demand • Areas may be left out due to informality and as-needed structure 	In the TB Control Demonstration Project, Public Health – Seattle & King County’s expertise in tuberculosis is available statewide through an online consultative program, to help LHJs assess and treat cases.

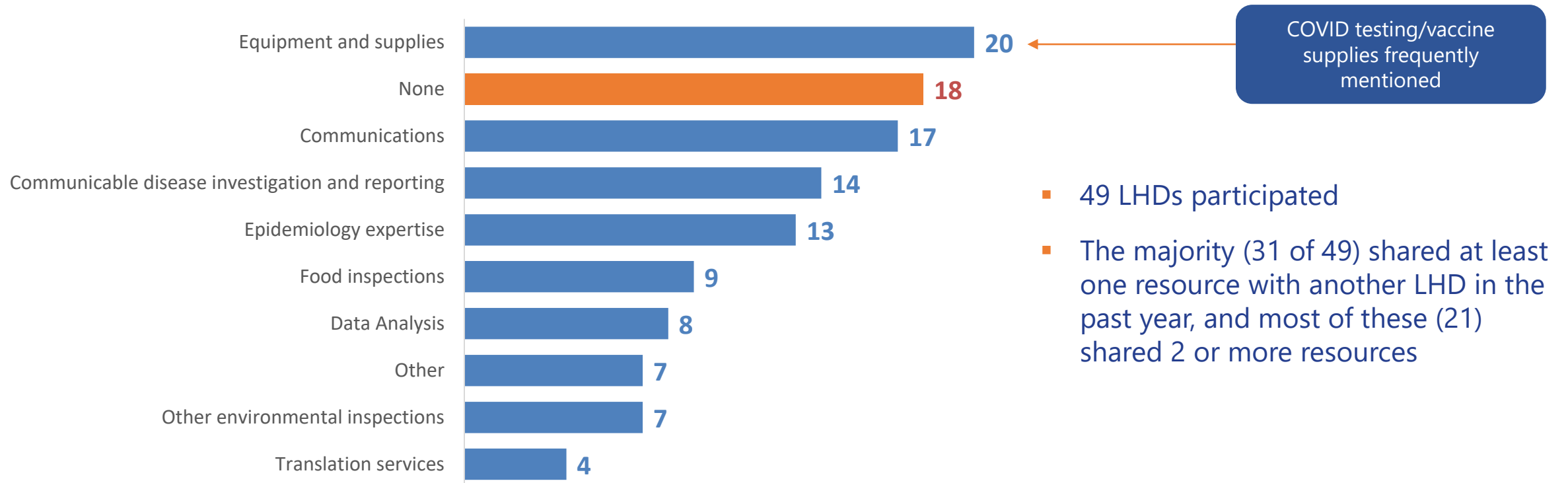
Washington State: Characteristics and examples of service delivery models *(cont.)*

Model Type	Characteristics	Examples
Combination (jurisdictions combine programs)	<ul style="list-style-type: none"> • Pools resources while retaining regional-level local control • Rural areas will face the same hiring and resource issues as full local control • Vulnerable to changes in personnel and elected officials 	Lewis and Thurston counties have combined their Nurse-Family Partnership programs into a joint team to make home visits to low-income, first-time mothers in the combined region.
Centralized	<ul style="list-style-type: none"> • Fewer redundancies • Able to attract and retain specialized personnel • Less aware of and responsive to local need 	DOH centrally manages statewide data systems and surveillance related to public health, including the Behavioral Risk Factor Surveillance System and the Washington Disease Reporting System (former Public Health Information Management System)



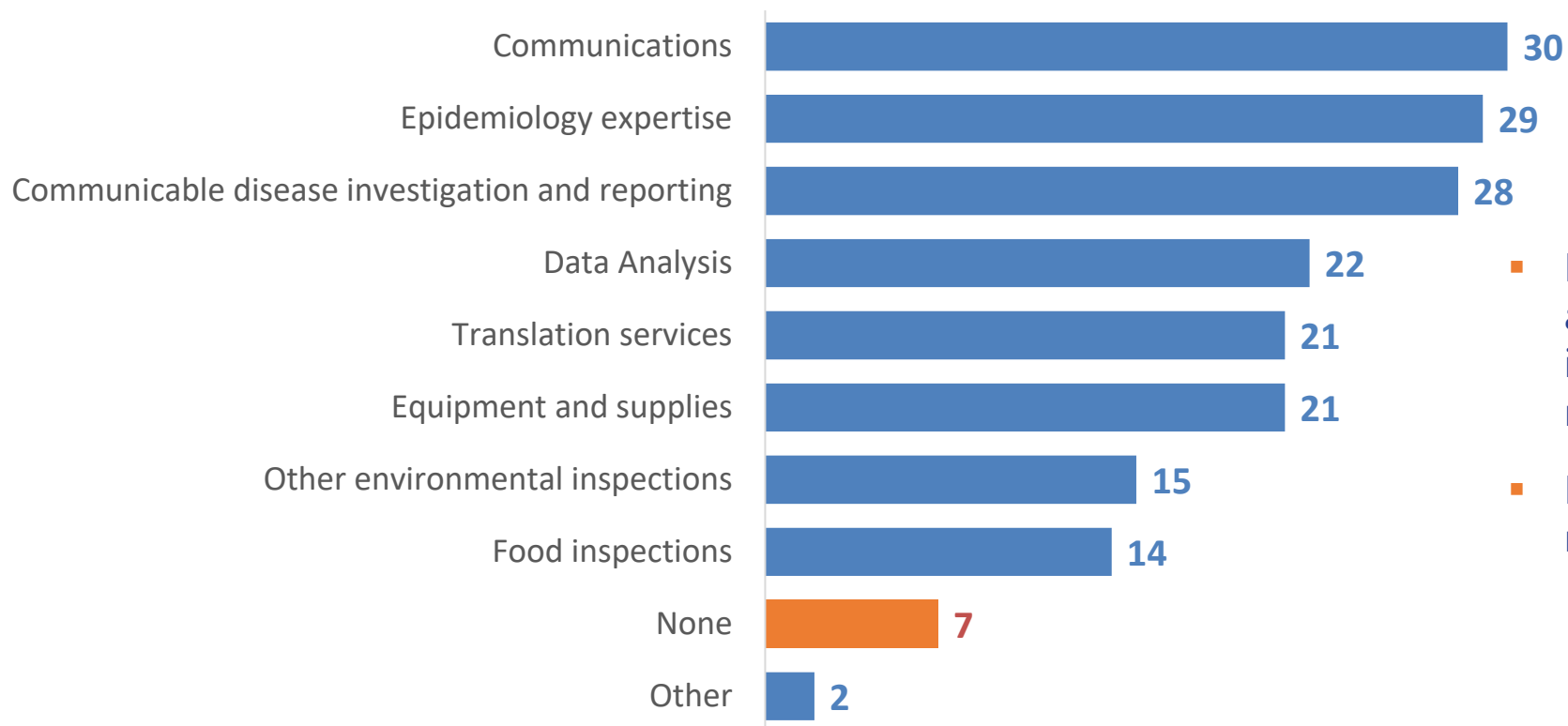
Per IDOH LHD Shared Resources Survey, equipment and supplies were the most commonly shared resource over the past year

Over the past year, has your LHD entered into a formal or informal arrangement to share any of the following public health resources or expertise with one or more LHDs in Indiana. (Check all that apply.)



Communications and public health messaging, epidemiology expertise, and communicable disease investigation are the top three resources LHDs would like to share

Please indicate any public health resources or expertise that your LHD would be most likely to take advantage of if a resource sharing arrangement with one or more LHDs were readily/easily available. (Check all that apply.)



- If sharing agreements were readily available, 42 of 49 responding LHDs indicated that they would share resources with one another
- Half of these (21) would share four or more resources

Almost all of the IDOH resources listed were interesting to a large number of LHDs.

Please indicate if your LHD would consider taking advantage of any of the following services or supports if provided or made easily accessible at the state level by the IDOH. (Check all that apply.)



Governance and Infrastructure Considerations/Questions

Possible considerations for future recommendations:

- **Access:** Ensuring/maintaining public access to an LHD in every county
- **Minimum PH Services:** Ensuring a defined set of core public health services and capabilities are available to every Hoosier, regardless of where they live
- **Feasibility of Resource Sharing:** Understanding that LHDs are resourced differently (e.g., from local and grant funding) and most serve <50,000 population, can service and capability gaps be filled through resource sharing arrangements?
 - If “yes,” what are the opportunities to formalize these arrangements?
- **Accreditation:** What should state policy and supports (e.g., training or other resources) be regarding LHD accreditation?
- **Modernizing Indiana Code:** What if any changes should be made?