STAND FOR HEALTH FREEDOM

Analysis of the Indiana Governor's Public Health Commission Report

Overview

The Proposal Changes Indiana's Decentralized Governance Structure

To begin, it is important to understand the governance of Indiana's public health system. Taken straight from page 31 of the report: "Indiana's public health system, comprised of the Indiana Department of Health (IDOH), and 94 local health departments (LHDs), operates under a decentralized, 'home rule' model, in which local governments retain substantial statutory autonomy to manage public health services and functions, including the structure, financing, size, and activities of LHDs." Please keep this in mind as you evaluate the following pages of this summary as well as the 32 recommendations offered by the Governor's Public Health Commission (GPHC). Many of their recommendations require overhauling this governance model and would instead centralize the public health system in Indiana. Stand for Health Freedom supports the current model where local units of government (local health departments, in this case) retain autonomy to operate as they see fit in their jurisdiction. Local control results in more accountability to voters, more fiscally conservative solutions focused specifically on local needs, and improved outcomes for Hoosiers. Public health needs in Peru, Indiana, for example, are going to be drastically different than public health needs in Indianapolis; our current, decentralized structure best addresses the unique needs of each local health department.

The Recommendations are Inconsistent with Evidence-Based Life Expectancy Gains

The Governor's Public Health Commission Executive Summary begins by introducing the concept of good health and the improvements in life expectancy in the 20th century. Here are a few excerpts:

> "Research shows that the biggest impacts to our health and wellbeing are outside of the physician's office." (Pg 6)
>
> "In fact, most of the life expectancy gains achieved during the 20th century- approximately 25 of 30 additional years- are attributable to public health programs and interventions focused on preventing people from getting sick or injured in the first place and on promoting wellness by encouraging healthy behaviors." (Pg 6)

This point was further made recently by Florida's Surgeon General, Joseph Ladapo:

> "We had two years of hardcore pandemic and to the best of my knowledge, not a single word about exercise, about weight loss, sun exposure. Things that we think, or very clearly know, are important factors in helping you live longer and survive, not just this virus, but other viruses and other conditions.
>
> Talk about a wasted opportunity. I mean, it's absurd that that wasn't a major part of the public health conversation over the last two or two and a half years. It's a real shame, and it's a mistake that we're not making here in Florida...."[1]

However, with the exception of Recommendation 27 in the adolescent and child health section, nowhere within the Commission's report do we find an emphasis on solutions that prioritize the importance of a balanced diet, sunshine, hydration, exercise, and all of the other aspects that contribute

[1] Dr. Mercola, Joseph. "Transcending Fear- Surgeon General of Florida Speaks Out". *Mercola,* 21 August 2022, https://media.mercola.com/ImageServer/Public/2022/August/PDF/transcend-fear-pdf.pdf

to health and wellbeing. In fact, of the Commission's 32 recommendations, only one touches on any of these aspects of a healthy lifestyle and healthy behaviors. Most of what the proposal suggests are clinical in nature. This focus is a departure from the GPHC's cited research.

The executive summary heavily emphasizes that Hoosiers' health and life span are declining. According to page 6 of the report, life expectancy in Indiana has been declining since 2010 when it peaked at 77.5 years. In 2019, Indiana's life expectancy was 77 years. More evidence is needed to determine which specific factors have contributed to earlier deaths in Hoosiers over the last 12 years since the decline began.

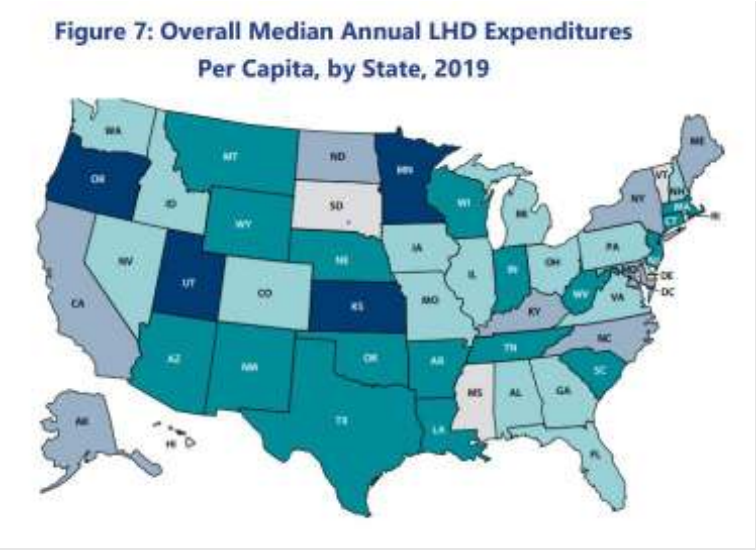
Increased Public Health Funding Is Not the Solution

The report highlights that there is a large disparity between the Indiana county with the highest life expectancy and with the lowest- 9 years' difference. However, the report does not suggest which factors may be causing this disparity. They simply state, "this is clear evidence of the health disparities that exist across our state." **More evidence is needed to determine which specific factors are contributing to the life expectancy disparity between counties so that a more targeted approach can be sought.** On page 15 of the report, the Commission cites reduced life expectancy in the 25–64-year-old age range and points to several causes: substance use disorder, suicide, teen and young adult vaping, consistent tobacco-use and obesity. None of these causes of death are considered public health issues within the current scope of statutorily required public health duties designated under Indiana Code and Indiana Administrative code. Please see a list of Mandatory functions and services on page 8 of this document. Also, we need to be cautious not to throw a pile of money (tax dollars) at these issues and apply one-size-fits-all approaches that do little to provide improve tangible outcomes. The role of public health on these topics should be focused on risk reduction rather than the reactionary approach the GPHC is suggesting. **Primary care providers are in the best position to address individual health concerns with their patients.** If public health agencies wish to increase their role with these issues, they should first be required to demonstrate that their current and previous interventions have resulted in documented positive outcomes. Further, if the 25–64-year-old Hoosiers do not wish to seek care from their doctor, that is within their right to decline treatment. With freedom comes responsibility, and ultimately, both rest heavily on the individual to decide what is best for their health.

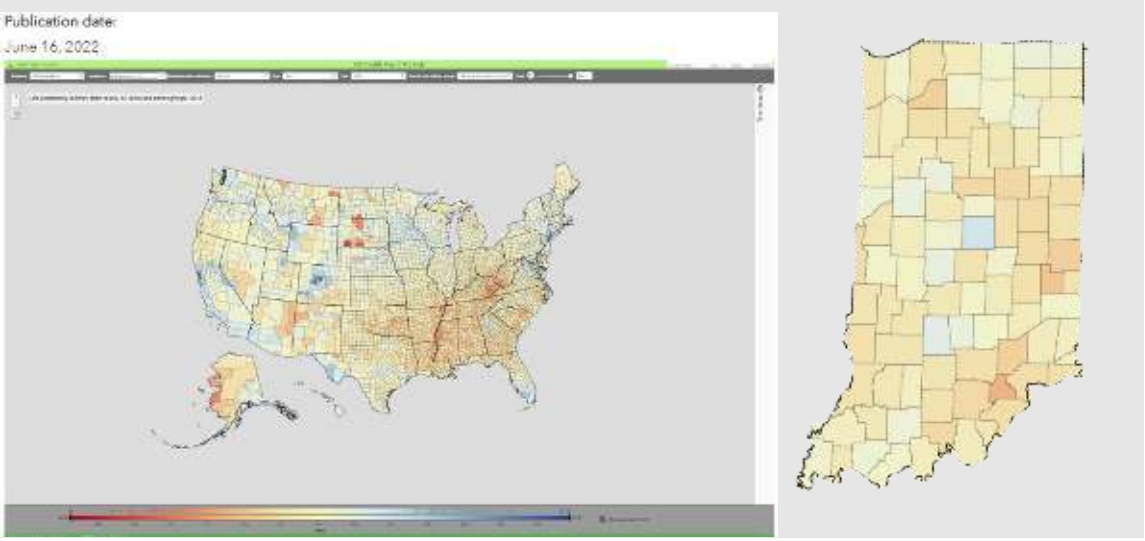
The report highlights "extreme underfunding" of public health throughout the 128 pages. Ironically, instead of listing specific areas that the Commission believes are underfunded and totaling up the additional funds needed for those initiatives, the Commission took the opposite approach. The Commission looked at what Indiana currently spends per capita on public health ($55), compared that to the national average ($91), and determined their goal should be to ask for that exact amount of money and figure out where to spend it after-the-fact. The funding proposal did not come from requests made in earnest to target specific programs. That kind of approach is not in line with Indiana's current budgetary process and does not reflect the fiscally conservative values that our current political landscape prioritizes. As our country battles historically unprecedented inflation, Hoosier lawmakers must reject this blanket public health spending increase in favor of a more targeted and efficient approach to address potential funding gaps on concerns within the scope of public health.

Finally, according to page 46 of the report, while most Indiana LHDs have per capita funding levels below the national average, some LHDs are right at or ***far*** above the national average- Marion County **doubles**

median funding, allocating $82.71 per capita while the national median is $41, according to NACCHO, the National Association of County and City Health Officials. Comparatively, Shelby County has the lowest spending of just $1.25 per capita. Is public health 66x worse in Shelby County compared to Marion County? Where is the evidence that dollar-for-dollar increased public health spending equates to improved public health outcomes?



Map from page 46 of the Commission's report. Indiana is not alone in its lower spending per capita on public health.



Map from healthdata.org showing the healthiest and least healthy areas of the US. Most of Indiana falls in the middle. [2]

[2] "Life Expectancy at Birth; Both Sexes; All Racial and Ethnic Groups, 2019." *The Institute for Health Metrics and Evaluation (IHME)*, Global Health Data Exchange (GHDx), 2019, https://vizhub.healthdata.org/subnational/usa. Accessed 10 Aug. 2022.

Data Surveillance Violates Fundamental Privacy Rights

COVID-19 has had a profound impact on the nature and scope of data collection nationwide, including in Indiana. Is the most recent health crisis enough justification to permanently allow all-encompassing access to Hoosier health data by CDC, IDOH, and other centralized and unaccountable agencies? Within the report, IDOH highlights their plans to centralize our health data, despite Indiana operating under a decentralized governance structure. The use of Health Information Exchanges helps accomplish this centralization and further degrades Hoosiers' privacy. Unfortunately, HIPAA does not protect Hoosiers from these threats as it **only** regulates data sharing between the patient, their healthcare provider, and the insurance company who pays the claim. HIPAA does not regulate data sharing beyond those specific relationships, including any information shared with health departments.[3] The P in HIPAA does not stand for "privacy", as is often mistaken; it stands for "portability".

Finally, the CDC just announced they will be asking Congress to bypass state and local control over health data to enable federal government access to private health information.[4] This request is not limited to public health emergencies. This presents a cybersecurity threat as well as a bioterrorism threat if health data gets into the wrong hands. International agreements, such as the WHO Treaty and other considerations, threaten the safety of the American public. Restricting access to health data to the local level eliminates most avenues of wrongful use of data, as long as additional safeguards are put into place. We must stop the expansion of health data sharing to protect Hoosiers' right to privacy.

Healthcare Does Not Belong in Schools

Stand for Health Freedom's concerns with the School Based Health Center (SBHC) model are many. Below we will list our top 5 concerns and detail them further in the analysis section to justify our concern.

1. **The scope of evaluation, treatment, and reporting impacts are drastically different than the school nurse model.**
2. **Parental involvement is paramount in improving child health outcomes.**
3. **Parental consent is dynamic and pre-consent is insufficient.**
4. **Medical injury/adverse effects could leave schools liable and/or parents vulnerable.**
5. **Schools say they are already stretched too thin- adding medical care to their scope will not help schools or students.**

Further, Stand for Health Freedom believes the current requirements under Indiana Administrative Code (listed in the chart below) need to be eliminated completely. These requirements are invasive to families and burdensome to schools. In addition, Stand for Health Freedom would like a rollback of SBHCs that are already in existence, based on the reasoning above.

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[3] "FAQs About HIPAA Privacy Rule, Provisions Relevant to Public Health Practice." *Centers for Disease Control and Prevention*, National Healthcare Safety Network (NHSN), 27 Jan. 2015, http://www.cdc.gov/nhsn/hipaa/index.html.

[4] Goodman, Brenda. "CDC Announces Sweeping Reorganization, Aimed at Changing the Agency's Culture and Restoring Public Trust." *Clayton News*, 17 Aug. 2022, https://www.news-daily.com/features/health/cdc-announces-sweeping-reorganization-aimed-at-changing-the-agencys-culture-and-restoring-public-trust/article_801f6514-3600-52f1-a664-1f498a61930d.html.

Table 13: Indiana Administrative Code School Health Services Requirements

Prevention	• Creating a safe and healthful school environment through a continuous health program • Employing principles of learning and appropriate teaching in the delivery of health education • Acting as a resource to students, families, staff, and the community regarding health services, health education, and a healthy environment
Assessment	• Maintaining a continuous health program for all students through implementing and monitoring health services • Using the nursing process to collect, interpret, and record information about the health, developmental, and educational status of students to determine a nursing diagnosis and develop healthcare plans
Intervention	• Implementing and monitoring a system for the provision of health services and emergency care • Providing individual and group counseling to students and staff in health-related matters • Communicating with parents and collaborating with others to facilitate the continuity of services and care
Referral	• Utilizing appropriate healthcare personnel and resources to meet individual student needs • Evaluating student and family responses to nursing actions and referrals • Coordinating health services with families, other school programs, in-school professionals, school-based and community-based resources

Governor Holcomb's Directive and the Commission's Workstreams

The GPHC was charged by Governor Holcomb with addressing Indiana's current public health structure, performance of state and local health departments, COVID-19 response, assessing delivery of public health services and funding, health equity, sustainability and emergency response improvements. The report to Governor Holcomb ("Report") and the pieces of the legislative proposal within the report ("Proposal") are the deliverables from the GPHC.

The GPHC worked with Designated Policy Advisors who conducted research, engaged experts and stakeholders, and developed draft recommendations for the Commission's consideration. The result was 6 workstreams:

1. **Emergency Preparedness**- Analyze the State and local health departments' response to the COVID-19 pandemic; make recommendations for future improvements
2. **Public Health Funding**- Review public health funding sources, current levels, and suggestions for standardization
3. **Governance, Infrastructure, and Services**- Review public health governance and infrastructure, public health services delivered through LHDs (local health departments), and shared service models
4. **Workforce**- Consider policies to support public health workforce planning and to identify and address workforce shortages
5. **Data and Information Integration**- Consider policies to improve the use and integration of public health data to better support public health programming and delivery
6. **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

Current Statutory Requirements of LHDs

Below is a list of statutory requirements of LHDs from Indiana Code and Indiana Administrative Code, according to a chart provided on page 36 of the Commission's report. Also included is a list of additional, optional services that LHDs sometimes offer which are not required by law. It is Stand for Health Freedom's position that the current scope should not be expanded and that COVID-19 should not be used to justify granting additional powers or territory to IDOH or LHDs.

Figure 2: Mandatory and Non-Mandatory LHD Functions and Services

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 habitation
- Pest control/vector abatement
- Public and semi-public pool/spa drain cover compliance (*federal reqmt.)*
- Health-related areas during emergencies/ disasters
- Temporary campgrounds
- Collect information on inspection/clean-up of meth-related contamination of property/vehicles
- Inspect/license railroad camp cars
- Refugee care
- Tattoo and body piercing safety and sanitation

Non-mandatory

- STIs, 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

Many Indiana LHDs also choose to provide public health services and functions that are not covered under Indiana laws or regulations, including:

- Women, Infants & Children (WIC) clinics
- Childhood immunizations
- Public nuisance ordinances
- Open burning enforcement
- Lead risk assessments/mold programs
- Massage parlor regulation
- Health promotion and education
- Travel clinics
- Beekeeping
- CPR ordinances
- Patient safety
- Well ordinances

The Commission's Recommendations

Stand for Health Freedom supports the recommendations denoted in **green** and opposes the recommendations denoted in **red**. Stand for Health Freedom takes no position on the remaining recommendations (which can be found in the footnotes), but will follow developments carefully for any new support or opposition.

Governance, Infrastructure, and Services

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 (LHO) 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. A 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

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 2024-2025 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.

Workforce

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

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 the 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 direct-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

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, that 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 (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. 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.

Child and Adolescent Health

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.[5]

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[5]**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 the 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 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.

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 positions 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 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.

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 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).

Stand for Health Freedom's Analysis

Governance, Infrastructure, and Services

Stand for Health Freedom supports the current public health governance model where LHDs retain substantial statutory autonomy to manage public health services and functions, including the structure, financing, size, and activities of LHDs. The GPHC's proposal would change Indiana's governance structure into a centralized model with IDOH at the center. We know that local control gives citizens a bigger voice in the discussion and allows for accountability at the polls. Indiana's decentralized governance model also lends credibility to LHDs and allows them to become a trusted source for health information. Local control also allows for faster, more customized responses to public health issues compared to centralized models where LHDs must suffer additional red-tape before being able to act.

Stand for Health Freedom is concerned that pages 37-38 infer that a lower uptake of services offered in smaller, rural areas are the result of lack of access to these services. Instead, let's consider that there is simply a difference in priorities among smaller, rural areas compared to larger cities. These differences may be politically motivated, related to lifestyle factors, religious beliefs, or simply personal preference. There is no evidence showing that the lower uptake is due to lack of access. In fact, based on comments from LHDs, sought during the Commission's research, the specific services not being accessed at these smaller, more rural LHDs are: tattoo and body piercing safety and sanitation, sexually transmitted diseases, HIV (testing, treatment, etc.), and syringe service programs. At no point in their report does the Commission offer consideration that these services are not valued or prioritized by the community that those LHDs serve. These may not be "gaps in services" after all. This highlights the importance of LHDs retaining autonomy and not allowing their control to be turned over to a more centralized public health system. Some counties may choose to invest more heavily in certain areas of public health than others, and a one-size-fits-all approach will likely result in poorer outcomes at the local level.

The same logic can be applied to data collection. Some LHDs may want to amass googolplexes of data to analyze and drill down on what makes the Hoosiers in their jurisdiction tick, but many others may not want to engage in this type of data collection and analysis. The IDOH and its affiliates should not be allowed to access data from local jurisdictions, especially if the LHDs do not want to participate. Even if the LHDs want to participate, we have to consider an even more local level - the family unit. Local control over private health data is paramount for Hoosier privacy and decision-making. We must retain the right to say no to the collection, storage, access, and sale of our personal health information.

In Indiana, only IDOH and three county health departments (in Montgomery, Rush, and Vanderburgh counties) are accredited by the Public Health Accreditation Board (PHAB). According to page 40 of the Commission's report (emphasis mine):

> "PHAB accreditation measures health department performance against a set of nationally recognized, practice-focused, and evidence-based standards. An external evaluation of accredited health departments found that a majority **believe** that accreditation:
>
> - Stimulated quality and performance improvement opportunities
> - Improved capacity to provide high quality programs and services

- Helped health departments use **equity** as a lens for identifying and addressing health priorities

Similarly, officials from the three accredited LHDs in Indiana reported that becoming accredited: increased their credibility; enhanced accountability; **made data-driven decisions part of the culture**; facilitated goal setting; strengthened community partnerships; and built staff confidence."

The justification for this accreditation is based on ***beliefs*** about what accreditation can do, not evidence of what it does do. In addition, accreditation weakens political values that Hoosiers have continually prioritized, such as privacy and local control. The forced "equity lens" is today's political buzzword and another example of political platforms percolating into public health, as it so often does.

Public Health Funding

At the state-level, "IDOH is primarily funded through federal grants (76%) and from the state's Tobacco Master Settlement Fund (12%), with State General Funds comprising only 3% of the FY 2022 budget," according to page 47 of the report. Page 48 says that about 30% of the IDOH funds for FY 2022 budget come from non-recurring COVID-19 supplemental funding that has expired along with the end of the pandemic. "Prior to the pandemic, the funding split was approximately 68% federal funds."

According to page 48 of the report, "about half of the IDOH funding [from CDC] is passed through or sub-granted to LHDs, WIC providers, health clinics, and other entities." If LHDs are the agencies actually providing the service, why are they only receiving half of the funds appropriated to provide those services? What is IDOH doing with the other 50% of those siloed grants? More transparency is needed, especially before the General Assembly considers appropriating an *additional* $242.6 million per year to IDOH. During the August 4, 2022 GPHC press briefing, Commission co-chair Luke Kenley, along with nods from Indiana Health Commissioner Dr. Box, stated that they do not know how much of the additional requested appropriations would be allocated to LHDs.[6]

A reporter from the Indiana Business Journal asked the question "How much of the additional $242.6 million per year would go to the local health departments and where else would it go at the state level?" After shifting uncomfortably in his chair, Senator Kenley replied:

> "Well, what we have laid out is a system of government and service delivery that really changes the dynamic. For example, we currently do not have any regional systems, personnel, to go out to the county health department and help them. So, some of the money is obviously going to have to be spent to develop that system, and some of the money would be spent right at the local health department. The whole objective of the thing is to provide a delivery system with the local health department as the retail store. If you look at it like a private business, you have your headquarters, your warehouse, and then you have your retailer out there. And so, we think the money is ALL in support of the retailer. And at this point in time, it would be hard to say how

[6] "Governor's Public Health Commission News Briefing 8.4.22." *YouTube*, 4 Aug. 2022, https://youtu.be/mqu41XlXX1U. Accessed 4 Aug. 2022.

much will end up at the local health department. But I can say this much, 100% of the money is designed to deliver the system from the local health departments."

So, if we go back to the Commission's report which states that only half of CDC funding is passed from IDOH through to LHDs, that means IDOH is keeping roughly $63 million per year of CDC grants already. And, if the General Assembly honors the Commission's request and appropriates another $242.6 million per year to IDOH, they may end up keeping an additional $121.3 million.

Further, Recommendation 6 from the Report would require all public health services be provided at the county level, and Recommendation 9 would condition receipt of funding to those counties on their vote to opt-in to some yet-to-be-disclosed program IDOH wants to run that would require compliance with the program's requirements, a 20% cost-sharing "co-pay", and a 5-year commitment from the county to participate in the program. This completely changes the governance structure of Indiana's decentralized public health system and truly gives IDOH the power to control all of Indiana's public health goals, initiatives, funding, delivery, and every individual citizen's health data. This health data would then, per Recommendation 17, be statutorily shared with a Health Information Exchange (HIE) partner, increasing the chances for data breeches and sales of Hoosiers' health data.[7] Since Big Data is now the largest for-profit industry and biggest threat to democracy, this is concerning. The Regenstrief Institute, as the world's largest data distributor, is one of the largest buyers and sellers of health data and happens to be headquartered right here in Indianapolis, sharing a building with the Marion County Health Department.

Going back to IDOH funding, page 49 of the report states, "one source of flexible funding within the IDOH budget is the annual distributions to LHDs from the *Local Health Maintenance (LHM) Fund* established by IC 16-46-10. LHM Fund allocations are highly valued by LHDs, as they represent a stable, recurring, and flexible funding source that can be used for a variety of purposes." However, the Commission plans to condition receipt of LHM Funds on whether or not the county opts-in to the program introduced in Recommendation 9. The Commission fully understands that LHDs will be forced to opt-in to the program or risk funding gaps to fulfill their statutorily-mandated duties. And yet, the GPHC maintains that program participation is not mandatory. Please see Stand for Health Freedom's video review[8] of the Commission's June 30th meeting for video clips of the comments made by the GPHC about how "brutal" it would be for counties who choose not to opt-in.

Finally, from page 66 of the report, "public health data encompasses a wide range of data sources, including health system data and disease incidence, population behavior data (e.g., smoking status, exercise patterns, diet, etc.), and environmental data (e.g., lead, drinking water pollution, restaurant safety, and septic system compliance)." But, if we look back on page 16, the table shows Indiana's stature in the ranking of "Best States" based on various metrics. It's interesting that Indiana's lowest ranking metric is "Natural Environment" which is defined below the table as being measured by air and water quality and pollution. Indiana is ranked 48th. Since environmental data is listed as an area encompassed by public health data, why is IDOH not prioritizing funding for this problem ahead of the others? Does air and water pollution not have a bigger effect on the health of **every** Hoosier than any of

[7] "U.S. Department of Health and Human Services Office for Civil ... - Hhs.gov." *U.S. Department of Health and Human Services, Office for Civil Rights*, 18 Dec. 2020, https://www.hhs.gov/sites/default/files/hie-faqs.pdf.

[8] "Indiana Governor's Public Health Commission." *Stand for Health Freedom*, 12 July 2022, https://standforhealthfreedom.com/uncategorized/indiana-governors-public-health-commission/.

the other recommendations offered by the Commission? Also, focusing on air and water pollution better aligns with the non-clinical gains to life expectancy mentioned earlier. Unfortunately, the Recommendations focus on stakeholder politics and priorities rather than on improving actual markers of health and wellbeing, such as clean air, safe water, exercise, and a balanced diet.

Table 1: 2021 US News and World Report "Best States" Rankings

Other Quality of Life Metrics	IN State Ranking	Public Health Metrics	IN State Ranking
Affordability[a]	6	Mental Health	35
Opportunity[b]	7	Infant Mortality	38
Pre-K through Grade 12 Education	9	Early Adult Mortality	41
Growth[c]	19	Obesity	40
Public Safety	25	Smoking	41
Natural Environment[d]	48	Suicide	13
Indiana's Overall State Ranking:	**32**	**Indiana's Overall Public Health Ranking:**	**40**

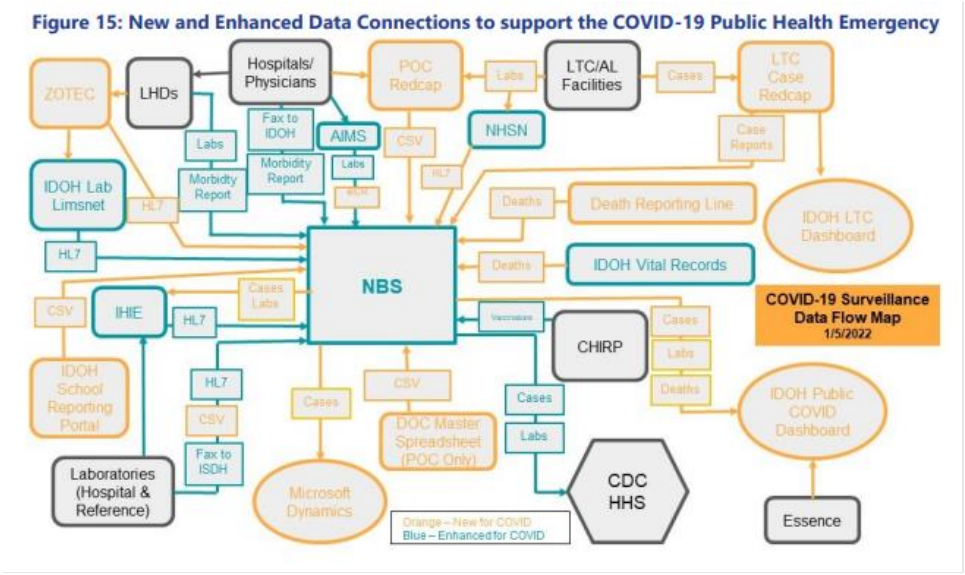
[a] Measures cost of living and housing affordability.
[b] Measures poverty, housing affordability, and equality for women, minorities, and people with disabilities.
[c] Measures growth of the young population, growth through migration, and the GDP growth rate.
[d] Measures air and water quality and pollution.

Workforce

While Stand for Health Freedom applauds the Commission's desire to increase public health wage ranges to better align with the private sector, and to consider incentives for workforce recruitment and retention, we cannot support the suggestion to centralize licensure functions within IDOH for all healthcare professionals. Currently, healthcare professionals are licensed through the Indiana Professional Licensing Agency (PLA) which allows for balanced, unbiased licensing guidelines. If licensing for healthcare professionals were brought under IDOH's governance, Stand for Health Freedom has grave concerns that IDOH will impose additional, undue burdens on healthcare professionals based on IDOH preference and policies, rather than on skills and ability requirements that currently exist. For example, we see this as an opportunity for IDOH to add vaccination requirements as a condition of licensure rather than allowing hospitals, physician offices, and other employers to make this decision. Vaccination status does not currently affect qualification for licensure, yet under IDOH we have serious concerns this would change. In addition, as already seen through Recommendation 20 of the Commission's proposal, IDOH would like to condition hospital licensure on participation with various IDOH sponsored services, like the EMResource tool. This demonstrates an overreach of power by IDOH that will only get worse if they have the ability to condition licensure of all healthcare professionals on whichever policies and partnerships they currently support. Keeping licensure with PLA ensures separation of powers and prevents potential abuse of those powers if licensing was centralized like the Commission and IDOH suggest in Recommendation 15 of the proposal.

Data and Information Integration

COVID-19 has had a profound impact on the nature and scope of data collection nationwide, including in Indiana. According to page 68 of the Commission's report, "a formal entity charged with the advancement of health and public health data and investment, oversight of health data governance and data privacy, and security could build on the progress made during the COVID-19 public health emergency in enhancing data connections and reducing manual reporting." This highlights the expanded reach of IDOH due to COVID-19 compared to the way they accessed and used health data for decades prior to COVID-19. Have the last two and a half years truly been enough justification to permanently allow this all-encompassing access by IDOH to every aspect of every Hoosiers' health data? In fact, the heading of this section of the report is titled, "Indiana Can Build on COVID-19 Response Enhancements". IDOH is capitalizing on COVID-19 to stretch their powers to a more centralized governance structure. A flow chart on page 68 of the report is color-coded to show all of the expanded and newly-created data connections COVID-19 granted IDOH. Compare their reach now compared to their reach without all of the orange and blue connections, as they were functioning prior to COVID-19.



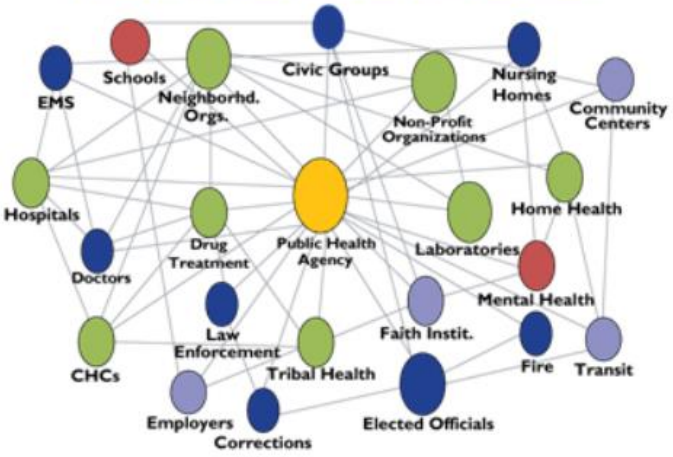
From page 71 of the report, "IDOH began a digital transformation project of its existing public health systems in 2020. In the current state, IDOH operates 105 systems, 54 of which contain critical health data. The systems are siloed, and no enterprise public health system supports data collection and analysis across all IDOH programs. The goals of the digital transformation project are to develop a data and technology roadmap, establish technology and data governance, create a centralized data and analytics platform, and improve data access." In black and white, IDOH lets us know their plans are underway to centralize our health data, despite Indiana functioning under a decentralized governance structure. This model comes from CDC guidance and objectives to centralize all state data into one national data system. More on that below.

The heading on page 68 of the report reads, "Greater State Coordination with Health Information Exchanges Would Promote Data Integration Goals". That section goes on to state: "One of the key stakeholders in the Indiana health and public health data system is the Indiana Health Information Exchange (IHIE). IHIE is a private not-for-profit entity that aggregates health data and facilitates health

system connections between enrolled providers, state agencies, and insurance companies." In the Commission's report under Recommendation 17, the Commission asks to formalize and strengthen existing relationships with HIEs and codify those relationships. IDOH would pay a fee to IHIE, using taxpayer dollars, to store Hoosier health data on IHIE's private servers, allowing IHIE access to sell Hoosier health data that Hoosiers never consented to be shared in the first place.[9] Health data is extremely sensitive data and yet there are major gaps in privacy protections for this data.

The report includes a graphic on page 66 titled "Public Health System- Data Owners and Utilizers" showing a web of data sharing between private entities and public health agencies. Some examples of data owners and utilizers who share with public health agencies include the expected (e.g., hospitals, doctors, EMS, nursing homes, laboratories, law enforcement, etc.) but also include the unexpected (e.g., neighborhood organizations, faith institutions, non-profit organizations, employers, community centers, and others).

Figure 14: Public Health System- Data Owners and Utilizers[63]



This highlights a major concern of Stand for Health Freedom: there are zero data privacy protection laws that protect health data from being shared outside health departments. Many legislators and most of the general public believe that HIPAA protects the sharing of sensitive health data, but that is not entirely correct. HIPAA imposes restrictions on health providers, payors, and clearinghouses that process health data. HIPAA does **not** prohibit data sharing beyond those specific relationships, including any information shared with health departments. In fact, HIPAA facilitates that data transfer by allowing it without specific informed consent from patients. Further, public health data is specifically excluded from data privacy laws in other states and from a federal bill moving through Congress now (the American Data Privacy and Protection Act or ADPPA). For some reason, it is not well-known that health departments have access to nearly all health data that exists and is under zero regulations for how that data should be stored, accessed, shared, or sold.

[9] "FAQs About HIPAA Privacy Rule, Provisions Relevant to Public Health Practice." *Centers for Disease Control and Prevention*, National Healthcare Safety Network (NHSN), 27 Jan. 2015, http://www.cdc.gov/nhsn/hipaa/index.html.

One major aspect relating to healthcare data that the GPHC fails to address is that errors in electronic health records (EHRs) are common.[10][11] "At least half of EHRs may contain an error, many related to medications. Overburdened practitioners may import inaccurate medication lists, propogate other erroneous information electronically by copying and pasting older parts of the record, or enter erroneous examination findings." [12] Currently, patients have no recourse to correct errors in their EHR and this has deadly consequences; the third leading cause of death in the US is a result of medical errors.[13] Unfortunately, most patients have no idea whether their records contain errors because the patient is left completely out of the EHR process. Patients should have the ability to access their EHR, make corrections, and grant and revoke consent instantly. If providers have this capability, patients should, also. Prior to the advent of EHRs, patients were responsible for sharing access to their medical records. At some point along the way, the patient was excluded from the process and now suffers increased risk of injury and death, as a result. Restoring patient access and ownership over medical records would be a simple way to reduce the third leading cause of death in this country while also empowering patients and providers to work together to find meaningful healthcare solutions.

Zooming out a bit, page 66 reads, "National efforts are underway to improve the interoperability and utility of data and systems that promote public health and specific actions can be taken at a state level to support the unique public health data and system needs in Indiana." Also, page 71 reads, "Efforts to

[10] "KFF Health Tracking Poll - January 2019." *Henry J. Kaiser Family Foundation*, Jan. 2019, https://files.kff.org/attachment/Topline-KFF-Health-Tracking-Poll-January-2019.

[11] "Patient Safety and Health Information Technology: Learning from Our Mistakes." *Patient Safety Network*, Agency for Healthcare Research and Quality, 1 July 2012, https://psnet.ahrq.gov/perspective/patient-safety-and-health-information-technology-learning-our-mistakes.

[12] Dr. Bell, Sigall K. "Patient-Reported Errors in Electronic Health Record Ambulatory Care Notes." *JAMA Network Open*, JAMA Network, 9 June 2020, https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2766834#:~:text=At%20least%20half%20of%20EHRs,error%2C%20many%20related%20to%20medications.&text=Overburdened%20practitioners%20may%20import%20inaccurate,or%20enter%20erroneous%20examination%20findings.

[13] Anderson, James G, and Kathleen Abrahamson. "Your Health Care May Kill You: Medical Errors." *Studies in Health Technology and Informatics*, U.S. National Library of Medicine, 2017, https://pubmed.ncbi.nlm.nih.gov/28186008/#:~:text=Recent%20studies%20of%20medical%20errors,third%20leading%20cause%20of%20death.

modernize public health systems and data policies are underway at the national and state level." We know the CDC is looking to expand federal access to all health data for every American because Director Rochelle Walensky announced this on August 17, 2022.[14] The plan is to ask Congress to expand the CDC's current data access powers rather than continue with the current system which gives authority to states and local jurisdictions to decide if, when, and what data they choose to share with the CDC. If all American data is collected and stored by the federal government, Stand for Health Freedom is concerned about where that data will be shared beyond our own country's borders, as well as the cybersecurity risk that a single database of all health data for every American presents. If the US considers signing the WHO Treaty or any other version of a similar agreement, that could compromise the health and safety of every American, especially considering which other world powers are able to access our data.

Combine that with bipartisan concerns raised by Congressmen from the House Intelligence Committee attending the July 2022 meeting of the Aspen Security Forum regarding the emerging threat of health-targeted attacks by foreign enemies.[15] Our health data, in the wrong hands, could further the bioterrorism goals of those who wish to hurt us. Stand for Health Freedom efforts are underway to oppose any Congressional approval of mandatory data sharing with the CDC, but more can be done at the state and local level to ensure our safety and security. Currently, LHDs have the authority not to share public health data with the state or beyond and it is **critical** that remains the case. LHDs can use the data collected during the course of providing service in their own departments to influence what information they share with IDOH and under which circumstances. Data collection may be a fact of life at this point but that doesn't mean it's a free-for-all. The more local we keep that data collection and sharing, the safer it is for all Hoosiers.

Stand for Health Freedom would like to see new laws improving Hoosier health data privacy including restricting the data that can be shared with IDOH. We believe keeping health data at the local level improves the safety and security of every Hoosier. Public health services are delivered at the local level and Hoosier health data should stay at the local level. Hoosier privacy must be prioritized to protect individual freedom and democracy.

Emergency Preparedness

One important aspect of the Commission's proposal touches on vitally important funding gaps for EMS services. As the Commission reports on page 78, "Traumatic injury is the leading cause of death for individuals between the ages of 1-44 years in the United States. Traumatic injury results in more years of potential life lost than any other disease process, including cancer and heart disease. Injury is America's most expensive disease process, costing nearly $180 million per year. In Indiana, the leading causes of death for individuals aged 1-44 are preventable injuries."

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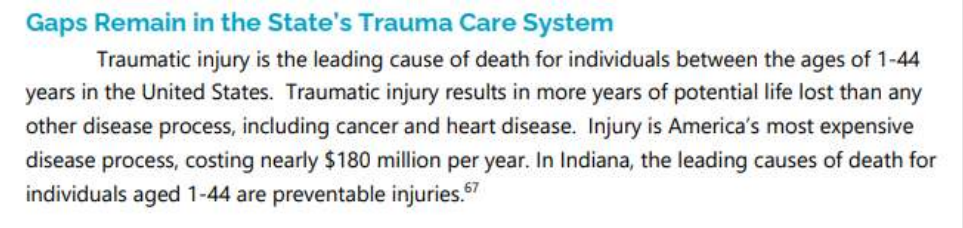
[14] Goodman, Brenda. "CDC Announces Sweeping Reorganization, Aimed at Changing the Agency's Culture and Restoring Public Trust." *Clayton News*, 17 Aug. 2022, https://www.news-daily.com/features/health/cdc-announces-sweeping-reorganization-aimed-at-changing-the-agencys-culture-and-restoring-public-trust/article_801f6514-3600-52f1-a664-1f498a61930d.html.

[15] Reyes, Ronny. "House Intelligence Committee Speaks about New DNA Bio-Weapons That Can Target a Single Person." *Daily Mail Online*, Associated Newspapers, 27 July 2022, https://www.dailymail.co.uk/news/article-11042835/House-intelligence-committee-speaks-new-DNA-bio-weapons-target-single-person.html.



Gaps Remain in the State's Trauma Care System

Traumatic injury is the leading cause of death for individuals between the ages of 1-44 years in the United States. Traumatic injury results in more years of potential life lost than any other disease process, including cancer and heart disease. Injury is America's most expensive disease process, costing nearly $180 million per year. In Indiana, the leading causes of death for individuals aged 1-44 are preventable injuries.[67]

The Commission's report highlights several areas for improvement and Stand for Health Freedom agrees that additional EMS funding and an increase in Level III trauma centers are important for improving life and health outcomes for Hoosiers. We rise in support of these initiatives.

However, Stand for Health Freedom has data privacy concerns surrounding the use of EMResource, which according to page 77 of the report is "a web-basesd tool that provides cross-sector communication during a disaster or disease outbreak." On the surface, it appears EMResource does not share individual health data, just data such as bed availability and diversion status at each hospital. If EMResource tool were expanded to include individual health data, Stand for Health Freedom would oppose. We do unequivocally oppose the requirement of hospitals to opt-in to this program as a condition of licensure, as Recommendation 20 suggests, because we see this as an overreach of power.

Child and Adolescent Health

There has been a shift in culture over the years to increase the role of schools in the child-rearing process. School administrators, teachers and teachers' unions, and others have developed a vernacular surrounding the ownership of our children that suggests we all share in their upbringing, with schools being the primary educator on health. However, this trend is troubling when those school personnel believe they have the **authority** to be included in parent decision-making. Parents are the sole authority for their children and while most parents elect to send their children to school, outsourcing the education of their children does not equate to outsourcing the health decision-making for their children.

An emerging trend has been for healthcare screenings and services to occur within the schools. A few current Indiana laws already grant some powers for schools to screen children for hearing and vision impairments; something Stand for Health Freedom would like to change. The commission is recommending that schools consider offering oral healthcare services now, too (recommendations 28 and 30). It is our strong belief that healthcare services should be administered in healthcare settings and that there is no place for healthcare services in schools.

Unfortunately, the GPHC, along with IDOH, are seeking to expand the scope of healthcare even more in schools. One way of accomplishing this is through School-Based Health Centers (SBHCs). According to the chart on page 90 of the report, a SBHC is a "health clinic located in or near school and organized through school, community, and health provider relationships." Pages 90 and 91 also include an overview of school health service delivery models under the traditional school nurse approach vs the use of SBHCs.

Table 14: Overview of School Health Service Delivery Model [78,79]

	School Nurses	SBHCs
Overview	Leads the school health services team to address barriers to student health and academic success. Serves as public health sentinel within and across school populations and is an advisory resource to teachers and staff.	Health clinic located in or near school and organized through school, community, and health provider relationships. Can serve the school population and surrounding community.
Funding	Employed or contracted by the school district and primarily funded with education dollars	Insurance reimbursement, foundations, healthcare systems, and community health center funding
Potential Available Services	• Identifying and addressing behavioral health issues • Leveling the field on health disparities and promoting healthy behaviors • Enrolling children in health insurance and connecting families to healthcare providers • Handling medical emergencies	• Primary care • Prevention and early intervention • Behavioral health counseling • Oral health services • Health education and nutrition counseling • Lab work and prescriptions
Location	Practice within the school; currently in Indiana, RN may be shared across schools within a district	Traditional: Fixed site on a school campus School-Linked: Fixed site near a school campus through formal or informal linkages with schools Mobile: Specially equipped van or bus parked on or near a school campus Telehealth-Exclusive: Patients access care at a fixed site on a school campus and providers are available remotely using telehealth
Parental Consent	Required to share information with a healthcare provider or for referral to a provider	Parental consent for treatment required
Medical Home Coordination	School nurse technology platforms exist but are not currently being utilized broadly across the state	May be facilitated via electronic health record, providing potential for broader health record access and coordination

Indiana had 48 SBHCs (including 3 telehealth-exclusive) as of a 2016-2017 national survey. An additional 38 telehealth SBHCs were launched by the IRSCN, and five more are in process.

Stand for Health Freedom's concerns with the SBHC model are many. Below we will list our top 5 concerns and then detail them further.

6. **The scope of evaluation, treatment, and reporting impacts are drastically different than the school nurse model.**
7. **Parental involvement is paramount in improving child health outcomes.**
8. **Parental consent is dynamic and pre-consent is insufficient in most situations.**
9. **Medical injury/adverse effects could leave schools liable and/or parents vulnerable.**
10. **Schools say they are already stretched too thin- adding medical care to their scope will not help schools or students.**

First, the scope of evaluation, treatment, and reporting impacts are drastically different. With a school nurse, the child first seeks care due to a sudden, acute ailment, the school nurse provides acute evaluation and offers pre-approved or real-time approved acute remedies, and typically the student is promptly sent back to class or sent home with a parent. Under the school nurse model, parents sign off at the beginning of the year for the interventions they pre-approve, such as Band-Aid and ice pack dispensing, over-the-counter medication dispensing such as Ibuprofen or Benadryl, and there is very little reporting impact to both parents and the school nurse (typically limited to a note in the child's file). However, under the SBHC model, healthcare services are proactive in nature; function as a source of primary care for the child; focus on prevention and early intervention, behavioral counseling, oral health services, health education and nutrition counseling, and even so far as lab work and prescription orders. The scope of care is *far* greater and drastically different from the traditional model of school nurses.

Second, parental involvement is paramount in improving child health outcomes.[16][17][18][19] According to data from youth.gov, research has shown that "meaningful family engagement positively impacts youth outcomes across various domains." Specifically, "family engagement with health care professionals improves care coordination and health outcomes at the individual, youth, and family level."[20] Removing parents from the equation reduces the chance that the child will have positive health outcomes, which is not in the best interest of the child, regardless of the convenience factor for healthcare providers and parents. Other insightful quotes from the cited research:

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[16] JM. "Benefits of Family Involvement in Patient Care." *Nursing Resource Center*, NRSNG, 3 Feb. 2022, https://nrsng.org/benefits-of-family-involvement-in-patient-care/.

[17] "Engaging Patients and Families in Their Health Care." *Agency for Healthcare Research and Quality*, July 2022, https://www.ahrq.gov/patient-safety/patients-families/index.html.

[18] "How Patient and Family Engagement Benefits Your Hospital." *Agency for Healthcare Research and Quality*, https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/howtogetstarted/How_PFE_Benefits_Hosp_508.pdf.

[19] Taylor, Sara E, et al. "Systematic Review of Father Involvement and Child Outcomes in Pediatric Chronic Illness Populations." *Journal of Clinical Psychology in Medical Settings*, U.S. National Library of Medicine, 27 Mar. 2020, https://pubmed.ncbi.nlm.nih.gov/31077009/.

[20] "Impact of Family Engagement." *Impact of Family Engagement | Youth.gov*, https://youth.gov/youth-topics/impact-family-engagement.

- Children and youth served by mental health system of care providers show increases in emotional and behavioral strengths and improved relationships with peers and adults when families are engaged.
- When child welfare staff involves families in the decision-making process and in developing the plans that affect them and their children, they are more invested in the plans and committed to achieving objectives and complying with treatment.
- Involving families in strength-based decision-making processes and modeling appropriate problem-solving approaches increases families' comfort with communicating their own problem-solving strategies and exploring new strategies that may benefit themselves and their children.
- Working collaboratively increases the likelihood of identifying a family's unique needs and developing relevant and culturally-appropriate service plans that address needs, build on family strengths, draw from community supports, and use resources more effectively.

Third, parental consent is dynamic. A parent may believe they will consent to an evaluation or procedure only to change their mind once it is further explained by the physician. Also, initial findings made during the appointment may change the decision and therefore consent, if a parent were present. Removing parents from the medical process removes clear and informed consent, a foundation for medical ethics and treatment. Informed consent is so important that it has special legal considerations.

> "Informed consent to medical treatment is fundamental in both ethics and law. Patients have the right to receive information and ask questions about recommended treatments so that they can make well-considered decisions about care. Successful communication in the patient-physician relationship fosters trust and supports shared decision making. The process of informed consent occurs when communication between a patient and physician results in the patient's authorization or agreement to undergo a specific medical intervention. In seeking a patient's informed consent (or the consent of the patient's surrogate if the patient lacks decision-making capacity or declines to participate in making decisions), physicians should:
>
> > (a) Assess the patient's ability to understand relevant medical information and the implications of treatment alternatives and to make an independent, voluntary decision.
> >
> > (b) Present relevant information accurately and sensitively, in keeping with the patient's preferences for receiving medical information. The physician should include information about:
> >
> > > (i) the diagnosis (when known);
> > >
> > > (ii) the nature and purpose of recommended interventions;
> > >
> > > (iii) the burdens, risks, and expected benefits of all options, including forgoing treatment.
> >
> > (c) Document the informed consent conversation and the patient's (or surrogate's) decision in the medical record in some manner. When the patient/surrogate has provided specific written consent, the consent form should be included in the record.

> In emergencies, when a decision must be made urgently, the patient is not able to participate in decision making, and the patient's surrogate is not available, physicians may initiate treatment without prior informed consent. In such situations, the physician should inform the patient/surrogate at the earliest opportunity and obtain consent for ongoing treatment in keeping with these guidelines."

AMA Principles of Medical Ethics: I,II,V,VIII[21]

Medical injury in a SBHCs could leave schools liable and/or parents vulnerable.[22] What happens if during the course of a SBHC service, the child suffers a medical injury or adverse reaction? What authority is present to monitor for medical malpractice if the only legal witness is the provider themself? Who will pay for the child's ongoing treatment, if needed, in the event of an adverse event? If not the doctor or the school, why is the parent stuck footing the bill when they were not even present to give real-time consent? None of these examples results in improved outcomes for the child and creates confusion over liability in the event the worst happens. This confusion further proves that healthcare does not belong in schools.

Fifth, schools say they are already stretched too thin and outcomes prove it.[23] Year after year the legislature hears testimony from teachers and their representatives about how stretched thin they are mentally, emotionally, and physically. We hear about lack of personnel, large student-to-teacher ratios, high teacher and support staff turnover, underfunding, and burnout. Does this sound like an environment ready to tackle the medical needs of minor students? SBHCs will not take any burden from these schools since teachers and support staff must continually monitor students after their health appointments for adverse reactions and trauma. Since trauma and injury is the number one cause of death for children in this age group, this is a serious issue that cannot be overlooked or minimized. Adding additional burdens to teachers and support staff will not improve outcomes or morale for the teachers nor will it improve educational or medical outcomes for the students.

Finally, the current law already includes too much healthcare integration within schools by requiring hearing and vision screenings. See the five reasons above why these should be conducted with a primary care provider. Further, Stand for Health Freedom believes the current requirements under Indiana Administrative Code (listed in the chart below) need to be eliminated completely. These requirements are invasive to families and burdensome to schools. In addition, Stand for Health Freedom would like a rollback of SBHCs that are already in existence, based on the reasoning above.

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[21] "Chapter 2: Opinions on Consent, Communication & Decision Making." *American Medical Association - Code of Medical Ethics*, June 2019, https://www.ama-assn.org/system/files/2019-06/code-of-medical-ethics-chapter-2.pdf.

[22] English, A, and L Tereszkiewicz. "School-Based Health Clinics: Legal Issues." *Office of Justice Programs*, U.S. Department of Justice, 1988, https://www.ojp.gov/ncjrs/virtual-library/abstracts/school-based-health-clinics-legal-issues.

[23] Barrington, Kate. "The 15 Biggest Failures of the American Public Education System." *Public School Review*, 27 May 2022, https://www.publicschoolreview.com/blog/the-15-biggest-failures-of-the-american-public-education-system.

Table 13: Indiana Administrative Code School Health Services Requirements

Prevention	• Creating a safe and healthful school environment through a continuous health program • Employing principles of learning and appropriate teaching in the delivery of health education • Acting as a resource to students, families, staff, and the community regarding health services, health education, and a healthy environment
Assessment	• Maintaining a continuous health program for all students through implementing and monitoring health services • Using the nursing process to collect, interpret, and record information about the health, developmental, and educational status of students to determine a nursing diagnosis and develop healthcare plans
Intervention	• Implementing and monitoring a system for the provision of health services and emergency care • Providing individual and group counseling to students and staff in health-related matters • Communicating with parents and collaborating with others to facilitate the continuity of services and care
Referral	• Utilizing appropriate healthcare personnel and resources to meet individual student needs • Evaluating student and family responses to nursing actions and referrals • Coordinating health services with families, other school programs, in-school professionals, school-based and community-based resources

Conclusion

According to the GPHC report, the leading cause of death for Hoosiers aged 1-44 (59% of Indiana's population) is trauma-related injuries. The leading cause of death for all Hoosiers, regardless of age, is heart disease, followed by cancer.[24] Unfortunately, none of the GPHC's recommendations will reduce these deaths, with the exception of their recommendation to increase EMS funding to better respond to trauma-related emergencies. In fact, the GPHC's recommendations will not reduce mortality for any of the top 10 causes of death in Indiana, with the exception of the potential increased EMS funding. Yet, their financial requests (of taxpayer dollars) are one of the largest budget increases in our state's history, at a time when most Hoosiers are experiencing profound suffering due to record-setting inflation. In the last year, inflation has risen over 9%, meaning Hoosiers now spend one month per year working for free compared to last year's dollars.[25] Any substantial budget increase always needs to be heavily scrutinized, but especially in the current climate and especially when the increase is permanent. In addition, the GPHC has provided zero evidence that their recommendations will lead to improved health outcomes for Hoosiers. Their legislative recommendations would substantially expand the scope and powers of IDOH, simultaneously reversing Indiana's decentralized public health structure. The current model provides local control and allows LHDs to determine their greatest needs, addressing them in whichever ways they think best (without the additional burden and red tape that a centralized model demands). Local control ensures credibility and accountability within the local jurisdiction and encourages public accessibility by tailoring services to the specific local needs.

[24] "Indiana." *National Center for Health Statistics*, Centers for Disease Control and Prevention, 9 Feb. 2022, https://www.cdc.gov/nchs/pressroom/states/indiana/in.htm.

[25] "Consumer Prices up 9.1 Percent over the Year Ended June 2022, Largest Increase in 40 Years." *TED: The Economics Daily*, U.S. Bureau of Labor Statistics, 18 July 2022, https://www.bls.gov/opub/ted/2022/consumer-prices-up-9-1-percent-over-the-year-ended-june-2022-largest-increase-in-40-years.htm.

The GPHC provides a helpful chart on page 36 which clarifies the statutory scope of duties for LHDs under current Indiana Code and Indiana Administrative Code. None of the existing public health statutory requirements demand additional powers of public health agencies to fulfill their duties. That means all of the GPHC recommendations require expansion of statutory duties, powers, and funding. Are these additional recommendations needed? For any that may be needed, are they truly public health issues or are they private health issues better resolved individually with a primary care provider? Stand for Health Freedom does not see the value of local health departments providing individualized healthcare services with taxpayer dollars, especially in a one-size-fits-all approach that public health delivery requires.

In addition, the GPHC recommendations would substantially and invasively increase public health surveillance of all Hoosiers **and** mandate the sharing of the additional data with private HIE partners who can use our data in whichever ways they see fit (including selling our data). COVID-19 drastically increased the amount of surveillance conducted on Americans (according to the report) and the GPHC is recommending the additional surveillance remain permanent, even expanding it further. Stand for Health Freedom intensely opposes any surveilling, tracking, and integration of individually identifiable Hoosier health data, including and especially in the public health sector. HIPAA regulations do not apply to public health agencies and when public health agencies share our health data with third parties, such as HIE partners, our data is also not governed by HIPAA.[26] Tighter regulation over health data is needed to close the gaps on these invasive practices and restore health privacy to Hoosiers.

Finally, the GPHC recommends increasing the amount of health services provided at school, disregarding research that shows family involvement is crucial to improving health outcomes in children. Whether these recommendations were made due to private profits or convenience, they do not prioritize the health of the child nor the role of the parents. Schools are a place for learning and hospitals and clinics are places for healthcare services; no amount of overlap is justifiable, especially when schools are already struggling to fulfill their primary responsibilities. Not only should the legislature reject the recommendations to expand SBHCs in schools, but they should go a step further and specifically disallow them while also removing the language requiring healthcare screening services (such as vision and hearing screenings) that occur in schools currently. Maybe then, schools can get back to focusing on the education of students, with fewer onerous, unrelated additional requirements being placed on them.

Stand for Health Freedom encourages feedback and an open dialogue with legislators and other stakeholders regarding our analysis. To continue the discussion, please reach out to Co-Founder and Executive Director, Leah Wilson at Leah@standforhealthfreedom.com.

[26] "FAQs About HIPAA Privacy Rule, Provisions Relevant to Public Health Practice." *Centers for Disease Control and Prevention*, National Healthcare Safety Network (NHSN), 27 Jan. 2015, http://www.cdc.gov/nhsn/hipaa/index.html.